the trial will coincide in proving that screening under the age of 50 has backing only from the emotive and from neither the scientific nor the economic communities.

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Greater attempts must be made to promote positive roles for elderly people

EDITOR—It is disappointing to read that the issue of family support for China's aging population is a "bad" consequence of the country's policy of controlling fertility.¹ Population aging is an inevitable consequence of successful social and economic development (including maternal and child health programmes), which results in demographic transitions from high to low mortality and fertility.² Labelling the social consequences of such trends as "bad" adds weight to negative images of elderly people in society.

Elderly people often have a major role in child care (and also in the care of frail and disabled people), which permits younger women to take up wage earning jobs. In poorer countries many elderly people remain economically and socially productive beyond usual retirement ages. Most families—in the West, in Asia, and elsewhere—want to support their elders when they become frail. Projections of crude aged dependency ratios (ratios of the population aged ≥ 60 to that aged 15-59) give little indication of true levels of dependency (which are affected by levels of unemployment, disability, and pensions) but give a negative stereotype of all elderly people as dependent and in need of support. Furthermore, elderly people in China have an important, but currently untapped, role as the repositories of a history and culture that has gone through substantial and rapid changes over recent years.

Aging populations require policy responses, but it is clear that no single formula or solution will fit all circumstances equally well. Public and private sector pensions and legislative and cultural support for unpaid family and community support may all be required, but the balance of each will differ over time and from place to place.³ A first and essential step, however, is to view "the elderly" as people with rights and not as problems.

Ageist societies deny these possibilities for elderly people and persist in promoting stereotypes of old age that bear little relation to reality. It is a pity that researchers at the Institute of International Child Health are not more aware of these issues, which are so relevant to many of their activities. The promotion of positive roles for elderly people,

family support, and intergenerational solidarity would be improved if organisations and individuals involved in health and social development were more aware of the positive aspects of population aging. Such awareness is now increasingly pursued by international agencies such as the World Health Organisation. Efforts from the academic sector would be timely and welcome.

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Alliance between medical profession and consumers already exists in breast cancer

EDITOR—The alliance between the medical profession and consumers that Liberati calls for in his editorial¹ is already a reality in the Britain; was promoted by its chairman (me) at the exploratory meeting of the Cochrane Collaboration Breast Cancer Review Group in Sydney, Australia, in August 1995; and is collaborating with interested clinicians in Germany to set up a similar group. It has received NHS funding for a project, "Using a consumers' advisory group to increase accrual into trials," to explore a methodology through use of focus groups. The results of this activity have gone forward to help shape the national randomised trial of hormone replacement therapy in women with early stage breast cancer. I, as the chairman of the Consumers' Advisory Group for Clinical Trials, and two representatives of patients from the focus groups are on the steering committee of this ground breaking trial. The provision of suitable and adequate information is seen as crucial: its provision has been guided by the views of women obtained in a project run by the consumers' advisory group in collaboration with the patient involvement unit at Mount Vernon Hospital.

The Consumers' Advisory Group for Clinical Trials is a small working group of professionals and patients that was established in September 1994. Its formation reflected a growing recognition by the health profession of the value of input from patients into the design of clinical trials.² In 1995 it was registered as a charity and was welcomed by the health select committee in its report on breast cancer,³ and its activity is furthered by the United Kingdom Coordinating Committee for Cancer Research. It has had opportunities to provide comment on other trials—for example, the Arimidex tamoxifen alone and in combination trial.

Our main activities are to work directly with the profession on protocols, to devise and improve methodologies, and to advance public education about clinical trials. We believe that awareness of the activities of other support and information organisations, and collaboration with them and others working in breast cancer will help achieve these aims. We wish to promote a new attitude to research based on the belief that patients and the profession alike have a responsibility to further the progress of research as rapidly as possible. Our type of collaborative activity is endlessly repeatable, in other countries and other disciplines.

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Practice in prescribing emergency contraceptives in A and E departments varies

EDITOR—The management of patients who present to accident and emergency departments requiring emergency contraception remains controversial and inconsistent. From a total of 400 consultants in accident and emergency medicine in the United Kingdom we randomly selected 130 and sent a questionnaire about prescription of the emergency contraceptive pill. Altogether 102 consultants (78.5%) replied, and the table gives their responses.

Responses of 102 accident and emergency consultants questioned about prescription of emergency contraceptive pill

Response	No
Never prescribe	39
Always prescribe	10
Prescribe only if patient can't see general practitioner within 72 hours	45
No fixed policy: at attending doctor's discretion	8

Our results show an alarming conflict of practice, which leaves patients unsure whether they will receive the required help when attending accident and emergency departments. Despite reports showing the safety of emergency contraception in all but a few situations, strong beliefs still persist among doctors that it is medically unsafe and should therefore be prescribed with great care.¹ Other studies have shown that providing women with a leaflet about emergency contraception was an effective means of communication.² Practices used by many of the respondents to our questionnaire were at variance with recommendations published recently encouraging the deregulation of the morning after pill.^{3 4}

We conclude, firstly, that the management of women who present to accident and emergency departments requiring emergency contraception is in disarray and that experts should suggest a common approach. This would ensure consistent management throughout the United Kingdom based on published data reflecting the safety of such drug treatment. Secondly, any protocol should be realistic and should spare women the inconvenience and often the embarrassment of seeking such emergency care; it should also include recommendations concerning follow up.

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cult cases were given the benefit of the doubt (that is, attributed to thalidomide), and some decisions were made by doctors who lacked the necessary experience. It was inevitable that some of these people had not, in fact, been damaged by thalidomide.

So long as the media are prepared to perpetuate the myth of second generation defects due to thalidomide, medical scientists must spend time refuting it. The myth raises hopes of additional compensation for the few but, more importantly, it raises fears among people with defects due to thalidomide that their future children are at serious risk of being born with similar defects. Even those who have completed their families and whose children are healthy may fear third generation defects in their grandchildren.

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Dominant gene probably caused some of defects ascribed to thalidomide

EDITOR—The journal *Teratogenesis, Carcinogenesis and Mutagenesis* published a highly controversial paper by Huang and McBride purporting to show experimental evidence which might "explain" second generation defects in the offspring of people accepted as having been damaged by thalidomide.¹ Bower asks why the journal should publish this paper alongside a devastating critique by Neubert, a member of the journal's editorial board, saying that "the paper ... contains so many inadequacies that it is impossible to draw any conclusions."²

I wish to put the record straight. Dr McBride's work was not "presented to the European Toxicology Society in Dublin five years ago." According to Professor Neubert's paper, Dr McBride's data were presented in Dublin at the time of the European Teratology Society's meeting but outside the regular programme and were therefore not included in the abstracts of that meeting. The data were "released by the authors (without knowledge of the organisers) to the press as highlight of this meeting." There is therefore no valid experimental evidence to support the "second generation" hypothesis.

The second strand to the media story is that a small number of people who were accepted as having been damaged by thalidomide have become parents of similarly affected children. The only reasonable conclusion is that a dominant gene is responsible in both generations. When decisions were being made in the 1960s and 1970s about who had and who had not been damaged by thalidomide, a number of diffi-

Allergic contact dermatitis to oestradiol patches might have been expected

EDITOR—In their comparison of two transdermal oestradiol patches Ross et al conclude that matrix patches of oestradiol irritate the skin less than reservoir patches.¹ They do not, however, distinguish between irritant and allergic skin reactions.

Allergic contact dermatitis is specific to a particular agent and has been reported as due to various components of the oestradiol patch system, including the active ingredient itself,² the adhesive,³ ethanol,⁴ and hydroxypropylcellulose.⁵ These reactions require sensitisation and occur only in genetically determined individuals capable of being sensitised to a given antigen. They tend to spread away from the contact site, consist of papules and vesicles, and increase in severity in the 48 hours after the patch is removed.

In contrast, irritant or non-immunological reactions are non-specific and do not require sensitisation. Responses to irritants occur in all members of the population, but susceptibility varies. Irritant reactions to transdermal delivery systems are more common than allergic reactions. They are due to the adhesive and frictional effects of the patch and consist mainly of erythema. The occlusive nature of the patch may also cause mechanical plugging of the follicular and sweat gland openings, resulting in folliculitis and miliaria rubra. These are usually localised to the site of contact and resolve quickly after removal of the patch.

Most of the women in Ross et al's study (70 of 82) had previously stopped using a reservoir patch because of a cutaneous reaction. If these were allergic reactions then most of the study population was

already sensitised to a component of the reservoir patch. It is therefore not unexpected that substitution with a matrix patch (with different components except for the active oestrogen ingredient) and avoidance of the allergen resulted in fewer cutaneous reactions.

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Potential biases were not taken into account in study of waiting times

EDITOR—Before Dowling's conclusion—that fundholding shortens waiting times—is accepted, four potential biases need to be considered.¹

Firstly, more information is required about the completeness and accuracy of the data that he analysed: only a small sample of patients' records in a single, possibly unrepresentative, general practice was checked. It would have been better to check a larger, randomly selected, sample at each of the four trusts.

Secondly, as Dowling points out, he limited the study to the 61% of patients placed on a waiting list without being given an indication of their time of admission. If this proportion differed between fundholding and non-fundholding practices a difference in waiting time could have arisen.

Thirdly, a difference in case mix (in particular, the mix of procedures) could have contributed to the observed differences in waiting times. Some attempt at risk adjustment using the variables he collected (age, sex, diagnosis) was needed and possible.

Fourthly, the results are based on the mean waiting time rather than the median. Distributions of waiting time are usually extremely skewed, and therefore the mean can give a misleading picture.

Possibly none of these potential biases will have affected the results. Nevertheless, a more cautious interpretation of the data is warranted until they have been considered.

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