United States was designed to reduce disparities in mortality due to cancer by targeting primarily low income and uninsured women. The programme has delivered notable improvements in access to screening for minority groups that lagged behind in the 1990s,⁸ with Hispanic and Native American women largely over-represented among its beneficiaries, relative to their share in the poorest 25% of the population.⁹ This result was obtained at the expense of an under-representation of white and African-American women. To what extent the redistribution of screening among racial and ethnic groups was planned is unclear, as many factors may have contributed to the outcome. For example, Hispanic women may be more likely to be targeted because of their higher uninsured rates, and more of them may have taken up screening independently of the programme.⁸

The question remains whether governments are prepared to step up efforts to reduce ethnic disparities to the point of implementing more aggressive measures to influence priorities in the delivery of health care. The spirit of the recent ruling by the US Supreme Court seems to permit this, as long as such measures are narrowly tailored. Recent legislation in the United Kingdom similarly places "a general duty on public authorities to work towards the elimination of unlawful discrimination and promote equality of opportunity ... between persons of different racial groups."¹⁰ Moving on from this statement of principle, national service frameworks and guidance from the National Institute for Clinical Excellence may increasingly be used to set priorities and standards for redressing disparities in relation to specific conditions and treatments. Primary care trusts may have to implement these priorities locally, through targeted resource allocation. Monitoring by the Commission for Healthcare Audit and Inspection, possibly based on systems currently being piloted in the United States,¹¹ may also help ensure progress towards a fair distribution of health care.

But difficult tradeoffs may be involved, given the strains on government resources.¹² Resistance to

accepting the consequences of such tradeoffs, coupled with the fragility of political coalitions supporting the underserved and deeply rooted cultural attitudes that tend to perpetuate disparities, require governments to be transparent and assertive about committing the appropriate resources, as well as about measuring the impact of their efforts.

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Vulval vestibulitis

Is a common and poorly recognised cause of dyspareunia

Vulval vestibulitis or vestibulodynia is one of the vulval pain syndromes and is characterised by burning and soreness at the vaginal introitus at attempted penetration.¹ It is found predominantly in young, well educated, white women. Although the prevalence is unknown, a recent, as yet unpublished, survey in community settings in west Hertfordshire shows a prevalence of 2.8-9.3%. The diagnosis is based on a triad of findings—penetrative pain, introital tenderness, and patchy erythema localised to the orifices of the vestibular glands in the absence of an infective, inflammatory, or neoplastic cause.¹ The burning nature of the pain is typical of dysaesthesia, and many patients go on to develop more persistent and generalised vulval pain that would be compatible with dysaesthetic vulvodynia, a condition classically found in older women. The pain of vulval

vestibulitis should be distinguished from vulval pruritus, which has different causes.

The cause of the condition is unknown, attempts to identify an infective cause have been unsuccessful, and no characteristic histological findings are known.² The subtlety of the physical findings may lead some clinicians to say that "there is nothing wrong" and attribute the symptoms to a psychosomatic disorder.

Vulval vestibulitis is poorly recognised by primary care doctors and some gynaecologists, and this may lead to patients repeatedly seeking a diagnosis from a variety of clinicians over a long period of time.³ A common misdiagnosis is recurrent thrush. Such patients will explain that they have tried all the currently available preparations against candidiasis, without relief of symptoms.

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Once the condition is recognised, the patient is best referred to a specialist vulval clinic. Different local arrangements pertain in the United Kingdom, some clinics being multidisciplinary and some led by dermatologists, gynaecologists, or genitourinary physicians. Since the cause of the condition is poorly understood, management is largely pragmatic and several models of care exist. The evidence base for treatment is poor.

Establishing the diagnosis and offering the patients a sympathetic hearing is an important first step. Patients are reassured by the fact that the condition is not psychosomatic in origin and that anxiety, low mood, and reduced pleasurable sensations with sexual arousal are common byproducts of chronic pain that has become associated with sex. No consistent evidence exists to date to show that women with vulval vestibulitis have an increased background rate of psychological disorders. The chronicity and severity of the symptoms often leads to secondary effects on psychological wellbeing and self esteem. This may lead to secondary sexual dysfunction in the patient or her partner, which in turn can exacerbate psychological distress, emotional disequilibrium, low self esteem, and reduced sexual and social functioning.⁴ All of these can become maintaining factors in the condition.

Advice about vulval hygiene practices is required, and patients should be advised to avoid soaps, shower gels, and similar products, and to wash with aqueous cream or emulsifying ointment.⁵ Topical local anaesthetics such as lignocaine ointment are often helpful.⁶ Topical steroid ointments and creams, oestrogen creams, and topical ketoconazole have been used in some centres,⁷ and anecdotal data support their use in some patients. A popular treatment in North America is the use of a diet low in oxalates. This was described in a single case report,⁸ but, in the absence of better evidence, it may perhaps be offered to some patients who prefer a non-medicalised approach to treatment.⁹ Many patients turn to complementary therapies.

Glazer et al have proposed that the condition is caused by a dysfunction of the pelvic floor muscles and have published impressive results for a biofeedback technique.¹⁰ Many patients do have pelvic floor dysfunction, but in some cases this seems to be secondary to the pain. Low dose amitriptyline is the treatment of choice for dysaesthetic vulvodynia and may be useful in some patients, particularly when the pain is not

restricted to attempted vaginal penetration.¹¹ In North America, vestibulectomy, a procedure that involves excision of all or part of the vestibule, has been a popular treatment. Bergeron et al have reviewed 20 published case series and note that impressive results have been obtained, but the lack of controlled studies or long term follow up throws considerable doubt on the validity of the conclusions.¹² In the United Kingdom, this procedure is rarely used.

Whatever therapeutic approach is adopted, the psychological, interpersonal, sexual, and social consequences of the condition need to be assessed. Every clinician managing patients with the condition should have access to a psychologist or psychotherapist with experience of managing sexual dysfunctions in individuals and couples. Many patients find that support from other patients may be helpful. In the United Kingdom, the Vulval Pain Society (www.vul-pain.dircon.co.uk) provides a useful handbook for patients, as does the US National Vulvodynia Association (www.nva.com).

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Inhaled insulin

May prove to be a panacea

For over 80 years exogenous insulin has been given by injection. The injection devices have improved—disposable syringes and pen injection devices are more convenient and less traumatic than the boil to sterilise, use until too blunt devices of yesterday—but patients and healthcare professionals remain uneasy about the concept of injections. Yet the evidence based drive for increasingly tight glycaemic control means that more patients should be offered more injections. A recent attempt to circumvent the need for injection that may soon hit a clinic near you is the use of the

lung as an absorption pathway, with the development of insulins to be taken by inhalation. Two versions, a powder and an aerosol, may be nearing launch.

Insulin can be effective given by inhalation. This was first shown in 1971, although the early work was not pursued, and it was not until 2000 that the modern era of inhaled insulin began.^{1 2} The bioavailability is 10-15% and the dose equivalent about three times that of injected insulin. The pharmacodynamics of inhaled insulin offer an action profile with a fast onset (although slightly longer run-off) akin to that of rapid