state to tattoo (CT, FL, IN, MA, VT);
- creating hygiene standards for the tattoo studios (AK, HI, ME);
- setting a minimum age below which a person is not permitted to receive a tattoo (IL, NH, NC, PA, TN, TX).

Since the 1950s it has been well documented that hepatitis B can be spread by tattooing, and there is some evidence to suggest that HIV (human immunodeficiency virus—the etiologic agent of acquired immunodeficiency syndrome) is also spread via this vector. Tattoo studios must be monitored to maintain a level of hygiene which requires the sterilization of the non-disposable equipment used during the process of tattooing.

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For a reprint of the cited article[1] contact the author at PO Box 1860, Warren, OH 44482-1860.

Comment on Changes in Alcohol-Related Inpatient Care

Romelsjö and Diderichsen do not pay enough attention to their data on women.[1] They fail to call attention to the most deviant cells in their data, a 1981/1976 Standardized Rate Ratio (SRR) of 1.73 for non-manual worker women for liver cirrhosis and an SRR of 1.39 for inpatient care for Alcohol Psychosis/Alcoholism/Alcohol Intoxication (AAA) for manual worker women. Most striking, however, are the increases between 1976 and 1981 in the rates of inpatient care for AAA for women age 25 and over regardless of socioeconomic status.

Elsewhere their data intriguingly suggest that despite general downward socioeconomic mobility in their entire sample (mainly associated, presumably, with age and separation from the workforce) proportionately more women than men seem to have experienced upward socioeconomic mobility. Is there a possible association between this apparently greater upward mobility for women and an increase in inpatient care for women for AAA? The only group of women who did not experience an increase in inpatient care for AAA were women ages 15 through 24, who had not yet had as much opportunity for upward mobility through employment.

Romelsjö and Diderichsen demonstrate that total rates of inpatient treatment for alcohol-related diagnoses have generally declined, but the gap between blue collar workers and white collar workers has widened. They conclude that the goal of a reduction of per capita consumption "should be combined with additional measures that will reach all social groups."[1] It would seem that such measures need to be addressed to blue collar workers in particular but to women in general.

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Response from Romelsjö and Diderichsen

Dr. Ernst is right; we did not explicitly comment on the 1981/1976 SRR values of 1.73 for non-manual worker women for liver cirrhosis and 1.39 for manual worker women for Alcohol Psychosis/Alcoholism/Alcohol Intoxication (AAA). The increase in liver cirrhosis for non-manual females employed was only seven cases, however. Our comment that the "the decrease was generally greater, or the increase smaller, among non-manual employees than among manual workers in both sexes"[1] is in agreement with the increase among female manual workers for AAA. The differences in trends generally among men and women was mentioned in the Introduction to our paper, and have been discussed in more detail elsewhere.[2–4] The changes can to some extent be attributed to an increase in real income from 1968 to 1981 especially among women (compared to men) and among manual employees.[5] Available survey data, albeit rather sparse, indicate an increase in alcohol consumption especially among manual workers in both sexes since the end of the 1960s.[2–4] So there is a rough correlation between data on trends in income, alcohol consumption and measures of alcohol problems with regard to sex, socioeconomic position, and age. The influence of an increase in employment rates for women in Stockholm county (from 67.5 percent in 1976 to 72.5 percent in 1981) on alcohol consumption is uncertain. The corresponding figures among men were 81.7 percent viz 80.0 percent, while the unemployment rates were around 1–1.5 percent for both sexes both in 1976 and in 1981.

We do not know with certainty if there has been an increase among physicians in the awareness of possible alcohol problems especially among female patients between 1976 and 1981, even if our questionnaire did not indicate such a change. The paper could have benefitted from a discussion of the relation between changes in economic and social position over time and alcohol consumption among various occupational categories, which Dr. Ernst seems to have had in mind. A general decline in the rates of an important health problem combined with increased social differences has been observed earlier.[6] Is there any strategy other than political to achieve a reduction in social inequalities of important health problems?

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Behavior of Clients of Prostitutes

Although some attention has focused on the role of female prostitutes in the contraction and transmission of