

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Should religious circumcisions be performed on the NHS?

SIR,—In areas such as west Yorkshire that have a large Moslem population a heavy demand exists for religious circumcisions. In 1989 we informed general practitioners that we were unable to perform religious circumcisions because of the length of our waiting lists. Since then we have admitted six boys with complications of religious circumcisions performed outside hospital.

Our first case was in a six week old boy admitted with convulsions and urinary retention due to septicaemia and urinary tract infection. He also had an associated urethral fistula. In the second case an 11 month old boy was admitted with a degloved penis two days after circumcison. Under general anaesthetic we obtained adequate skin coverage at the expense of a 30° rotational deformity.

The next cases were in two brothers aged 2 and 3, who presented one week after circumcison, with adherent bandages contaminated by the wound. Attempts to remove the bandages by bathing failed, so they were removed under anaesthetic. In both boys the skin and mucosa had separated over more than half of the circumference and they needed formal suturing. Two other boys, aged 2 and 5 presented after being circumcised with Plastibels. The boys needed a general anaesthetic to permit removal of these devices. One boy had pus underneath the Plastibel, and the

other had complete separation of the skin and mucosa, which required secondary suture.

During 1989, 104 circumcisions were performed in our unit. Only one boy had to be taken back to the operating theatre: from the recovery room to control bleeding. Other lesser complications followed a similar pattern to those reported by others.¹

Neonatal circumcisions in the Jewish faith are performed on the 8 day old boys by specially trained Rabbis, but the timing and arrangements for Moslem circumcison are less uniform. Patients requiring religious circumcison payed £25-30 for the operation, with the price rising to £50 if an inhalational anaesthetic was given.

If the six boys described had been circumcised in hospital we believe that these complications would have been avoided. Moreover, all six patients required admission to hospital for at least one night, costing the NHS more than if they had initially been treated as a day case. Thus the waiting list pressures that forced us to stop performing religious circumcisions have incurred unforeseen costs to the NHS.

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¹ Griffiths DM, Atwell JD, Freeman ND. A prospective survey of the indications and morbidity of circumcison in children. *Eur Urol* 1985;11:184-7.

Diagnosis of Alzheimer's disease

SIR,—We are somewhat perplexed by the paper by Dr Alistair Burns and colleagues, which purports to show that Alzheimer's disease can be accurately diagnosed during life without the need for extensive investigation and resources.¹ Would that it were so.

To prove their point they took 50 patients whom they had diagnosed as having probable or possible Alzheimer's disease and who had had a neuropathological diagnosis. Their diagnosis was correct in 75% of patients with probable disease and 56% of those with possible disease (these figures are lower than the ones that they quoted as we have excluded patients with mixed pictures in whom the other condition could be the more important). Though their success rate was slightly higher for patients with probable disease than for those with possible disease, the difference was not significant. This information tells us little about their diagnostic accuracy as we do not know how many patients were thought not to have Alzheimer's disease and were subsequently found to have it. We would question a study in which no patients were found

to have multi-infarct dementia as in our study 16 out of 27 patients had this diagnosis.² Multi-infarct dementia is known to be more difficult to diagnose clinically.³

We also dispute their conclusion that accurate diagnosis does not require extensive investigation and resources. Quite apart from their own moderate level of accuracy the criteria they used includes the statement "absence of systemic disorders or other brain diseases that in and of themselves could account for the progressive deficits in memory and cognition." Clearly the accuracy of the diagnosis will depend on the rigour with which these diseases are sought and excluded. We are not told which investigations were performed, and thus could critically affect the success rate and the truth of the need for extensive investigations and resources.

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¹ Burns A, Luthert P, Levy R, Jacoby R, Lantos P. Accuracy of clinical diagnosis of Alzheimer's disease. *BMJ* 1990;301:1026. (3 November.)

² Homer A, Honavar M, Lantos P, Hastie I, Kellett J, Millard P. Diagnosing dementia: Do we get it right? *BMJ* 1989;297:894-6.

³ Fischer P, Gatterer G, Marterer A, Simanyi M, Danielczyk W. Course characteristics in the differentiation of dementia of the Alzheimer type and multi-infarct dementia. *Acta Psychiatr Scand* 1990;81:551-3.

SIR,—Dr Alistair Burns and colleagues provided too little detail of their methods to allow useful interpretation of their results.¹ Many questions remain unanswered.

How were the patients identified and selected? Referral bias may distort the results considerably. For example, the length of the dementing history is important: if only patients with longstanding dementia are studied those patients with dementias that lead to an early death will be underrepresented. Did all the patients have computed tomography? Were the neuropathologists blind to the clinical classification of the patients? If they were unblinded reporting bias may have led to a falsely high rate of pathological confirmation of Alzheimer's disease in this cohort.

By reporting interim results on the first 86 patients who have died they have biased their results to include patients with the worst survival. These patients, for example, may have been older or have had a more severe dementia than the survivors in this cohort.

Their paper refers to the accuracy of diagnosis, which is usually taken to imply both sensitivity and specificity. The authors incorrectly refer to the sensitivity of the clinical criteria; they should have used the term positive predictive value, which in this case is 84% (42/50).

To conclude from a study of highly selected patients who were thought to have Alzheimer's disease that cortical Lewy body disease is the second most common neurodegenerative dementia in old age seems unwise. This conclusion should be drawn only from a study of unselected elderly patients with dementia. It is to be hoped that in the next few years we will have more treatments to test in Alzheimer's disease, and it is therefore vital that we develop accurate methods of diagnosing Alzheimer's disease during life.

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¹ Burns A, Luthert P, Levy R, Jacoby R, Lantos P. Accuracy of clinical diagnosis of Alzheimer's disease. *BMJ* 1990;301:1026. (3 November.)

² McKhann G, Drachman D, Folstein M, Katzman R, Price D, Stadlan E. Clinical diagnosis of Alzheimer's disease: report of the NINCDS/ADRDA work group under the auspices of Department of Health and Human Services Task Force on Alzheimer's Disease. *Neurology* 1984;34:939-44.

SIR,—The results of Dr Alistair Burns and colleagues are not a measure of sensitivity of the