though the drug had been stopped several years previously.[4] More recently 25% of 60 patients given thalidomide to manage chronic discoid lupus erythematosus were reported to have developed thalidomide neuropathy[5] and all eight patients given thalidomide for nodular prurigo and aphthous stomatitis were found to have a neuropathy.[6]

Despite warnings,[7,8] thalidomide has been used for over 20 years to manage erythema nodosum leprosum, and Waters states that "thalidomide peripheral neuropathy has not yet been reported" in such patients.[3] This statement requires clarification. Is it implying that neuropathy does not occur in patients with erythema nodosum leprosum given the drug or is it that Waters and leprologists who use thalidomide are unable to detect symptoms and signs of nerve damage?

C L CRAWFORD

Department of Anatomy,
Charing Cross and Westminster Medical School,
London W6 8RF

1 Malin AS, Waters MFR, Shehade SA, Roberts MM. Leprosy in reaction: a medical emergency. *BMJ* 1991;**302**:1324-6. (1 June.)
2 Anonymous. Thalidomide. In: Reynolds JEF, ed. *Martindale: the extra pharmacopoeia*. 29th ed. London: Pharmaceutical Press, 1989:1621-2.
3 Waters MFR. Leprosy (Hansen's disease/hanseniasis). In: Weatherall DJ, Ledingham JGG, Warrell DA, eds. *Oxford textbook of medicine*. 2nd ed. Oxford: Oxford University Press, 1987:5.305-13.
4 Fullerton PM, O'Sullivan DJ. Thalidomide neuropathy; a clinical, electrophysiological, and histological follow-up study. *J Neurol Neurosurg Psychiatry* 1968;**31**:543-51.
5 Knop J, Bonsmann G, Happle R, Ludolph A, Matz DR, Mifsud EJ, *et al*. Thalidomide in the treatment of 60 cases of chronic discoid lupus erythematosus. *Br J Dermatol* 1983;**108**:461-6.
6 Wulf CH, Hoyer H, Asboe-Hansen G, Brodthagen H. Development of polyneuropathy during thalidomide therapy. *Br J Dermatol* 1985;**112**:475-80.
7 Crawford CL. Thalidomide neuropathy. *Lepr Rev* 1969;**40**: 126-8.
8 Crawford CL. Treatment of erythema nodosum leprosum with thalidomide. *Lancet* 1973;ii:567-8.

HIV infection and hepatitis B in adopted Romanian children

SIR,—Dr John Kurtz's letter[1] did not surprise me: I have seen the conditions in which babies live in orphanages in Romania. Many are said to be infected with HIV and hepatitis B virus because they were underweight at birth and given a transfusion of blood. Rudimentary precautions are still not taken, and syringes are reused many times because of shortages. We send over disposable syringes and disposal bins, but there are no high temperature incinerators in which to burn them. The dustbin area of one orphanage was littered with used syringes and dirty dressings.

Our basic training programme tries to teach proper procedures to the untrained care staff and inadequately trained medical staff, but they are so used to supplies running out that they are unwilling to throw something away when it is not actually broken. They generally haven't heard of AIDS.

PAM HANNAM

Bristol Society for the Mentally Handicapped (Mencap),
Bristol BS8 3ES

1 Kurtz J. HIV infection and hepatitis B in adopted Romanian children. *BMJ* 1991;**302**:1399. (8 June.)

SIR,—Having recently returned from working in Romania for four months, I am not surprised by Dr John Kurtz's report of the numbers of adopted Romanian children he has tested who are positive for markers of HIV infection and hepatitis B.[1] Both conditions are common in the orphanages for children up to 3 years old. Though accurate figures for the numbers of affected children are difficult to obtain, many Romanian paediatricians are increasingly aware of the extent of the problem.

The deficiencies of the service in terms of both equipment and knowledge, however, take time to rectify. Unfortunately, palatable oral antibiotics are scarce and therefore most antibiotics are given intramuscularly. The immunisation programme in Romania has an excellent uptake rate (100% in the orphanages in the Bacau area), but this also increases the number of injections children receive.

Though generous people from many countries have sent large numbers of disposable syringes and needles to orphanages, clinics, and hospitals, there is a continuing shortage. For those staff who have had to save and make do with minimal equipment for so many years in the past, to throw out a syringe and needle after a single use is difficult. There is also now the practical problem of how to get rid of large amounts of single use equipment. The risk of infection from contaminated syringes therefore remains and seems to be far greater than that of intrauterine spread.[2,3]

I am therefore greatly concerned that the newborn babies who are adopted straight from maternity hospital may be put at risk by having a blood sample taken for tests for markers of hepatitis B or HIV infection before they leave the hospital; these tests are unreliable in neonates, who are, anyway, a low risk group.

JUDITH M DARMADY

Basingstoke District Hospital,
Basingstoke,
Hants RG24 9NA

1 Kurtz J. HIV infection and hepatitis B in adopted Romanian children. *BMJ* 1991;**302**:1399. (8 June.)
2 Rubin CH, Berger R, Tobler R, Nars PW, Just M, Pavic N. HIV, hepatitis (A, B, and C) and measles in Romanian children. *Lancet* 1990;**336**:1592-3.
3 Patrascan IV, Constantinescu SN, Dublant A. HIV-1 infections in Romanian children. *Lancet* 1990;**335**:672.

Product licence for an injectable contraceptive

SIR,—The emphasis on promoting wider use of injectable contraception in the review article on the current state of contraception was heartening.[1] The nature of the limited licence granted for Depo-Provera (medroxyprogesterone acetate) in the United Kingdom, however, needs clarifying.

The product licence on the datasheet, following the guidelines of the Committee on Safety of Medicines, says that it is intended for long term contraception "only in women in whom other contraceptives are contraindicated or have caused unacceptable side effects or are otherwise unsatisfactory." In reality this does not limit its prescription at all and allows it and similar preparations to be included in the range of contraceptives we can offer patients in the United Kingdom.

ELIZABETH SUDLOW

Family Planning and Well Woman Services,
Lothian Health Board Primary Care and Community Unit,
Edinburgh EH4 1NL

1 Szarewski A, Guillebaud J. Contraception. *BMJ* 1991;**302**: 1224-6. (25 May.)

Morphine for painful crises in sickle cell disease

SIR,—I agree entirely with Professor Geoffrey Chamberlain's statement in his comprehensive account of medical problems in pregnancy that "controversy exists about the value of regular exchange transfusions" in sickle cell disease.[1] But he places "Morphine for pain" at the top of a list of six items required for the treatment of sickle cell crisis without any indication that this is also controversial.

In nearly 1000 cases of painful crisis in sickle cell disease I have never once prescribed morphine. Indeed, I have "hardly ever had to use pethidine for sickle cell crisis in Accra. Most pains improve on less potent analgesics."[2] Only in one adult with sickle cell anaemia (who had at most one admission a year in crisis) was the pain so severe "that even pethidine was not immediately effective."[2] Mine is not a peculiar experience. Serjeant, who has also seen hundreds of cases of painful crises in sickle cell disease, says: "In Jamaican experience, morphia or its derivatives are rarely used or necessary."[3]

The question that puzzles me is: Why do west African and West Indian patients with sickle cell disease who did without morphine in their countries have to be given morphine pumps during sickle cell crises when they come to the United Kingdom? In any case, in obstetrics what happens to fetal respiration when morphine is used?

F I D KONOTEY-AHULU

Cromwell Hospital,
London SW5 0TU

1 Chamberlain G. Medical problems in pregnancy. II. *BMJ* 1991;**302**:1327-30. (1 June.)
2 Konotey-Ahulu FID. *The sickle cell disease patient*. London: Macmillan Education, 1991:502.
3 Serjeant GR. *Sickle cell disease*. Oxford: Oxford University Press, 1985:204.

Cerebral ring enhancing lesions and antituberculous treatment

SIR,—Drs David Fegan and Jacqueline Glennon recommend giving antituberculous treatment to Nepalese patients presenting with a seizure when computed tomography of the brain shows a ring enhancing lesion.[1] I have reported a prospective study of Nepalese adults who presented with epileptiform seizures of adult onset.[2] A ring enhancing lesion was found on computed tomography in seven out of eight patients, all of whom proved to have cerebral cysticercosis. A single ring enhancing lesion has been reported in 26% of computed tomograms of Indian patients with seizures.[3] The lesions are commonly managed as tuberculomas.[3] Chardy *et al*, however, showed by excision biopsy the presence of cysticerci in 12 of 15 consecutive patients with seizures and single small lesions on computed tomography.[4] No tuberculomas were recorded.

Though I do not deny that tuberculosis is endemic in Nepal, a single ring enhancing lesion evident on computed tomography does not alone justify giving antituberculous treatment.

BRYAN HEAP

Department of Public Health Medicine,
Norwich Health Authority,
Norwich NR7 0SS

1 Fegan D, Glennon J. Epilepsy and disappearing lesions: adopting a wait and see policy. *BMJ* 1991;**302**:1402. (8 June.)
2 Heap BJ. Cerebral cysticercosis as a common cause of epilepsy in Gurkhas in Hong Kong. *Journal of the Royal Army Medical Corps* 1990;**136**:146-9.
3 Wadia RS, Makhale CN, Kelkar AV, *et al*. Focal epilepsy in India with special reference to lesions showing ring or disc-like enhancement on contrast computed tomography. *J Neurol Neurosurg Psychiatry* 1987;**50**:1298-301.
4 Chandy MJ, Rajshekhar V, Prakash S, *et al*. Cysticercosis causing single, small CT lesions in Indian patients with seizures. *Lancet* 1989;i:390-1.

Birth weight, current body weight, and blood pressure

SIR,—The finding of Dr Daniel S Seidman and colleagues that blood pressure in adolescence is weakly correlated with birth weight[1] is crucially dependent on the blood pressure readings not being biased with respect to present body weight.

It is widely accepted that a blood pressure cuff

will overestimate arterial blood pressure if the ratio of the cuff's width to the circumference of the arm is less than 0·4,[2] and that there is therefore a tendency to overestimate blood pressure in obese people unless large cuffs are used. The American Heart Association recommends four sizes of cuff for routine clinical use to overcome this. Although Dr Seidman and colleagues state that a cuff of "appropriate" size was used, it is unclear what they mean by this. Even when the four cuffs recommended by the American Heart Association are used up to 7% of interindividual variation in blood pressure may be accounted for by variation in the ratio of the cuff width to arm circumference.[3] In other words, even within the band of arm circumference for which one size of blood pressure cuff is recommended those with larger arms will still tend to have a higher blood pressure recorded simply because they have a lower ratio of cuff width to arm circumference. In epidemiological terms this is analogous to residual confounding.

Present body weight is correlated with birth weight, with a correlation coefficient of approximately 0·4,[4] so it is quite possible that the small correlation found between birth weight and adult blood pressure is simply the result of the intercorrelation of birth weight and adult weight and the measurement bias described above.

Although the blood pressure measurement described may well have been appropriate for clinical practice, it may not be appropriate for investigating the relation between blood pressure and a correlate of adult obesity, birth weight.

ANDREW GRULICH

Department of Epidemiology and Population Sciences,
London School of Hygiene and Tropical Medicine,
London WC1E 7HT

1 Seidman DS, Laor A, Gale R, Stevenson DK, Mashiach S, Danon YL. Birth weight, current body weight, and blood pressure in late adolescence. *BMJ* 1991;**302**:1235-7. (25 May.)
2 Frohlich E, Grim C, Labarthe D, *et al*. Recommendations for human blood pressure determination by sphygmomanometers. *Circulation* 1988;**77**:501-14A.
3 Rastam L, Prineas RJ, Gomez-Martin O. Ratio of cuff width/arm circumference as a determinant of arterial blood pressure measurements in adults. *J Intern Med* 1990;**227**:225-32.
4 Tanner J, Healy M, Lockhart R, Mackenzie J, Whitehouse R. Aberdeen growth study. 1. The prediction of adult body measurements from measurements taken each year from birth to five years. *Arch Dis Child* 1956;**31**:372-81.

A two tier system

SIR,—In the continuing debate in the medical press and elsewhere the belief that fundholding practices will result in a two tier system within the NHS seems to be widespread—inevitably so, one feels, despite bland assurances to the contrary. Indeed, if this were not the case and fundholding practices were able to offer their patients no advantages in terms of access to specialist and other services, what has become of the intended introduction of "internal market forces" in primary health care, which was a cornerstone of Mr Kenneth Clarke's ill considered resolution and for which the selected practices were wooed and rewarded?

Perhaps the present administration is just beginning to recognise what many general practitioners recognised from the outset would be the outcome of deliberately introducing a competitive or divisive element into primary care. Instead of the general public perceiving the benefits available to the minority of patients belonging to fundholding practices as something to be sought by changing their own allegiance they will be dismayed by the realisation that such advantages can be bought only at someone else's expense. The British respect for fair play has meant a willingness to accept waiting lists and delays as long as everyone is manifestly keeping his or her place in the same queue. Once the reality of the principle of the internal market dawns there will not be a wholesale rush of patients to join the lists of fundholders (nor, I suspect, a clamour of general practitioners to enlist in that self selected elite) but an outcry of such enormous chagrin by the great majority, who will think themselves disadvantaged by the system, that the debacle over the poll tax will seem a minor miscalculation by comparison.

Many former loyal Conservative supporters, myself included, tried in vain to warn our MPs of the folly of so determined a destabilisation of a system that had given such good value for money and was rated so highly by just about every survey of consumer satisfaction ever undertaken—and this in the only service industry expected to function effectively without the normal economic restraints that balance demand and supply.

I suggest that as the anger and public outcry over the injustice of the poll tax were sufficient to sweep Mrs Thatcher from her position her erstwhile Cabinet colleagues should be working furiously to devise a formula to defuse the missile they have launched at their own feet. Before that happens perhaps the "more able colleagues" who rushed to accept the doubtful privileges of fundholding should pause to reflect on the fate of the Judas goat once his usefulness has passed.

R A YARDLEY

Hinckley Health Centre,
Hinckley,
Leicestershire LE10 1DS

General practitioners and postgraduate education

SIR,—In their report on the characteristics of general practitioners who did not claim the first postgraduate educationa allowance Dr T S Murray and colleagues say that "The general practitioners most in need of postgraduate education took the least part in it."[1]

I wonder what evidence they have for this statement. There are many ways of pursuing postgraduate education. Excellent journals, tapes, and videos are available specifically for general practitioners. The cost:benefit ratio in time and convenience alone strongly favours these options over that of attending meetings. Specific problems can be discussed on the telephone. I suspect that there is little evidence that meetings change the practice of doctors more than other forms of postgraduate medical education do. Non-attenders should not be branded bad doctors.

During my time as a clinical tutor in general practice I found some evidence (from many personal communications) that attendance at meetings had a strong social element.

R M MOFFITT

Haverbreaks,
Lancaster LA1 5BJ

1 Murray TS, Dykes GS, Campbell LM. Characteristics of general practitioners who did not claim the first postgraduate education allowance. *BMJ* 1991;**302**:1377. (8 June.)

Evaluating the effects of fundholding

SIR,—We were interested to read that the General Medical Services Committee is calling for an evaluation of the general practice fundholding scheme.[1] It is a pity that the Department of Health did not see fit to initiate an evaluation a year ago. The opportunity to collect baseline data from a national sample of fundholders and control practices before the scheme was implemented has now been lost. Much of the necessary information cannot be collected retrospectively with any accuracy.

Fortunately, Oxford Regional Health Authority was not so short sighted and is funding our three year evaluation of the scheme, which began in April last year. We are monitoring the scheme's effects by studying the experiences of 10 fundholding and 10 control practices in the Oxford region throughout this period.

Our study aims to answer the following questions: Will the scheme affect hospital utilisation rates? Will fundholders use a broader range of hospitals than those for whom the district health authority is the contractor? Will the scheme affect communications between the practices and hospital specialists? Will it affect the speed and nature of a hospital's response to requests from general practice? Will it affect prescribing costs? Will it lead to an extension of practice based facilities and facilities offering direct access?

In addition to collecting quantitative data on activity our study aims to monitor the views and experience of general practitioners, hospital consultants, and patients. We believe that evaluation along these lines should be an essential component of all major innovations in health policy. This will require a much greater commitment to funding health services research than has been the case so far.

ANGELA COULTER
JEAN BRADLOW

Health Services Research Unit,
Department of Public Health and Primary Care,
University of Oxford,
Radcliffe Infirmary,
Oxford OX2 6HE

1 Beecham L. GMSC calls for fundholding to be evaluated. *BMJ* 1991;**302**:1279. (25 May.)

Hospital case notes and medical audit

SIR,—We were not surprised to learn that Dr M C Gulliford and colleagues found that the availability of case notes for medical audit was a potential cause for bias.[1] In two recent reviews of our work in Leicester we have experienced major difficulties in obtaining case notes: a review of all barium enemas performed during one year at a hospital in Leicester yielded only 70% of case notes, attempts to locate the notes extending over six months; and only 59% of case notes on patients having isotope bone scans were obtained over a similar period. Informal discussion with colleagues suggests that these rates of return are not unusual.

Both concern for patients' wellbeing and resource management demand that we adequately review the value of our work. Radiologists audit an increasingly wide range of techniques and investigations and rely heavily on case notes for this. These may be "out of file," for genuine reasons but occasionally may be untraceable for long periods only to reappear mysteriously later. The problem of unavailability extends to *x* ray, ultrasound, and other images which also form part of patients' records. A particular problem for radiologists is when a single film is absent from the film packet (often the most important film in a rare, interesting, or unusual case).

If audit is to be meaningful the reasons for low return rates must be addressed. Some centres achieve return rates of 100%, and ideally this should be possible everywhere. At present some isolated areas can be helped by storing records on computer (for example, *x* ray reports and biochemistry results), but centralised storage of all of a patient's records on computer is not yet a reality. Until such a time we have to rely on the traditional methods of record keeping. The demand for audit places an increased load on departments and individual staff (both doctors and support staff), and adequate funding and time must be available to make rapid processing of records possible.

Difficulty in obtaining records has implications