

does not even mention genital warts among the listed risk factors,³ at the top of which is a twofold to threefold increase in risk for women who have had more than one sexual partner. It would not seem unreasonable to suspect that this might apply to the women in the series from Rochester at least.

The real question should be whether women who have genital warts have any greater risk than sexually comparable women who do not. The answer given in an editorial review last year bears repeating: "Recent publicity has engendered much public anxiety about this disease, but it has never been shown that women with genital warts have an increased risk of developing cervical cancer. Their vigorous treatment, and obsessive search for sub-clinical infections, appears to be unnecessary. Perhaps the time has come for a pause in the development of new clinical policies while further research into these matters is undertaken."⁴

Perhaps future studies should also include an assessment of anxiety, inconvenience, discomfort, and physical hazards in the benefit-risk equation.

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Growth of asthmatic children

SIR,—Drs Ole D Wolthers and Søren Pedersen report reduced growth of the lower leg in asthmatic children receiving inhaled budesonide.¹ In a letter in response to their paper Dr Suzanne Crowley and Professor C G D Brook make several welcome comments, particularly the statement that a "safe" dose of budesonide is one that controls a child's asthma rather than one that produces no detectable effect on growth.²

Two further points deserve to be made. The first is that the effect found in the study is necessarily temporary. If the results are extrapolated to a child treated with budesonide from the age of 6 to 13 (the age range of patients in the study), and if the most conservative assumptions are made, height would fall from the 50th centile to the 25th centile with a dose of 200 µg daily or from the 50th to the third centile with a dose of 800 µg daily. An effect of this magnitude is simply not seen in clinical practice, nor is it hinted at by longer term clinical studies. (I have assumed that growth in the upper leg would respond similarly to that in the lower leg, but, not wanting to make assumptions about axial growth, I have assumed that this is not affected by the treatment. I have also taken into account that the children in the study seem to have been going through a particularly rapid period of growth (perhaps after a short illness).)

The second point is that the effects of high and low dose corticosteroid on growth may be entirely different, both in mechanism and in final outcome. It would certainly be wrong to assume a difference in magnitude of effect alone. It is well established that high dose steroid treatment given for prolonged periods may result in permanent stunting. The effect of low dose corticosteroid on growth, however, is probably through delayed maturation consequent on reduced adrenal androgen secretion, and final height may well not be compromised. Adrenocorticotrophic hormone enjoyed a false popularity in the past, largely because of its positive effects on growth, until people realised that these effects were caused through accelerated

maturation and were therefore transitory.³ It would be a pity if the safety and long term health of subjects with asthma were to be put at risk through what may be a similar misapprehension.

Inhaled steroids should continue to be used cautiously as some absorption occurs and metabolism is not rapid or complete enough to prevent detectable systemic effects occurring. This provides a logical argument for attempting to limit the dose to the minimum necessary to control symptoms, but in my opinion it does not justify attempting to limit the number of children to whom inhaled steroids are prescribed. Growth should, however, always be monitored as there is some suggestion from case histories that rare idiosyncratic sensitivity may occur.

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Vital statistics at birth

SIR,—Professor Geoffrey Chamberlain mentions a College of Midwives founded in 1933.¹ The significant dates in our 110 year history are 1881—formation of Matron's Aid or Trained Midwives' Registration Society; 1886—name change to Midwives Institute and Trained Nurses Club; 1889—incorporated under the Companies Act; 1902—after 20 years of campaigning by the Midwives Institute the first Midwives Act received royal assent on July 31; 1941—Midwives Institute renamed the College of Midwives; 1947—granting of a royal charter meant another name change to the Royal College of Midwives.

From its foundation the college has fought for the regulation of a fully trained midwifery profession. In 1881 the major qualification recognised was issued by the London Obstetrical Society, and the Midwives Institute offered courses of lectures to prepare candidates for these examinations. In July 1891 the institute published a pamphlet listing those midwives who had passed the examination from 1872-91.² That the list contained over 100 names showed that the basis of a fully qualified midwifery profession already existed 11 years before the first act of parliament requiring such training and 42 years before Professor Chamberlain acknowledges.

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New deal for old hearts

SIR,—We were interested to read the recent editorial by Dr N A Boon¹ as we have recently completed a survey of the policies of coronary care units in the United Kingdom regarding admission and thrombolysis.

A questionnaire was sent to the consultant in charge of all coronary care units listed in the *Directory of Emergency and Special Care Units*.² Replies were received from 134 (77%) of the 175 units circulated. One fifth of coronary care units (26) operated an age related admission policy, and 23 units used an age limit of 75 years or less. Two fifths of coronary care units (54) operated an age

related policy for the administration of thrombolytic treatment; the commonest age limit used was 75 years. In all, 32 units (24% of responders) operated an age limit of 75 years or less.

Ten responders qualified their replies by indicating that patients' biological age would be considered or that patients above their age limit who had suffered complications of infarction such as dysrhythmias may be admitted to their units.

Thus a substantial number of coronary care units in the United Kingdom continue to deny potentially life saving treatment to elderly patients on the grounds of age alone. We support Dr Boon's call for a more rational and equitable approach to the treatment of myocardial infarction in elderly patients.

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The mysterious "urethral syndrome"

SIR,—Dr Rosalind Maskell¹ takes us² to task for being unconvinced by her suggestion that the "urethral syndrome" is caused by excessive multiplication of lactobacilli in the urethra when the balance between these normally protective organisms and other bacteria has been upset by previous antibiotic treatment. She criticises the Bristol study on the grounds that the antibiotic data were incomplete; but this study was not intended to investigate the role of previous antibiotic treatment on the development of the urethral syndrome.³ It was undertaken to record the numbers of lactobacilli and of leucocytes in the urine of patients with the "urethral syndrome." Neither patients nor control subjects were receiving antibiotics. The patients were seen by the urologist at least twice during the year of the study (not once, as Dr Maskell states). Findings in the urines of patients and control subjects were remarkably similar, irrespective of the severity or duration of the patients' symptoms.

The results of the Bristol study differed from those of Dr Maskell and her colleagues.⁴ This may be because their patients were selected for their symptoms and for high initial counts of "fastidious" organisms in their urine. In the Bristol study, the patients were selected only by their symptoms.

We question Dr Maskell's use of the term "fastidious" in a microbiological setting. A genuinely fastidious organism, such as the gonococcus or *Haemophilus influenzae*, requires nutrients not available in simple culture mediums based on peptones and meat extracts. On the other hand, lactobacilli from urine are not "fastidious" in this sense but merely slow growing.⁵ Lactobacilli grow well on dipslides after 48 hours without needing carbon dioxide.

We do not understand why Dr Maskell asserts that our recent clinical trial data⁶ are not conclusive. The only possible conclusion from our findings that patients with the classical "urethral syndrome" responded equally well (or badly) to treatment with co-amoxiclav (active against lactobacilli) or fosfomicin (inactive against lactobacilli) is that lactobacilli are not aetiological agents.

Although we disagree with Dr Maskell about the role of lactobacilli in the "urethral syndrome," we acknowledge that her work has stimulated research into this mysterious condition. We agree with her that the genitourinary organs are subject to many septic conditions in addition to acute bacterial cystitis.⁷ The original draft of our editorial had 27 references, including several to her work, but for reasons of space we had to reduce these.

Dobbs and Fleming have succeeded in using history, symptoms, and dipstick tests to distinguish between the "urethral syndrome" and urinary infection where many others have failed.⁷ However, our own experience with these criteria has been disappointing.

Ditchburn and Ditchburn's use of microscopy⁹ is commendable, and we have also recommended it.¹⁰ However, some patients without significant bacteriuria have pyuria and some with significant bacteriuria have few if any leucocytes in their urine.¹¹ Further, not all medical students are taught to use a microscope well enough to be able to recognise leucocytes in urine. Thus, the use of the microscope would require postgraduate training in many cases.

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Requests for organ donation

SIR,—Ms Luisa Dillner's news item on organ transplantation suggests that "junior doctors are getting better at approaching relatives" for consent to organ donation, thereby implying that in some intensive therapy units this stressful task is left to junior medical staff.¹ This practice is inappropriate and unnecessary as such doctors may not possess the necessary skills, knowledge, and experience.

There is seldom any urgency to diagnose brain stem death or to request organ donation; with proper supportive care the onset of asystole in brain dead subjects can be delayed. Formal testing of brain stem function and consultation with relatives should therefore be unhurried and undertaken only when senior staff are available. This complies with the recommendation in the United Kingdom that the diagnosis of brain stem death should be made by two senior doctors.² The approach to relatives for organ donation is best made by the same doctors, preferably immediately after the tests.

Increasing public awareness of conditions such as the persistent vegetative state make it common, and appropriate, for informed relatives to ask probing questions concerning the patient's prognosis. Such inquiries may not be handled well by inexperienced junior staff. Reports such as that of

the confidential inquiry into perioperative deaths have emphasised the need for consultants to support junior staff in difficult or demanding situations.³ Without this, junior staff cannot be expected to learn how to perform these tasks or to develop a sense of responsibility for their own future practice.

HIV infection must now be excluded in potential donors.⁴ The lag period to seroconversion may make it necessary to inquire into the lifestyle of the donor as well as to request an HIV test. This has many distressing implications and may, regardless of the result, have lasting effects on the surviving family. This sensitive task is possibly more demanding than requesting organ donation itself and should not be left to junior medical staff.

Finally, if patients are to be admitted to intensive therapy units before brain stem death solely for elective ventilation and subsequent organ donation,⁵ experienced senior medical staff must participate in the negotiations.

In the two intensive therapy units in Portsmouth the relatives are always approached by a consultant in the unit, usually immediately after the absence of brain stem function has been confirmed. The nurse caring for the potential donor and the duty registrar in the unit are always involved. Adherence to this policy has ensured that potential organ donors are not overlooked and has resulted, with a few understandable exceptions, in the donation of all those organs deemed suitable for transplantation.

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Assault after ingestion of antidepressant

SIR,—We were interested in Ms Clare Dyer's report from the Court of Appeal of murder during mania after ingestion of amitriptyline.¹ We have a 46 year old inpatient who assaulted his daughter and wife the day after taking 75 mg of amitriptyline.

The man does not have a history of violence or criminality, but from the age of 16 he has experienced bouts of severe sleeplessness, irritability, overactivity, poor concentration, and worrying each spring. His mother has a closely similar history. At 21 he had an episode of considerable overtalkativeness and jocularity followed by several weeks of mild disinhibition.

This year he was sleepless for some weeks. For three days he did not sleep at all, and he developed delusions that his daughter was illegitimate and his wife unfaithful. One night he took three tablets of amitriptyline 25 mg, which had been prescribed two years earlier, which he believed to be sleeping tablets. He woke at 4 am to find himself overactive and his thoughts racing and subsequently experienced his mind being "pushed out by another mind." Later he picked up a large pair of scissors and stabbed his daughter repeatedly. She sustained a pneumothorax. He then felt an urge to gouge his wife's eyes out and made some attempt to strangle her, although she was not injured.

The police found him standing on his bed over two ornamental bayonets, which he made no attempt to use. On arrest he was shouting "God rules." Later he thought that he had killed his family. Surprisingly, he was not charged but taken

to a local hospital. He had to be restrained from attacking nursing staff, but his symptoms settled over four days with small doses of chlorpromazine and did not recur.

The datasheet for amitriptyline warns that "psychotic manifestations, including mania and paranoid delusions, may be exacerbated," and it is well known that antidepressants can cause mania.² In view of these two cases, it may be that severe and uncharacteristic violence may be precipitated by amitriptyline in those with a predisposition to manic-depressive illness. A similar suggestion has been made about fluoxetine ("The Prozac file," *Dispatches*, Channel 4, 1990 Dec 19). Perhaps other such cases are known to readers.

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Tattoos

SIR,—Messrs N S G Mercer and D M Davies point out that tattoo artists may provide a service to remove tattoos by injecting tannic acid into the area to induce a partial thickness burn.¹ We have treated several patients recently who have received this costly treatment and have suffered full thickness burns. These patients presented many weeks after being treated with tannic acid with inflamed full thickness burns that required formal tangential excision and split skin grafting to obtain satisfactory healing.

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SIR,—Although I found the editorial on tattoos¹ and the research paper from Drs Hall-Smith and Bennett² of great interest, I was left with the feeling that both articles failed adequately to address the possible solutions to this prevalent but forsaken problem in young people.

As most of those affected have been shown to be children of school age it would not seem too difficult for doctors to arrange for appropriate education in the matter of tattoos and their sequelae to be given at school, both primary and secondary. The messages may be transmitted by committed teachers, but it is possible that the greatest positive effect may follow the same educational message being promoted in the school by a plastic surgeon, dermatologist, or local general practitioner.

A health promotion policy aimed at adolescents at school could well fall within the context of paid promotional clinics by the family health services authority, and in any group practices the sum of all attending patients of any doctor may be included in the list of clinic attenders. A greater long term benefit may be seen by taking an active health promotion policy, in schools, aimed at susceptible adolescents and conducted by some of those who are likely to bear the brunt of this particular patient group who, once they are out of their teens, may decide that they have made a mistake.

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