periods of 6-39 months. This finding, together with evidence of persisting enteroviral RNA in skeletal muscle[5] and persistent enterovirus excretion in stool,[6] indicates that enteroviruses may be involved in a proportion of patients with the postviral fatigue syndrome, notwithstanding the inconclusive results of cross sectional sero-epidemiological studies. The study of Dr Miller and colleagues emphasises that a single diagnostic test for the syndrome does not exist at present and shows that screening of single serum samples for enterovirus specific IgM antibody is of little value.

P MUIR
F NICHOLSON
J E BANATVALA

United Medical and Dental Schools of Guy's and St Thomas's Hospitals, London SE1 7EH

P J BINGLEY

St Bartholomew's Hospital, London EC1

1 Miller NA, Carmichael HA, Calder BD, *et al.* Antibody to coxsackie B virus in diagnosing postviral fatigue syndrome. *BMJ* 1991;**302**:140-3. (19 January.)
2 King ML, Shaikh A, Bidwell D, Voller A, Banatvala JE. Coxsackie B virus-specific IgM responses in children with insulin-dependent (juvenile onset; type I) diabetes mellitus. *Lancet* 1983;i:1397-9.
3 El-Hagrassy MMO, Banatvala JE, Coltart DJ. Coxsackie B virus-specific IgM responses in patients with cardiac and other diseases. *Lancet* 1980;ii:1160-2.
4 Muir P, Nicholson F, Tilzey AJ, Signy M, English TAH, Banatvala JE. Chronic relapsing pericarditis and dilated cardiomyopathy: serological evidence of persistent enterovirus infection. *Lancet* 1989;i:804-7.
5 Yousef GE, Bell EJ, Mann GF, *et al.* Chronic enterovirus infection in patients with postviral fatigue syndrome. *Lancet* 1988;i:146-50.
6 Archard LC, Bowles NE, Behan PO, Bell EJ, Doyle D. Postviral fatigue syndrome: persistence of enterovirus RNA in muscle and elevated creatine kinase. *J R Soc Med* 1988;**81**:326-9.

Viruses and cervical cancer

SIR,—Drs Albert Singer and David Jenkins stated that during the past decade there has been a strong link of human papillomavirus to cervical cancer although, according to recent findings, it may not be the aetiological agent.[1] Therefore genital viral infections should not have radical treatment. They also gave the opinion that only vulval warts should be treated. I do not agree with them.

My own study showed that 17% of patients with genital warts had cervical intraepithelial neoplasia of varying degrees confirmed by histology.[2] Because of the available reports and general consensus on treatment for low grade cervical intraepithelial neoplasia we observed, with colposcopic examination every six months, patients with cervical intraepithelial neoplasia grade I and found that 16 patients (53%) progressed to grades II and III during the subsequent 18 months and required radical treatment by laser or cone biopsy. Furthermore, two studies showed that if subclinical human papillomavirus infection of the cervix is not treated it could develop to overt clinical warts within 18 months.[2,3] Therefore I recommended that subclinical human papillomavirus infections of the cervix be treated with cryosurgery or cold coagulation, depending on availability.

Cervical or vaginal warts, or both, should be treated to prevent their spread to other areas (vulva, perianal region, pubic region, upper thighs, etc) and to prevent the transmission of human papillomavirus to sexual partners. Such warts are known to produce offensive vaginal discharge owing to partial obstruction. Affected patients should receive treatment after pre-malignant lesions of the cervix have been excluded by colposcopy.

The polymerase chain reaction and DNA hybridisation techniques are helpful in detecting latent infection with human papillomavirus. I do not recommend any treatment for latent infection as the presence of human papillomavirus on the surface epithelium could be transitory or a false positive result of polymerase chain reaction. I believe that the time for treatment is when the balance between the host and virus is altered to initiate the subclinical stage diagnosed by histology.

K C MOHANTY

St Luke's Hospital, Bradford BD5 0NA

1 Singer A, Jenkins D. Viruses and cervical cancer. *BMJ* 1991; **302**:251-2. (2 February.)
2 Mohanty KC, Lowe JW. Cryotherapy in the management of histologically diagnosed subclinical HPV infection of the cervix. *Br J Clin Pract* 1990;**44**:574-7.
3 Mohanty KC, Lowe JW. Cold coagulation in the management of histologically diagnosed subclinical HPV infection of the cervix. *Br J Clin Pract* (in press).

The yellow card: mark II

SIR,—The Committee on Safety of Medicines noted Dr J P Griffin's comments, which were based on an analysis of spontaneous reporting of adverse drug reactions in Britain between 1972 and 1980.[1] Since then the committee has taken many initiatives to encourage widespread reporting. These have resulted in a doubling of the number of reports received annually between 1980 and 1990.

The availability of reporting forms in FP10 prescription pads and a variety of prescribing texts have had a major impact on the ease and frequency of reporting. In addition, collaborative schemes have been set up to encourage reporting from specialist groups including anaesthetists and dermatologists, and pharmacists have successfully encouraged reporting by other hospital doctors.

A further scheme is now under way to allow pharmacists to report directly to the committee. The regional monitoring centres in Birmingham, Cardiff, Liverpool, and Newcastle all have an important role in encouraging reporting in their regions. An educational video on adverse reactions, publications, lectures, and regular information through "current problems" bulletins have all promoted reporting of suspected reactions.

We believe that both the Association of the British Pharmaceutical Industry and individual pharmaceutical companies could play a greater part in encouraging reporting. More prominent display of the inverted black triangle symbol on promotional material to draw doctors' attention to newly introduced medicines would be one method of achieving this desirable aim.

Irrespective of the undoubted importance of encouraging widespread reporting of suspected reactions, well documented reports—even when emanating from a small core of prescribers—have provided early warning of many previously unrecognised reactions related to drugs.

A W ASSCHER
D H LAWSON

Committee on Safety of Medicines, London SW8 5NQ

1 Griffin JP. The yellow card: mark II. *BMJ* 1991;**302**:50. (5 January.)

Detecting diabetic retinopathy

SIR,—As pointed out by some correspondents,[1] the inadequacy of current screening methods has been highlighted yet again by the study of Dr Roy Taylor and colleagues.[2] Some of the solutions suggested by correspondents were, however, unrealistic—for example, that screening should be done by ophthalmologists, or that we should simply hope that all those doctors involved in diabetic retinopathy screening across the land will get better at it.

The study of Dr Taylor and colleagues showed that if used alone both clinic ophthalmoscopy and photography may miss serious retinopathy detected by the other method. This raises the possibility that we should consider using both methods together—as the chest physician uses both *x* rays and auscultation to examine the chest. To explore this possibility, we have conducted a pilot study to assess photography with a non-mydriatic camera (Polaroid) combined with diabetic clinic ophthalmoscopy[3] in screening for retinopathy. Our data, taken in conjunction with other work,[4-6] suggest that more retinopathy may be detected by ophthalmoscopy and photography combined than by ophthalmoscopy alone.

Patients deserving an ophthalmologist's opinion but not referred by less experienced clinic doctors may be picked up from the Polaroid photographs at subsequent clinic visits by more experienced members of the team. This also provides an opportunity to audit the performance of more junior members and, where necessary, to provide training. In cases of doubt the photograph can be discussed with the ophthalmologist without the patient being present, the ophthalmologist deciding whom to see further.

Our study also showed that it may be necessary to dilate pharmacologically only about 17% of eyes to obtain greater than 90% good quality Polaroid photographs. Thus it would seem appropriate to stop calling the camera a "non-mydriatic camera" and call it instead a "4 mm pupil camera," the pupil being dilated pharmacologically or not, as necessary. Finally, the pilot study suggested that it may not be necessary to use ophthalmoscopy if there is definitely no evidence of retinopathy in good quality photographs.

R E J RYDER

Diabetic Unit, Royal Hallamshire Hospital, Sheffield S10 2JF

C A HARDISTY

Diabetes Research Unit, Clinical Sciences Centre, Northern General Hospital, Sheffield S5 7AU

1 Correspondence. Detecting diabetic retinopathy. *BMJ* 1991; **302**:174-6. (19 January.)
2 Taylor R, Lovelock L, Tunbridge WMG, *et al.* Comparison of non-mydriatic retinal photography with ophthalmoscopy in 2159 patients: mobile camera study. *BMJ* 1990;**301**:1243-7. (1 December.)
3 Ryder REJ, Griffiths H, Moriarty KT, Kennedy RL, Blumsohn A, Hardisty CA. Superimposing retinal photography with a "non-mydriatic camera" on existing retinopathy screening services in the diabetic clinic. *Practical Diabetes* (in press).
4 Ryder REJ, Hayes TM. Nonmydriatic retinal photography in screening for diabetic retinopathy. *Seminars in Ophthalmology* 1987;2:26-9.
5 Smith SA, Shilling JS, Sonksen PH, *et al.* Retinopathy screening using fundal photography. *Diabetic Medicine* 1989;**6**(suppl 2):11A.
6 Moriarty A, Anastasiou H, Williams CD, Smith SE, Lowy C, Shilling JS. Audit of retinal screening: a role for retinal photography. *Diabetic Medicine* (in press).

Someone to turn to

SIR,—As a Samaritan volunteer of many years' standing I was concerned that Dr Hilary Aitken did not mention the Samaritans in her personal view[1] since the reason for their existence is to help people who find themselves under great stress and feel unable to cope. In 1989 over 22 000 Samaritans gave over 3½ million hours of their time to listen to those who needed someone to turn to. We are so used to listening that we are not always very good at telling others about ourselves and how we can help those who need somebody to confide in.

As Dr Aitken rightly points out, "the therapeutic value of a good cry is so incalculable." And you don't have to worry about the stigma attached to a doctor who cannot cope as anything said to a Samaritan is totally confidential. The Samaritans are always available, 24 hours a day, 365 days a year, including Christmas Day, and there are more than 180 branches throughout the United Kingdom. Every branch is listed in the local