medical records. Many family practitioner committees are taking initiatives to ensure that addresses are accurate. General practitioners are encouraged to notify the committee when they become aware that a patient has moved. Some committees have also taken the initiative to advise the general public to notify them of a change of address, so that a new medical card can be issued. Some activities within the committees also automatically update addresses. For example, every woman registered with a doctor for contraceptive services has her address updated when the doctor submits his or her annual claim. People exempt from prescription charges, including expectant and nursing mothers, need certificates and again the opportunity is taken to update addresses. These measures together ensure that the standard of accuracy is rapidly improving, particularly among women likely to be called for cervical cytology screening.

Of course, no system can be 100% accurate. At any one time people are moving. There is inflation in the numbers of people registered with doctors—overall around 6%. If a notification, however, is sent out in one area to a woman no longer living there I do not think that it can automatically be taken as a failure of the system. If she has moved to another area and registered with a doctor and, for whatever reason, a link has not been achieved she will receive a notification from the new area.

I accept, however, the comments that comparison between family practitioner committee registers and electoral registers would be desirable. Again, however, I think that Dr Beardow and others are either overcritical about family practitioner committee registers or perhaps a little behind the times. Postcodes are recorded routinely on the committees' registers. Though I cannot speak for all family practitioner committees, in my area all postcodes will be completed by the end of the year. The current database does allow recording of the postcode in a separate field, but I suspect that the authors' criticism is that information may not be manipulated by postcode alone on the general registration system. It is, however, fairly simple to put the registration database on to microcomputers and rearrange in simple spreadsheet format so that postal code information can be interrogated, primarily for planning purposes, but just as easily for data verification.

Finally, Dr Beardow and others refer to staff of the family practitioner committees inputting test results on to the computer. This may be true in some parts of the country, but in others advances have been made so that the inputting is direct from the pathology laboratory by way of a modem link, and again I sense a lack of appreciation by the authors about progress made during the past 12 months.

Though no one can claim that the family practitioner committee registers or system are perfect, the authors underestimate the value of the use of the family practitioner committee register, which is the most comprehensive database in the NHS. Considerable advances have been made over the past 12 months and will continue to be made while the first cycle of call and recalls is under way. By the end of a three or five year cycle, depending on the district, an attempt will have been made to reach every woman who needs to be screened. At the end of this time the effectiveness of the system can then be properly evaluated and I have no doubt that when that full evaluation is carried out the family practitioner committee registers will be seen to be the most effective database for operating a comprehensive complete service.

PETER DOBSON

West Sussex Family Practitioner Committee,
Chichester PO19 4AD

1 Beardow R, Oerton J, Victor C. Evaluation of the cervical cytology screening programme in an inner city health district. *Br Med J* 1989;**299**:98-100. (8 July.)

Accuracy in clinically evaluating pigmented lesions

SIR,—We agree with the remarks of Dr R K Curley and others on the difficulty in the differential diagnosis of pigmented lesions[1] and would like to draw attention to the potential value of skin surface markings. A change in the microtopography of the skin overlying pigmented lesions may aid differential diagnosis.

We analysed the microtopography of the skin surface overlying various pigmented lesions using a rubber based dental impression material (Impregnum F; ESPE, Federal Republic of Germany). The impressions were examined under a binocular dissecting microscope at a magnification of $\times 10$ to $\times 30$. In 90 lesions the surface pattern correlated well with the underlying histology.

Macular lesions, such as flat seborrhoeic warts, lentigos, lentigo malignas, and junctional naevi produce little disturbance of the surface markings. Compound naevi generally retain their surface markings to a greater extent than other raised intradermal naevi. The raised areas of papular pigmented lesions are more distinct in benign than in malignant lesions. A honeycomb pattern is seen in some seborrhoeic warts and naevi,[2] which has so far not been seen in malignant lesions.

Superficial spreading melanomas may show some preservation of surface markings but also have smooth areas. The poorly defined edge that is often seen with such lesions adds to their differentiation from dysplastic naevi, in which the skin surface markings are well preserved and edges of raised areas show clear demarcation.[3] These features can be readily seen in the clinic with a powerful hand lens.

A L WRIGHT
R MURPHY
A J G McDONAGH
D W K COTTON
S S BLEEHEN

Royal Hallamshire Hospital,
Sheffield S10 2JF

1 Curley RK, Cook MG, Fallowfield ME, Marsden RA. Accuracy in clinically evaluating pigmented lesions. *Br Med J* 1989;**299**: 16-8. (1 July.)
2 Marks R, Dawber RPR. Skin surface biopsy: an improved technique for the examination of the horny layer. *Br J Dermatol* 1971;**84**:117-23.
3 Wright AL, Murphy R, McDonagh AJG, Cotton DKW, Bleehen SS. Skin surface markings: an aid to the diagnosis in dysplastic naevi and malignant melanoma. *Br J Dermatol* 1989;(suppl 34):66-7.

Excess naevi after chemotherapy in childhood

SIR,—Dr Bronwyn R Hughes and colleagues reported on the possible association between chemotherapy and an increased risk of benign melanocytic naevi among survivors of childhood cancer; they also indicate the potential for increased risk of malignant melanoma.[1] If confirmed, this finding has considerable implications in terms of the risk of subsequent malignant melanoma.[2] The Childhood Cancer Research Group maintains a register of second primary tumours after childhood cancer treated in Great Britain.[3] At present the register comprises 217 cases. Excluding malignant melanoma after retinoblastoma (four cases), for which the interpretation is complicated by genetic predisposition,[4] we observed only two other cases in which malignant melanoma developed as a second primary tumour. The first primary tumours were Hodgkin's disease and neuroblastoma and neither patient was treated with chemotherapy or hormones.

We are currently obtaining complete follow up data until the end of 1987 for all survivors treated before 1983, but it is unlikely that the number of second malignant melanomas will increase greatly. Thus there is no present evidence of a substantial excess of malignant melanoma after chemotherapy for childhood cancer in Great Britain, but we shall continue our monitoring.

It is also important to conduct prospective studies of naevus development in relation to chemotherapy, in which naevi are counted in the same children before, during, and after treatment. Such a study is being carried out at St Bartholomew's Hospital, London, and this will provide an independent assessment of the suggested association.

M M HAWKINS
J E KINGSTON
L M KINNIER WILSON

Childhood Cancer Research Group,
Radcliffe Infirmary,
Oxford OX2 6HE

1 Hughes BR, Cunliffe WJ, Bailey CC. Excess benign melanocytic naevi after chemotherapy for malignancy in childhood. *Br Med J* 1989;**299**:88-91. (8 July.)
2 Swerdlow AJ, English J, MacKie RM, *et al.* Benign melanocytic naevi as a risk factor for malignant melanoma. *Br Med J* 1986;**292**:1555-9.
3 Hawkins MM, Draper GJ, Kingston JE. Incidence of second primary tumours among childhood cancer survivors. *Br J Cancer* 1987;**56**:339-47.
4 Traboulsi EI, Zimmerman LE, Manz HJ. Cutaneous malignant melanoma in survivors of heritable retinoblastoma. *Arch Ophthalmol* 1988;**106**:1059-61.

Donating drugs to the Third World

SIR,—Minerva pointed out the usefulness of old copies of the *British National Formulary* to students in Third World countries.[1] Yet some appeals for medical supplies[2] seem to go against the move towards more rational prescribing represented by the *Britsh National Formulary* and, in the Third World, by the World Health Organisation's model list.[3,4] I therefore examined what our practice receives in drug samples and recently dispensed items from patients to see how appropriate they would be for rural African hospitals.

Over three months I collected the drugs received by three partners. The 33 items filled a carrier bag and varied in size from two tablets to 100. I sorted the collection following guidelines on drug donations and the World Health Organisation's model list of essential drugs.[3]

Firstly, I excluded eight items with no expiry date and one expiring within six months. The guidelines recommend that donated drugs should have a life of at least one year after arrival in the receiving country.

Secondly, I excluded six items because the model list does not recommend fixed ratio combination drugs. Of the remainder, four items were new drugs without an established position in therapeutics in Britain and two were commonly used here but were certainly not on the basic drug list. Ten items, although not named on the basic drug list, could be reasonable alternatives to the drug or form listed. For these to be useful the same drug, strength, and form would need to be supplied regularly to avoid confusion with changes. Two items were included on the basic drug list.

I canvassed my partners to establish which drugs they would find useful for their drug bags. The response included both of the items on the basic drug list and five of the ten that could be substitutes. This left me with five items which might be useful in some circumstances in rural Africa, but anyone sending these drugs would need to ensure that they would not be undermining the local policy of the receivers. The World Health Organisation recommends that each country should adapt the basic list according to local needs and resources.

The guidelines I used point out that a financial contribution to enable local purchase of drugs is often more appropriate. This has the advantage of reducing transport costs and supporting local industry