with exogenous cytomegalovirus DNA. The high sensitivity of the polymerase chain reaction makes exclusion of specimen contamination very difficult.[8,9] It is thus impossible on the basis of the evidence currently available to say whether the polymerase chain reaction can detect cytomegalovirus DNA in peripheral blood mononuclear cells collected from people with latent infection. If the polymerase chain reaction is adequately sensitive for this purpose it may prove valuable in studying the nature of latent cytomegalovirus infection and screening patients for this infection.

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1 Stanier P, Taylor DL, Kitchen AD, Wales N, Tryhorn Y, Tyms AS. Persistence of cytomegalovirus in mononuclear cells in peripheral blood from blood donors. *Br Med J* 1989;**299**:897-8. (7 October.)
2 Saiki RK, Gelford DH, Stoffel S, *et al*. Primer-directed enzymatic amplification of DNA with a thermostable DNA polymerase. *Science* 1988;**239**:487-94.
3 Jahn G, Kouzarides T, Mach M, *et al*. Map position and nucleotide sequence of the gene for the large structural phosphoprotein of human cytomegalovirus. *J Virol* 1987;**61**: 1358-67.
4 Berry NJ, Grundy JE, Griffiths PD. An improved radioimmunoassay method for the detection of IgG antibodies against cytomegalovirus. *J Virol Methods* 1986;**13**:343-50.
5 Schibata D, Martin WJ, Appleman MD, Causey DM, Leedom JM, Arnheim N. Detection of cytomegalovirus DNA in peripheral blood of patients with human immunodeficiency virus infection. *J Infect Dis* 1988;**158**:1184-92.
6 Cassol SA, Poon M-C, Pal R, *et al*. Primer-mediated enzymatic amplification of cytomegalovirus (CMV) DNA. *J Clin Invest* 1989;**83**:1109-15.
7 Jiwa NM, Van Genert GW, Raap AK, *et al*. Rapid detection of human cytomegalovirus DNA in peripheral blood leukocytes of viremic transplant recipients by polymerase chain reaction. *Transplantation* 1989;**48**:72-6.
8 Kwok S, Higashi R. Avoiding false positives with PCR. *Nature* 1989;**339**:237-8.
9 Lo Y-MD, Mehal WZ, Fleming KA. False positive results and the polymerase chain reaction. *Lancet* 1988;ii:679.

Twenty four hour care in inner cities

SIR,—We are glad to see that our paper[1] has stimulated a wide ranging discussion, not only on out of hour call rates in many different areas and the method of their collection but also on the general problem posed by the 1990 contract in relation to areas of deprivation and to night work.[2-5]

Comparison of out of hours work depends on the differing roles of Saturday surgery, the proportion of advice given on the telephone, and whether deputising services are used. Doctors from deputising services visit 97% of all callers[6] so a meaningful comparison of demand between practices requires the production of a request rate or summing of telephone and visit rates. Thus our request rate for night visiting of 31·8 per 1000 patients per year is comparable with the rate in Bethnal Green of 29·7[2] and greater than the rate of 24·6 (all deputised) in Plymouth.[3] We operate personal lists and, like the doctors in Bethnal Green, find different call rates between different doctors' patients. We believe that this relates mainly to proportions of under 5s and young women, of whom we have many and who make high demand on services. Distance from a casualty department is also a factor. In addition, the increased morbidity of manual workers and their families, and in particular of the unemployed, places a considerable demand on primary care services. Apart from sometimes having inappropriate consultations because of the alienation of urban deprivation, these groups experience more sickness and more severe sickness.

It is clear that the government has not appropriately addressed the problem of how to provide a 24 hour emergency service in general practice. The 1990 contract rests on the plank of increased working hours for general practice principals. It increases the "salaried" aspects of the job—five days of work and 26 hours' patient contact—while retaining the "independent" contractors' 24 hour responsibility. It also reduces the financial viability of practices that wish to offer breadth and quality of care, without placing excessive demands on individuals, by increasing numbers of partners and staff. This is particularly the case in inner London, where costs are higher, but there is no London weighting for general practitioners.

We accept, however, the point made by Drs Main and Main of Bristol[4] and Dr Gibbons of West Glamorgan[5] that the variables in the Jarman index, on which the proposed deprivation weighting would be paid, would not reflect the deprivation and morbidity that increase their workload in outer urban areas, and that they, too, need to receive a much needed deprivation allowance. An enhanced night visit fee for non-deputised visits does nothing to reduce the excessive working hours of doctors (although obviously we would appreciate being paid properly for what we do). There are no proposals to tackle the other issues facing doctors who do their own night calls, particularly in deprived areas, such as the fear and danger of violence. Full funding for a local telephone answering service, driver-escort, and mobile telephone would be a start.

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1 Livingstone AE, Jewell JA, Robson J. Twenty four hour care in inner cities: two years' out of hours workload in east London general practice. *Br Med J* 1989;**299**:368-70. (5 August.)
2 Hardy JN, Patel RM. Twenty four hour care in inner cities. *Br Med J* 1989;**299**:741. (16 September.)
3 Brown EL. Twenty four hour care in inner cities. *Br Med J* 1989;**299**:856-7. (30 September.)
4 Main JA, Main PGN. Twenty four hour care in inner cities. *Br Med J* 1989;**299**:627. (2 September.)
5 Gibbons B. Twenty four hour care in inner cities. *Br Med J* 1989;**299**:856. (30 September.)
6 Riddell JA. Out of hours visits in a group practice. *Br Med J* 1980;**280**:1518-9.

Dietary calcium, physical activity, and risk of hip fracture

SIR,—Dr C A C Wickham and colleagues[1] provide "hard" evidence for the belief in west Africa that dietary calcium may not be an important risk factor for hip fracture. We have been struck by the low prevalence of osteoporosis in the region even though dietary calcium intake is on average lower than that in the United Kingdom and in some rural dwellers is considerably lower than the Food and Agriculture Organisation's recommended daily allowance. In a recent retrospective review of hip fractures seen in our teaching hospital over a one year period we found only 11 patients with such fractures in a catchment population of over one million. This gives a low incidence of hip fracture, even allowing for some underdiagnosis, as this represents all ages and both sexes.

Preliminary studies in the region indicate radial bone densities similar to those of white Europeans. Low calcium intake does not seem to compromise bone mineralisation even among rural west Africans. The belief that Africans have larger and denser bones has previously been disputed in a study on west Africans, albeit using the crude radiological measurement of metacarpal index.[2]

Similar observations to ours have been documented elsewhere in Africa.[3] We believe that the high level of physical activity even among our ever growing geriatric population is the most likely explanation for the low incidence of osteoporosis in the region. We are currently testing this assertion through longitudinal studies.

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1 Wickham CAC, Walsh K, Cooper C, *et al*. Dietary calcium, physical activity, and risk of hip fracture: a prospective study. *Br Med J* 1989;**299**:889-92. (7 October.)
2 Dequeker J. Quantitative radiology: radio-grammetry of cortical bone. *Br J Radiol* 1976;**49**:912-20.
3 Solomon L. Bone density in ageing Caucasian and African populations. *Lancet* 1979;ii:1326-30.

Use of cyanoacrylate tissue adhesive

SIR,—I wish to add two complications of using cyanoacrylate to those mentioned by Dr David P Watson in his timely article.[1]

Firstly, when the adhesive is applied to the laceration an exothermic reaction occurs and produces a momentary sharp pricking sensation. This may cause the patient some distress, particularly if no warning was given.

Secondly, additional care needs to be taken for periorbital skin cuts: if the adhesive runs into the eye the eyelid becomes sealed to the cornea. In the few instances in which this has occurred the eye has spontaneously opened in five to seven days, and subsequent ophthalmological referral showed no corneal damage. Reassurance of both parent and child is all that is required.

The glue is a valuable addition to the treatment options for wound care. We have also found it useful in securing skin grafts to their recipient site.

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1 Watson DP. Use of cyanoacrylate tissue adhesive for closing facial lacerations in children. *Br Med J* 1989;**299**:1014. (21 October.)

Looking after a visiting speaker

SIR,—Every organiser of a meeting should keep copies of the excellent article by Dr Patrick Hoyte[1] and an article on the same theme entitled "Nice people with no manners" written by the editor of the *BMJ* some years ago.[2] Both writers emphasised that as speakers they were usually looked after well but it is the inept organisers whom they remembered. Please permit me to add a few do's and don'ts to Dr Hoyte's useful list for organisers.

- Check all lines of communication. I know of three occasions when the porter at the entrance to a building denied that a meeting was being held there. Advise speakers either to show the porter the programme and insist that he telephones around to find out where the meeting is being held or, failing this, to search the building themselves.

- Educate the chairperson about how to pronounce and remember the speaker's name. Stephen Leacock, humorist and professor of economics at McGill University, described how, during lecture tours, the chairman might have to consult the programme to find the speaker's name or the title of the talk,[3] and this still happens. Also it is helpful for the audience to be told something of the speaker's credentials, and a little flattery boosts his or her ego. No need to overdo it. Mark Twain, his biographer wrote,[4] introduced himself because he had never met anyone who could pay proper tribute to his talents; but no humorist could take himself so seriously, and he no doubt had his tongue in his cheek.