SIR,—Robert J Biggar rightly points out that prevention and treatment of sexually transmitted diseases form an important approach to dealing with an epidemic of AIDS in developing countries.[1] Prevention strategies for sexually transmitted diseases aimed at changing behaviour will largely overlap with those applicable to controlling AIDS. Sustainable and effective interventions must be formulated and introduced as close to the community as possible.

Treating sexually transmitted diseases requires knowledge about cultural interpretations of these diseases and of related patterns of health seeking behaviour. As in the case of AIDS, knowledge of social science is required to develop effective prevention and more appropriate treatment strategies. Culturally appropriate responses should be developed in close collaboration with the community. Unfortunately, in many developing countries the anthropology of health and health care is not strongly developed. An important reason is the dominance of epidemiologists and public health doctors in much applied research related to disease. They tend to use a rather narrow definition of social science, emphasising its methodological side in research.[2] Moreover, they are often hesitant in admitting that social science may contribute to a better understanding of problems in the health sector. Both factors are not conducive to the emergence of a strong and sizable group of medical anthropologists and sociologists in developing countries. In view of the serious challenges to be met and the need for innovative approaches the lag in involving social scientists can hardly be afforded.

P H STREEFLAND

Royal Tropical Institute,
1092 AD Amsterdam,
Netherlands

1 Biggar RJ. Preventing AIDS now. *BMJ* 1991;**303**:1150-1. (9 November.)
2 Foster GM. World Health Organisation social science research: problems and prospects. *Soc Sci Med* 1987;**24**:709-17.

Case definitions for AIDS surveillance in Africa

SIR,—I agree with Kevin M De Cock and colleagues[1] and Charles F Gilks[2] about the need to review and replace the World Health Organisation's case definition for AIDS drawn up after a workshop in Bangui, Central African Republic.[3] The following experiences from Zambia show why.

Firstly, although the presence of generalised Kaposi's sarcoma in itself is deemed sufficient for the diagnosis of AIDS,[3] Bayley *et al* reported some overlap in clinical presentation between atypical and endemic Kaposi's sarcoma, such that distinction between the two was sometimes possible only after HIV testing: 24% of their patients clinically classified as having endemic Kaposi's sarcoma were HIV positive and 9% of those clinically classified as having atypical Kaposi's sarcoma were HIV negative.[4]

Secondly, Hira *et al* showed that (*a*) apart from weight loss, which had highest specificity among those aged 15-19, all signs and symptoms used in the WHO case definition have a high specificity (>70%) and positive predictive value (>70%) only in patients aged 25-39; and (*b*) the WHO case definition has a low sensitivity (39·8%) and an extremely low positive predictive value (8·8%) for AIDS.[5]

From the data in Hira *et al*'s study[5] I have calculated the false negative and false positive rates for the WHO case definition to be 0·60 (60%) and 0·26 (26%), respectively. This clearly indicates that the definition is wrong and a poor tool in AIDS surveillance. The high false negative rate and very low positive predictive value for AIDS have been attributed to the definition combining clinical features of AIDS related complex to make a diagnosis of AIDS and the non-inclusion of locally more sensitive diseases like tuberculosis.[5]

The inadequacies and other problems of WHO's provisional clinical case definition for AIDS in adults[1 2 4 5] justify calls for its review and replacement.[1 2] The definition proposed by De Cock and colleagues is a refinement and expansion of the definition and is therefore worth considering. Its inbuilt requirement of HIV seropositivity safeguards against patients not infected with HIV being reported as having AIDS. But this may also be its major limitation in countries with poor or limited facilities for HIV testing. Hence the financial, material, and manpower implications will need to be meticulously appraised and assured beforehand so that its use will not hinder reporting of AIDS.

PATRICK MATONDO

Institute of Dermatology,
St Thomas's Hospital,
London SE1 7EH

1 De Cock KM, Selik RM, Soro B, Gayle H, Colebuners RL. AIDS surveillance in Africa: a reappraisal of case definitions. *BMJ* 1991;**303**:1185-8. (9 November.)
2 Gilks CF. What use is a clinical case definition for AIDS in Africa? *BMJ* 1991;**303**:1189-90. (9 November.)
3 World Health Organisation. Provisional clinical case definition for AIDS. *Wkly Epidemiol Rec* 1986;**61**:72-3.
4 Bayley AC, Cheingsong-popov R, Dalgleish AG, Downing RG, Tedder RS, Weiss RA. HTLV-3 serology distinguishes atypical and endemic Kaposi's sarcoma in Africa. *Lancet* 1985;i:359-61.
5 Hira SK, Ng'andu N, Wadhawan D, Nkowane B, Baboo KS, Kamanga J, *et al*. Clinical features of HIV disease in Lusaka: sensitivity, specificity, and positive predictive value. *Med J Zambia* 1989;**24**:6-10.

Chorionic villus sampling

SIR,—Richard J Lilford has always been an advocate of decision analysis and frequently expounds on the question of choice. His statement that "midtrimester amniocentesis is usually preferable" and his inference that chorionic villus sampling in the first trimester is passé[1] contradict what most practising clinicians appreciate—namely, appropriate risk framing.

The higher rate of fetal loss before 28 weeks reported in the European trial[2] was not substantiated by the Canadian study.[3] Lilford conceded that the operator's experience and skill count. A trial in which 17% of procedures were considered to be difficult and 31% required more than one attempt to obtain adequate diagnostic material cannot suggest that villus sampling is more risky than amniocentesis. Villus sampling, however, should be done by experts.

World cohort experience and my experience of over 1000 samplings suggest that the rate of fetal loss associated with chorionic villus sampling is similar to or within 1-2% of the rate associated with amniocentesis (1·6% in the Medical Research Council's trial). Who chooses? Many mothers would not consider midtrimester amniocentesis to be preferable when faced with the emotive and physical cost of a midtrimester abortion.[4 5]

Facial clefting defects are common abnormalities and are often associated with limb defects in many syndromes.[6] These defects are evident by the third or fourth week and established by the sixth week of gestation. The question of risk framing is important as many women seeking diagnosis may not consider oromandibular-limb hypogenesis to be a threat when the calculated incidence is 0·3 per 1000[1] or, as in our own and other large series, when the problem has not been encountered after more than 1000 procedures.[7]

Ambiguous mosaic results reported in the Canadian trial were not a major problem in the Medical Research Council's trial or the United States multicentre study of over 6000 women.[1] Clearly, there is also a learning curve for cytogenetists and experience counts.[9] Amniocentesis before 12 weeks is unlikely to be safer than that at midtrimester, and interpretation at that stage of gestation may be difficult because the origin of the amniocytes is uncertain.

Chorionic villus sampling was developed to meet women's needs to avoid midtrimester diagnosis and late abortion. As a member of the working party for the Medical Research Council's trial I am acutely aware of inadequacies where participants are still on the learning curve, and results will differ if the trial is repeated. Lilford must remember that trials are conducted to provide answers and figures, the ingredients for risk framing and decision analysis. The choice must remain with the consumer, who may not be impressed by risk below statistical detection.

D T Y LIU

Department of Obstetrics and Gynaecology,
City Hospital,
Nottingham NG5 1PB

1 Lilford RJ. The rise and fall of chorionic villus sampling. *BMJ* 1991;**303**:936-7. (19 October.)
2 MRC working party on the evaluation of chorion villus sampling. Medical Research Council European trial of chorion villus sampling. *Lancet* 1991;**337**:1491-9.
3 Canadian Collaborative CVS-Amniocentesis Clinical Trial Group. Multicentre randomised clinical trial of chorionic villus sampling and amniocentesis. *Lancet* 1989;i:1-6.
4 McCormack MJ, Rylance ME, MacKenzie WE, Newton J. Patients' attitudes following chorion villus sampling. *Prenat Diagn* 1990;**10**:253-5.
5 Abramsky L, Rodeck CH. Women's choice for fetal chromosome analysis. *Prenat Diagn* 1991;**11**:23-8.
6 Romero R, Pilu G, Jeanty P, Ghidini A, Hobbins JC. *Prenatal diagnosis of congenital abnormalities*. San Mateo, California: Appleton and Lange, 1988:101-5.
7 Liu DTY, Mitchell J, Johnson J, Wass DM. Trophoblast biopsy by blind transcervical aspiration. *Br J Obstet Gynaecol* 1983;**90**: 119-23.
8 Ledbetter DH, Martin AO, Verlinsky Y, Pergament E, Jackson L, Yang-Fent T, *et al*. Cytogenetic results of chorionic villus sampling. High success rate and diagnostic accuracy in the United States collaborative study. *Am J Obstet Gynecol* 1990; **162**:495-501.
9 Rooney DG. The interpretation of cytogenetic results. In: Liu DTY, ed. *A practical guide to chorion villus sampling*. Oxford: Oxford Medical Publications 1991:62-72.

Genitourinary tract infections in pregnancy and low birth weight

SIR,—In a retrospective case-control study of low birthweight infants Rosalie Schultz and colleagues reported a strong association between genitourinary tract infection in pregnant Australian Aboriginal women and subsequent low birth weight.[1] They claim that "efforts to identify and treat women at high risk of preterm birth have not significantly changed the proportion of women giving birth before term." They fail to discuss any relevant published work.

Ten randomised trials have evaluated the effect of antibiotic treatment for asymptomatic bacteriuria on preterm delivery or low birth weight (none is acknowledged by Schultz and colleagues): the treatment of asymptomatic bacteriuria in pregnancy is associated with a reduction in preterm delivery or low birth weight (odds ratio 0·60, 95% confidence interval 0·45 to 0·80).[2] It is particularly surprising that the authors make no reference to the trial reported fairly recently by Thomsen *et al*.[3]

A clinical trial of screening and treatment is not required. Resources should be directed at providing Australian Aboriginal women with a form of care that is known to be effective.

FIONA SMAILL

McMaster University,
Hamilton,
Ontario,
Canada L8N 3Z5

1 Schultz R, Read AW, Straton JAY, Stanley FJ, Morich P. Genitourinary tract infections in pregnancy and low birth weight: case-control study in Australian Aboriginal women. *BMJ* 1991;**303**:1369-73. (30 November.)
2 Smaill F. Antibiotic vs no treatment for asymptomatic bacteriuria.

In: Chalmers I, ed. *Oxford database of perinatal trials*. Version 1.2, disk issue 4, August 1990. Record 3170.
3 Thomsen AC, Mørup L, Brogaard Hansen K. Antibiotic elimination of group-B streptococci in urine in prevention of preterm labour. *Lancet* 1987;i:591-3.

Training in obstetrics

SIR,—The meeting on recruitment in obstetrics and gynaecology reported by Susan M Blunt attracted a biased group of doctors, largely intent on achieving consultant status.[1] It was hardly surprising that we concentrated on the need for consultant expansion in addressing the need for more manpower. The terms associate specialist and clinical assistant were virtually unheard.

As a profession with a pyramidal hierarchy, medicine must be unique in training all those at the base to expect to rise to the apex and to make practically no provision for any to stay at an intermediate level. It would seem ridiculous if all bank employees expected to become a manager. Can we in medicine be so blinkered as to ignore the valuable resource of those we train who may not wish to climb the pyramid with the inherent risk of falling off? What is it about consultancy that we all want? Not the hours spent in administration, the nights on call, or the remoteness from clinical practice. Perhaps it is status. Doctors are trained to need the respect of the public and their peers and to believe that, in hospital medicine, consultancy is the only way to achieve this.

If we are to attract doctors back into our specialty, and keep them, perhaps we should expand the non-consultant permanent posts and promote them to the ranks of respectability. Or are we such hostages to the need for power that the practice of obstetrics and gynaecology ceases to be sufficiently exciting and challenging in itself?

CHARLOTTE FLEMING

Bristol University IVF Unit,
BUPA Hospital,
Bristol BS6 7JJ

1 Blunt SM. Training in obstetrics. *BMJ* 1991;**303**:1416. (7 December.)

More oncologists, please

SIR,—In his plea for more radiotherapists Jeffrey Tobias raised the difficult question of how best to organise the nation's cancer services in the future.[1] He points out the rise in referral rates for radiotherapy and contrasts this with the static number of consultant radiotherapists. By his own admission, clinical oncology has become more diverse with increasingly complex chemotherapy regimens, the development of palliative care, and the need for support services. This has been reflected by the development of medical oncology and palliative care as separate specialties. His suggested solution, however, of more radiotherapists to provide comprehensive cancer care fails to recognise this growing diversification.

Let us take Tobias's example of breast cancer. The past decade has seen the move away from radical surgery to conservative surgery plus radiotherapy. Recently, however, adjuvant chemotherapy has been shown to confer a survival benefit on many patients with breast cancer.[2] A recent study showed that adjuvant chemotherapy for Dukes's C colonic carcinoma also confers a survival benefit.[3] Development of chemotherapy regimens which confer survival benefit is likely to lead to a large increase in the use of adjuvant chemotherapy in the next decade. The number of medical oncologists has remained static in Britain over the past 10 years. Not only are more medical oncologists needed but these posts should be created in many more regions across the country to provide a uniform service.

The future planning of cancer services should reflect trends in treatment and not only appoint more radiotherapists but also build up the developing specialties of medical oncology and palliative care. An integrated national service with all three specialties working together would provide more comprehensive cancer care.

STEPHEN JOHNSTON
TIM IVESON

Department of Medicine,
Royal Marsden Hospital,
London SW3 6JJ

1 Tobias J. More radiotherapists, please. *BMJ* 1991;**303**:1085-6. (2 November.)
2 Early Breast Cancer Trialists' Collaborative Group. *Treatment of early breast cancer*. Oxford: Oxford University Press, 1990.
3 Moertel CG, Fleming TR, MacDonald JS, Halter DG, Lawrie JA, Goodman PJ, *et al*. Levamisole and fluorouracil for adjuvant therapy of resected colon carcinoma. *N Engl J Med* 1990;**322**:352-8.

Parent support groups

SIR,—The editorial by J V Leonard is timely and factual but the subheading—"doctors should work closely with them"—was somewhat misleading as the text discussed only the important aspect of doctors listening to parents and patients.[1] Parent support groups can be a negative influence if professionals are not involved in monitoring the activities. In the same issue the personal view by A Gerrard describes a family that gained in a positive way from the experiences and problems of having a child with a serious metabolic disorder,[2] and those of us working with families of children with chronic disease have had all the advantage of learning from such encounters. Some families, however, see their problems in a very negative light and remain bitter and angry—unfortunately these families may become very influential in parent groups and are detrimental to parents of newly diagnosed children. Unless professionals are on hand to detect, help, and direct the energies of such people, they can taint and reduce the effectiveness of the group support.

Parents can and do teach professionals and they make powerful allies if they see themselves as such. If they are adversarial their impact will be of greater detriment to fellow families than to professionals and it is our duty to prevent this.

P MORRIS JONES

Royal Manchester Children's Hospital,
Pendlebury,
Manchester M27 1HA

1 Leonard JV. Parent support groups. *BMJ* 1991;**303**:1152. (9 November.)
2 Gerrard A. We have a metabolic disease. *BMJ* 1991;**303**:1208. (9 November.)

General practitioners awareness of COSHH regulations

SIR,—R A Cooke and colleagues' comments on general practitioner's knowledge of the Control of Substances Hazardous to Health (COSHH) regulations is borne out by my similar study undertaken last year but extended to assess knowledge of the law relating to health and safety rather than just COSHH.

A questionniare was distributed to 86 general practitioners attending a research meeting of the Royal College of General Practitioners in Birmingham on November 1990. A total of 52 (60%) were returned from the attendees, of whom all held either the MRCGP or the FRCGP. Forty one (79%) of those who completed the questionnaire recognised that if a member of their staff had an accident which resulted in a fractured ulna then it should be reported, but only one correctly stated that the accident should be reported under RIDDOR (Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations) to the Health and Safety Executive. No general practitioner correctly recognised that an accident to a member of staff resulting in a five day absence for a bruised foot without bones being broken was also reportable under the same regulations.

Although 47 general practitioners worked in practices with more than five employees, only 25 (53%) had a written safety policy as required under the Health and Safety at Work Act 1974, and only 24 (46%) displayed a notice or gave out a leaflet outlining basic health and safety arrangements as required under the same act.

Procedures to account for staff in the event of a fire on practice premises and guidance on the management of a sharps injury were present in 62% (32) and 73% (38) of practices respectively.

Turning to COSHH, 23 (44%) general practitioners had heard of the regulations, compared with 59% in Cooke *et al*'s study, but only nine (17%) had undertaken any assessments.

As in Cooke *et al*'s study the survey yielded a poor response rate but those who did reply did not seem to be aware of the requirements of the Health and Safety at Work Act or the need to report specific types of workplace accident.

Health and safety legislation is increasing in volume with the consultative documents on visual display units and manual handling being released next year, both of which will affect all employers including general practitioners. Cooke *et al* have already suggested where guidance can be obtained, but inclusion of health and safety law in trainee and postgraduate education could also be of benefit.

N R WILLIAMS

Beckenham,
Kent BR3 4TL

1 Cooke RA, Gavaghan S, Hodgson EB, Moore S. General practitioners awareness of COSHH regulations. *BMJ* 1991; **303**:1132. (2 November.)
2 Health and Safety Commission. *The Control of Substances Hazardous to Health Regulations 1988. Approved code of practice*. London: HMSO, 1988.
3 Health and Safety Executive. *The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations*. London: HMSO, 1985.
4 Health and Safety at Work Act 1974. London: HMSO, 1974.

Unemployment rates: an alternative to the Jarman index?

SIR,—Brian Jarman comments on the advantages of using unemployment as a measure of deprivation.[1] We wish to respond to what he perceives to be the drawbacks of the unemployment variable.

He points out that unemployment applies only to the economically active population and does not count children and elderly people. This is to miss the point somewhat. In our study we used the unemployment rate as a proxy for deprivation in a geographical community.[2] It was used in a population context. There was no requirement to count subjects at risk or any implication that the link between unemployment and ill health is necessarily causal. What was shown was a strong correlation between high unemployment rates and high morbidity for the population as a whole, at small area level. The association demonstrably applies to children and elderly people. Despite the inclusion of the lone elderly variable in the Jarman index the correlation with rates of admission to hospital in those aged over 75 was stronger with unemployment in each of the years 1981, 1985, and 1990 than with the Jarman index. The differential was even greater for admission rates in those aged under 15, with an R value of 0·769 with the unemployment rate in 1990 compared with 0·494 with the Jarman index.

Though we accept Jarman's point that constructing the denominator at electoral ward level is