

Bovine spongiform encephalopathy threatens drugs in European Union

EDITOR—While the debates about bovine spongiform encephalopathy periodically have a high profile in public health, food safety, and agricultural and political environments, the pharmaceutical environment is now becoming seriously entangled in the web of controversy. On 20 February this year the pharmaceutical council of the European parliament accepted the European Commission's proposed revisions to directive 75/18/EEC.

If the revisions are accepted by the European Union's Council of Ministers it will mean that drugs for human consumption that have bovine, ovine, or caprine ingredients, or ingredients derived from such, will (with one exception) not be allowed on any member state's market after 31 December. Over 200 drugs with gelatin capsules will be affected, as will specific products such as HibTITER (*Haemophilus influenzae* type b vaccine), Hyalase (hyaluronidase), and Hypurin (insulin).¹

The only exception to the ban will be drugs with such ingredients that have or secure a pan-European Union product licence through the European Medicines Evaluation Agency's centralised route and for which no alternative drug is available. This escape route shows another aspect of the growing importance of the pan-European Union drug licensing system.²

On 10 June this year Emma Bonino, the commissioner for fisheries, consumer policy, and the European humanitarian office, announced the creation of another committee of the European Union, the scientific steering committee. This will act as the supreme source of expertise for the commission and offer excellence, independence, and transparency.

The first task for the scientific steering committee must be to make available the scientific evidence and rationale underpinning the decision to revise directive 75/18/EEC. If there is a scientific basis for the policy the committee should, being excellent and independent, produce it for all to see. The more obvious reason for the commission's actions is that the European parliament had earlier threatened by 422 votes to 49 to force the commission to resign in a body if it did not act on the crises over bovine spongiform encephalopathy. Whether the emerging responses are justified or prudent remains questionable. Who

is going to benefit from this malaise in policy and this lack of evidence based decision making: the millions of consumers of meat, jellies, sweets, and drugs?³⁻⁵

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- 1 Association of the British Pharmaceutical Industry. *Compendium of data sheets and summaries of product characteristics*. London: ABPI, 1996.
- 2 Earl-Slater A. Recent developments in regulating the pharmaceutical business in the EU. *European Business Review* 1996;96(1):17-25.
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- 4 Coghlan T. New Labour, new Europe. *BMJ* 1997;314:1506. (24 May.)
- 5 Davis P. *Managing medicines: public policy and therapeutic drugs*. Buckingham: Open University Press, 1997.

Figures given for bed complement in Edinburgh were wrong

EDITOR—In a letter the chief executive and chairman of the Royal Infirmary of Edinburgh object to the figures that Allyson M Pollock and colleagues used when they considered the implications of a private finance initiative in Edinburgh.¹ Included in their letter was a table that documented the bed status at 31 March 1997. This table included the bed status of the Eastern (not Edinburgh as printed) General Hospital. Unfortunately, the figures for the Eastern General Hospital that John J Owens and Cairns Aitken used were incorrect; the table shows the correct figures.

The figures that Owens and Aitken used were projected figures that had been calculated on the basis of several assumptions and were not the actual staffed bed

complement at 31 March 1997. Contrary to what Owens and Aitken state in their letter, these were not discussed with the clinicians involved.

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- 1 Owens JJ, Aitken C. What happens when the private sector plans hospital services for the NHS. *BMJ* 1997;314:1619-20. (31 May.)

Delays in diagnosing oesophagogastric cancer

Attempts to reduce delays in diagnosis should be done in controlled trial

EDITOR—The finding that gastric cancer detected early has a long doubling time (several years) whereas that diagnosed in an advanced stage has a short doubling time (several months)¹ is consistent with the well known length bias. A non-aggressive course is associated with a long subclinical period with a high chance of early detection, whereas aggressive growth with a rapid onset of severe clinical symptoms leaves little chance of recognition of disease in an early stage. This confounds the observation that "early" cancer has a better prognosis than "late stage" cancer. The low case fatality from gastric cancer in Japan is a logical consequence of such biases, given that over six million Japanese people (presumably a selection of healthy people) have stomach screening annually. The suggestion that "patients with new onset dyspepsia and with changes in long standing dyspepsia must be referred promptly [for gastroscopy]"¹ is therefore not evidence based.

In practice, early detection of cancer means not only the possible advantage of better curability in some cases but also the possible disadvantage of overdiagnosis and overtreatment in many other cases. Necropsy

Bed complement at Eastern General Hospital, Edinburgh, at 31 March 1997

	Bed complement at Eastern General Hospital		60% of complement at Eastern General Hospital*
	As stated by Owens and Aitken	Actual	
General surgery	10	42	25
General medicine	48	107	64
Gynaecology	15	13	8
Obstetrics	15	37	37 (all to RIE)
Neonatology	8	7	7 (all to RIE)
Subtotal	96	206	141

*Calculations assume that 60% of beds at Eastern General Hospital are moved to Royal Infirmary of Edinburgh (RIE) and 40% to Western General Hospital, Edinburgh, except where otherwise stated.

studies show that 25% of women have cancerous breast tissue at the time of death, but in only 29% of these was it diagnosed during their lifetime.² Screening or case finding has invariably resulted in a considerable increase in diagnosed breast cancer. The incidence of malignant melanoma, similarly, has doubled in places where early detection campaigns took place, with no subsequent change in mortality being observed. "It is possible that earlier diagnosis has uncovered a pre-existing nonmetastasising, nonfatal form of melanoma, and that this accounts for a substantial proportion of increases in incidence."³ Furthermore, necropsy studies indicate that prostate cancer is present in nearly half of older men, suggesting that many occult cancers detected through screening would not manifest themselves during the patient's lifetime.⁴

The medical community has hesitantly learnt to accept that screening for prostate cancer is not useful.⁴ We will perhaps be forced to accept that even the benefit of screening for breast² and cervical cancer⁵ is equivocal. It is time to stop publishing papers suggesting that more should be done about early detection of cancer without suggesting that length and lead time bias and the dilemma of overdiagnosis should be addressed. The important question is not whether cancer statistics can be improved but whether interventions truly do more good than harm to patients. If Britain is to rush to "improve" on delays in the diagnosis of gastric cancer it should be done in a controlled trial.

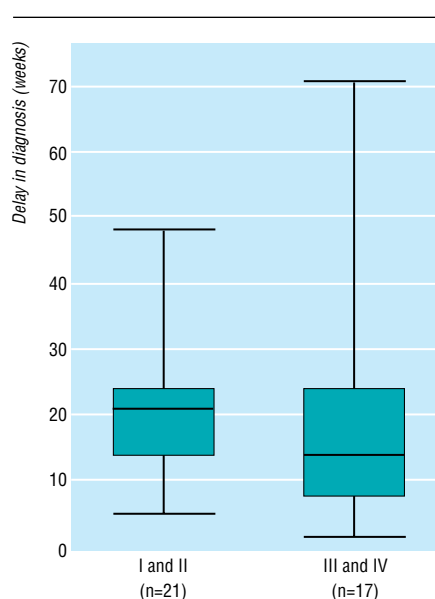
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Small study showed no difference in delay with stage

EDITOR—We agree with Iain G Martin and colleagues' wish to see more patients at an earlier stage of their disease.¹ We are, however, unhappy about their conclusion from such a small number of patients with oesophageal cancer and its implication.

Over the past two years, one of us (WG) personally visited over 50 patients before intended oesophagectomy at four West Midlands hospitals. A brief questionnaire was administered, which included an inquiry about the onset of relevant symptoms in each patient so that the interval between that time and both diagnosis and treatment could be estimated. We had hoped to reach a conclusion identical with that of Martin and



Delay in diagnosis of oesophageal cancer according to stage

colleagues to justify a nationwide awareness campaign to the public as well as to primary carers. Thirty eight of the interviewed patients had a full resection so that the tumour, node, metastases (TNM) status and grade could be recorded.

The figure shows that we found no difference in delay; delay in presentation was not related to prognosis. Now that the incidence of adenocarcinoma exceeds that of squamous carcinoma,² perhaps screening of certain patients with a Barrett's oesophagus will be the next hope. Wright et al, however, showed that this was not cost effective as it cost £14 868 to detect an asymptomatic man and £42 084 to detect a woman with early cancer.³ Van der Burgh et al also found screening not to be cost effective, though they suggested that patients with either an ulcer or columnar epithelium longer than 7 cm were more vulnerable to malignant change.⁴

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Provision of endoscopy in primary care speeds diagnosis

EDITOR—Iain G Martin and colleagues highlight the delays in reaching a histological diagnosis of upper gastrointestinal

cancer in a specialised hospital with open access gastroscopy.¹ They suggest a one stop service as a remedy. Most hospital units, however, are already struggling to provide an open access service and would be overwhelmed if 1% more of the population were examined annually, as recommended by the British Society of Gastroenterology. Increasing endoscopy services in hospitals also has cost implications.

An alternative is to establish diagnostic endoscopy clinics from within primary care that are run by experienced general practitioner endoscopists in accordance with the guidelines set out by the British Society of Gastroenterologists. Such units would cater for a more local population. During the past two years over 700 patients have had gastroscopy at our two surgeries, with an average waiting time of two weeks from the date of referral. Excellent "turn round" times from our local pathology department add, on average, a further week to obtain a histological diagnosis. Speed of communication between the referring general practitioner and the endoscopist is enhanced by the use of fax to transfer details of referrals and reports. Our cost per case is much less than that charged by our local trust hospitals because of reduced overheads and the omission of sedation.

Faster, cheaper, and easier local access to diagnostic endoscopy is one key element in the earlier diagnosis of upper gastrointestinal malignancy. Although in its infancy, the provision of endoscopy in primary care is highly efficient and looks set to expand, provided support continues from our political masters.

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Misconceptions exist over whether delay in diagnosis influences survival

EDITOR—Iain G Martin and colleagues report the causes of delays in the diagnosis of oesophagogastric cancer.¹ Against a background of a median delay of 17 weeks, the authors argue that long delays matter to outcome. With respect to gastric cancer, this extrapolation should be interpreted with caution.

The basic assumption is that advanced cancers presenting after long delays in diagnosis were potentially earlier stage tumours when their symptoms began; this assumption is questionable. Using a model of tumour doubling times is simplistic. Tumour stage is related more to invasion and spread than simply to tumour size,² and a tumour may double in size but not be upstaged. Equally, this model assumes that the doubling time occurs within the window of delay, and clearly this is not so for some "early" cancers, where doubling times may be very long (up to 10 years; references 11 and 12 in the paper).

A distinction must be drawn between early diagnosis and the diagnosis of "early" cancer. In units with dedicated endoscopic services the proportion of early cancers diagnosed may reach 15%³ and 26%,⁴ but most symptomatic cases present as advanced disease. The implication is that a large number of early cancers are clinically silent and therefore would never present for early investigation.

The important question is whether delay in diagnosis influences survival. This cannot be answered from the present data as survival was not reported. Both this study and the analysis by J R Siewert and U Fink in their commentary on the paper showed no correlation between the duration of delay and tumour stage. As stage is the main predictor of survival,⁵ delay would be unlikely to correlate with survival. The failure to show a relation between delay and the success of potentially curative resection is further indirect evidence that diagnostic delay may not be of prognostic importance.

We write not to question the principle of early investigation (which we support) but rather to address some misconceptions about delay in diagnosis. If nothing else, this is important for its medicolegal implications.

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- 5 Miwa K. Japanese Research Society for Gastric Cancer. Evaluation of the TNM classification of stomach cancer and proposal for its rational stage-grouping. *Jpn J Clin Oncol* 1984;14:385-410.

Small study found that four fifths of delay was due to patients

EDITOR—Iain G Martin and colleagues show that there are significant delays in the diagnosis of oesophagogastric cancer.¹ Using similar methodology, we have investigated diagnostic delay in a consecutive group of patients with gastric cancer. Overall, we found longer delay than that described by Martin and colleagues (table).

For the purposes of our study we divided this delay into the time from onset of new upper gastrointestinal symptoms to presentation to a general practitioner ("patient delay") and the time from attending the general practitioner to histological diagnosis ("medical delay"). In our study four fifths of the delay was patient delay (compared with 29% in Martin and colleagues' study). We attributed considerable delay to patients' ignorance, general practitioners' reluctance to refer patients, and logistical problems inherent in referral. In our experience, once a patient attended hospital, diagnosis was swift. It is worrying that Martin and colleagues found that two fifths of patients attending a specialist centre did not receive a diagnosis for four weeks and a quarter remained undiagnosed for over two months. We note that the authors allowed 43% of patients to be referred "conventionally," and we assume that they saw them in an outpatient clinic initially. In our practice, this diagnostic delay can be reduced not only by open access endoscopy but by filtering and channelling general practitioners' referrals. Since endoscopy is usually mandatory by the time of referral, we direct to endoscopy initially those patients with upper gastrointestinal symptoms (between the ages of 35 and 80) who are newly referred by general practitioners. Like Martin and colleagues, we found that many patients with gastric cancer (half) were taking some form of antisecretory drug at the time of diagnosis. In some cases the patients had self administered over the counter medicines (mainly H₂ antagonists). Of more concern, however, was that almost a third of patients with gastric cancer had been prescribed proton pump inhibitors before an endoscopic or histological diagnosis had been established. Empirical prescription of a proton pump inhibitor was associated with a significant increase in medical delay (median 12 v 4 weeks; P<0.005). We endorse Martin and colleagues' conclusion that early referral for investigation and prompt endoscopic assessment of patients with upper gastrointestinal symptoms should be encouraged. Our units clearly differ in the areas in which we need to improve practice. If we could emulate the authors' success with educating general practitioners and patients and the authors could address their local problems

of delay in hospital, both our units would reduce considerably the delay in diagnosing oesophagogastric cancer.

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Screening for mannose binding protein gene in routine practice is unnecessary

EDITOR—John A Summerfield and colleagues suggest that mutations in the mannose binding protein gene are associated with infections in children attending their hospital paediatric department.¹ They also conclude that screening for such mutations should be included in the investigation of severe or frequent infections, but they fail to explain why. What is the point of screening? How can identifying such mutations in these children improve outcome? They mention no effective interventions for patients carrying the gene.

The number of new tests introduced into routine laboratory practice has increased steadily,² and there is no authority responsible for evaluating them. The research and development programme aims to identify priorities for research, and many innovations are being evaluated; an unknown quantity, however, are creeping into practice. To get some idea of the scale of diffusion of new biochemical tests into practice I surveyed three centres in the Anglia and Oxford region. I found that, of new tests introduced in the past five years, only just over half were known to improve clinical outcomes or to be more sensitive and specific than their predecessors. Hospital specialists were the group most influential at getting the new tests into routine practice.

The introduction of new tests often seems to be due to the enthusiasm of individuals rather than to systematic evaluation to prove appropriateness, effectiveness, and good value for money matched with corresponding clinical knowledge and a corresponding research base. The cost of the tests is often low and hidden from commissioners of health care within clinical contracts. The burden falls on other budgets as patients with false positive results are inappropriately investigated and treated.

Screening for the mannose binding protein gene as part of a controlled study to identify the risk conferred or as part of other research is acceptable. We should not, however, rush into recommending that yet another test is introduced into routine prac-

Comparison of delay in diagnosis and relative contribution to this of "patient delay" and "medical delay" between two similar centres

Delay	Leeds ¹ (n=88)		Newcastle (n=110)	
	% of total delay	Median delay (weeks)	% of total delay	Median delay (weeks)
Overall		17.3		20.4
Patient delay*	29	2.0	80	16.3
Medical delay†:				
Before admission to hospital	39	NS	16	3.0
In hospital	32	3.1	4	1.0

NS=Not stated.

*Delay from onset of new upper gastrointestinal symptoms to attending general practitioner.

†Delay from attending general practitioner to histological diagnosis.

tice when there is no evidence to suggest that it will do more good than harm.

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2 Audit Commission. *Critical path, an analysis of pathology services*. London: HMSO, 1993.

Sexual medicine

Integrated services for sexual health care are the way forward

EDITOR—In their editorial, Jona Lewin and Michael King concluded that there was an urgent need for the emergence of sexual medicine as a new specialty.¹ They called for closer liaison between medical and other relevant disciplines. Family planning, genitourinary medicine, gynaecology services, and primary care are separated in geographical and political terms. Furthermore, the narrow focus of most medical training compounds the problem. Integrated services are the way forward.

In light of this radical vision for the future it was depressing to read Virginia Royston's personal view on the forced change in her family planning service from one available to all to one geared only towards young people.² She claims that general practice is for the "really ill" and not an appropriate place for women with contraceptive problems. In fact, the bulk of a general practitioner's workload consists of psychosocial and preventive care. General practitioners should (and usually do) provide a holistic response to their patients' health needs. They are well placed to address the contraceptive needs of their patients. General practitioners have access to their patients' medical and social histories, unlike practitioners in family planning clinics, who carry a great responsibility in terms of eliciting a thorough family and personal history of risk factors from young patients.

In 1992 the British government made sexual health a priority in the Health of the Nation strategy. The new Labour government must also take sexual health seriously. Doctors at undergraduate and postgraduate levels must be trained in the practice of sexual medicine. Payments for contraceptive care in general practice must be linked to some criteria showing evidence of competence.

Royston also raises the issue of choice. The concept of a general practitioner as the first point of contact for patients is well established. So long as family planning clinics and general practitioners continue to compete for the same clients, there is little hope of cooperation in terms of a sensible delegation of the workload or a more coordinated approach to the problem of unwanted pregnancy.

During the next decade there may still be problems within primary care in terms of attitudes towards sexuality. This is particu-

larly true when the needs of young people and women with unwanted pregnancies are concerned. For this reason an easily accessible contraceptive service catering to these groups should continue.

In the longer term, the emergence of family planning and reproductive health care as a consultant led specialty supporting primary care should help eliminate outdated ideas about sexual medicine. Providing training for doctors to enable them to discuss sexual health issues with ease is another essential strategy.

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2 Royston V. Memoirs of a service reduction survivor. *BMJ* 1997;314:1490-1. (17 May.)

Models of integrated sexual health services already exist

EDITOR—As officers of the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists we were disappointed not to have been consulted by Jona Lewin and Michael King as part of the preparation for their editorial on sexual medicine.¹ This faculty was established in 1993 and is at an advanced stage in preparing a syllabus for higher specialist training. The syllabus includes a compulsory unit on training in sexual dysfunction together with an option for further specialist training. Our discipline clearly fulfils a need in society; so far there are 72 consultants in family planning, reproductive health care, or community gynaecology in the United Kingdom.

There are already models of integrated sexual health services—for example, between family planning and genitourinary medicine—and some of these have input from psychological or psychiatric services. We support closer liaison between relevant medical disciplines in the development of better sexual health services and suggest that our faculty's training programme may be a useful model for the training of other specialists.

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Genitourinary medicine clinics are an obvious place for treatment of sexual dysfunction

EDITOR—Jona Lewin and Michael King are correct in emphasising the importance of a collaborative approach to the treatment of sexual dysfunction and the need to provide training in sexual medicine.¹ We are concerned, however, at their lack of recognition of the increasingly important role of genitourinary medicine clinics in the treatment of sexual dysfunction.

Several studies have suggested that the prevalence of sexual dysfunction is high

among those attending genitourinary medicine clinics.^{2,3} This may be associated with the open access nature of these clinics, which attract patients who feel uncomfortable discussing their sexual health needs with their general practitioners. As a result of the increase in the number of patients attending these clinics, many services have established specific multidisciplinary sexual dysfunction clinics.⁴

Additionally, the Genitourinary Physicians Study Group in Sexual Dysfunction—of which one of us is the chairman (PK) and one the secretary (WD)—has been established and has hosted several interdisciplinary meetings at the Royal Society of Medicine.⁵ The study group has discussed issues of standards of care for sexual dysfunction within genitourinary medicine and also looked at training in sexual medicine, but unlike the authors, the group thinks that there are courses that offer balanced training, in both London and Manchester among other places. The group has also set up a network of clinics where colleagues have gained practical experience in the management of sexual dysfunction, particularly erectile dysfunction. The study group will hold further meetings dealing directly with how to establish a specialist clinic in sexual medicine.

We agree with Lewin and King that a holistic approach to sexual medicine is required. We suggest that as genitourinary medicine sheds its old image of treating only venereal infection and addresses more general sexual health needs, genitourinary medicine clinics are an obvious place for treating sexual dysfunction.

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2 Catalan J, Bradley M, Gallwey J, Hawton K. Sexual dysfunction and psychiatric morbidity in patients attending a clinic for sexually transmitted diseases. *Br J Psychiatr* 1981;138:292-6.

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Safety in acupuncture

Rigorous accreditation schedule for acupuncture already exists

EDITOR—E Ernst and A White raise important points about the safe practice of acupuncture.¹ Most people would agree that sticking needles into patients, however fine they are, has the potential for harm. What I find surprising, having chaired the British Acupuncture Accreditation Board since its beginnings in 1989, is that the authors seem to be calling for a solution that has been in place for nearly eight years; bylaws governing aspects of safe practice in acupuncture clinics have been in place considerably

longer.² The "system of self regulation" that the British Acupuncture Accreditation Board embodies is not "likely to gain support from ... official bodies": it has already gained it, as Ernst and White will see if they reread the BMA's 1993 report on complementary medicine³ or talk to people in the Department of Health. We set a rigorous accreditation schedule, which makes stern demands on the acupuncture training colleges and includes the issues of safety and familiarity with orthodox medicine (comprising a third of the syllabus) that the authors are rightly concerned about.

Ernst and White overlooked a development that is known to most of those working in complementary medicine. As with homoeopathy, historically one of the difficulties has been to get medical practitioners round the same table as their non-medical counterparts. This has shown itself recently in the field of regulation and accreditation, and one result of Ernst and White's editorial might be to spur both camps to come together for the benefit of the general public.

Incidentally, the authors may prove unduly pessimistic about statutory registration for acupuncturists. Osteopathy, with which they seek to contrast acupuncture, was not defined in legislation either.

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- 1 Ernst E, White A. Acupuncture: safety first. *BMJ* 1997;314:1362. (10 May)
- 2 Local Authorities (Miscellaneous Provisions) Act 1982. London: HMSO, 1982.
- 3 BMA. *Complementary medicine: new approaches to good practice*. Oxford: Oxford University Press, 1993:135.

Core curriculum is important

EDITOR—As representatives of a college with candidacy status with the British Acupuncture Accreditation Board, we agree with E Ernst and A White's plea for "basic medical knowledge and experience" to be included in acupuncture training programmes.¹ The authors are concerned about the safety of acupuncture as practised in Britain, citing reports of complications resulting from acupuncture (most of which occurred outside Britain) and suggesting that these are consequences of inadequate training and naivete of practitioners. We are sorry that they did not mention that the British Acupuncture Accreditation Board has a core curriculum for students, which emphasises a grounding in anatomy, physiology, and pathology; a knowledge of presentations of disease requiring referral to a conventional practitioner; and sterile and safe needle technique.²

Acupuncture practised by graduates of accredited colleges entails the insertion of sterile needles into acupoints located with the aid of a thorough knowledge of surface anatomy. Needles are usually retained for no more than 30 minutes. Needles are either single use needles or sterilised; there is no risk of the transmission of diseases such as HIV or hepatitis between patients and a minimal risk of skin flora being introduced into subcutaneous tissues.

Guidelines from the Royal College of Physicians suggest that prophylaxis for infective endocarditis should be considered only when the skin has been breached for invasive gastrointestinal, urological, or cardiac surgery.³ This suggests that expert opinion is that acupuncture does not pose the risk that concerns Ernst and White. Surely there must be greater risk in the use of larger gauge needles for venepuncture and injections.

Students are trained in the anatomy of vital organs and how these are avoided during needling. Correct knowledge of the depth of thoracic acupoints reduces the risk of reaching a visceral organ. We believe that the risks of acupuncture are bound to increase in inverse relation to the training of the practitioner. We therefore disagree that a medically qualified acupuncturist is less likely to cause complications: most doctors seek only a cursory training in acupuncture.

We find the phrase "overoptimistic prognoses naively based on the theory of Chi" to be a derogatory and inappropriate way of describing a sensitive diagnostic system that has stood the test of time. We are perplexed that a professor of complementary medicine should apparently hold such a negative view of an approach that acupuncturists worldwide would consider the essence of their practice.

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- 1 Ernst E, White A. Acupuncture: safety first. *BMJ* 1997;314:1362. (10 May)
- 2 British Acupuncture Accreditation Board. *Accreditation handbook*. London: BAAB, 1995.
- 3 Shanson DC. Prophylaxis and treatment of infective endocarditis. *J R Coll Physicians Lond* 1981;15:169-72.

Guidelines on practice of acupuncture exist

EDITOR—E Ernst and A White provide outdated information about the safety of acupuncture and seem to ignore current standards of practice in Britain.¹ There have undoubtedly been many instances of infection in over 3000 years of use of acupuncture as well as some adverse reactions, but this would also be true of other invasive techniques and the use of Western medicine. What matters most to British patients is what happens in Britain now. Ernst and White's references give a global picture, in some cases referring to the 1970s and 1980s and to acupuncture given by doctors.

In Britain all healthcare professionals and patients can be assured that guidelines that minimise the risk of infection have existed for some time. These guidelines, which have been adopted by the British Acupuncture Council and its 1600 members, were independently developed by Professor Norman Noah (of King's College, London). They cover the use of sterile acupuncture needles, the techniques of sterilisation, and the hygiene measures used to minimise any risk of infection due to insertion through "dirty

skin." Indeed, the National Blood Transfusion Service allows patients who have recently had acupuncture treatment by members of the British Acupuncture Council to give blood because it is happy with these guidelines.

The British Acupuncture Accreditation Board advocates strict guidelines for a core syllabus in traditional acupuncture, which includes Western medicine. These guidelines, together with strict codes of ethics, practice, and professional conduct, ensure that those people graduating from accredited or candidate colleges and those already on the register of the British Acupuncture Council, practise traditional acupuncture safely and competently—patients' safety being the overriding consideration. Even so, the council, its members, and colleges of traditional acupuncture that are either accredited or going through the accreditation process of the British Acupuncture Accreditation Board, are not complacent about any of these issues.

Many of the ideas and solutions suggested by Ernst and White are essentially in place. The British Acupuncture Council recognises that it represents only traditional acupuncture and that many doctors and physiotherapists also perform a more limited style of acupuncture. The council would happily enter into discussions with a view to the adoption of a British or even European set of regulations and standards.

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- 1 Ernst E, White A. Acupuncture: safety first. *BMJ* 1997;314:1362. (10 May)

Association between voting patterns and mortality remains

EDITOR—We reported on the association between voting patterns and mortality in England and Wales during the 1983, 1987, and 1992 British general elections.¹ There was a strong negative association between voting Conservative and mortality and a strong positive association between voting Labour and mortality; there was a weaker negative association between voting Liberal Democrat and mortality and a weaker positive association between abstention and mortality. The recent general election, in which a Labour government was elected with a large majority, has been interpreted as reflecting a breakdown of traditional voting loyalties.^{2,3} We have analysed the results of the 1997 general election in England and Wales with the exception of two seats: Tatton, in which an independent candidate stood against a Conservative alleged to have taken money in return for asking questions in parliament, and West Bromwich West, where the speaker of the House of Commons was unopposed. We used mortality data for 1990-2; these are the most recent data from the 1991 census for which estimates of the population at risk of death are available. In the table we have added our

Correlation between party voted for and mortality, 1983-97

Election year	Overall standardised mortality ratio	Male standardised mortality ratio	Female standardised mortality ratio
1983:			
Conservative	-0.76	-0.81	-0.65
Labour	0.76	0.79	0.67
Liberal Democrat	-0.49	-0.52	-0.42
Abstention	0.36	0.43	0.27
1987:			
Conservative	-0.75	-0.80	-0.64
Labour	0.77	0.80	0.68
Liberal Democrat	-0.52	-0.54	-0.45
Abstention	0.37	0.43	0.28
1992:			
Conservative	-0.74	-0.79	-0.61
Labour	0.73	0.75	0.63
Liberal Democrat	-0.50	-0.53	-0.42
Abstention	0.54	0.62	0.40
1997:			
Conservative	-0.72	-0.79	-0.58
Labour	0.66	0.69	0.57
Liberal Democrat	-0.49	-0.52	-0.41
Referendum	-0.27	-0.29	-0.22
Abstention	0.61	0.69	0.47

All standardised mortality ratios $P < 0.0001$.

findings for the 1997 election to the results from previous elections.

The correlations between voting Conservative, Labour, or Liberal Democrat and mortality have changed little. There is a weak negative correlation between voting for the Referendum party and mortality; the Referendum party fielded candidates in 547 constituencies and won 2.7% of the vote. The main change over time is the continuing strengthening of the positive correlation between abstaining and mortality. The 60% variance in mortality explained by the voting data is virtually identical with the 61% explained by voting in the 1992 election. Correlations in the analysis for the 1997 election may be weakened by the fact that the mortality data are taken from six years before the election. The main change is that for the 1997 election, voting for Labour and abstaining are the most important variables in explaining the variance in mortality in multiple regression analyses, while in the 1992 election Labour and Conservative voting contributed most to the analyses.

Frank Dobson, the new health secretary, has stated that "Labour will tackle the underlying causes of bad health and if we succeed we will be able to use the slogan 'vote Labour, live longer.'"¹ Increasingly it is young adults living in places where few people vote who die youngest. Perhaps the new Labour government should concentrate on socially excluded groups, who may not contribute to electoral success but nevertheless require the most from an administration that offered to lead us away from 18 years of selfishness under the Conservative government.

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1 Davey Smith G, Dorling D. "I'm all right, John": voting patterns and mortality in England and Wales, 1981-92. *BMJ* 1996;313:1573-7.

2 Cornford J, Dorling D, Tether B. Historical precedent and British electoral prospects. *Electoral Studies* 1995;14: 123-42.

3 Pattie C, Johnston R, Dorling D, Rossiter D, Tunstall H, MacAllister I. New Labour, new geography? The electoral geography of the 1997 British general election. *Area* (in press).

4 Hall C. NHS change will take years, says Dobson. *Daily Telegraph* 1997 May 20:9.

Changes in laws are necessary to allow patients detained under Mental Health Act to vote

EDITOR—Before the Representation of the People Act 1983 came into force many people with mental illness were denied the right to vote. Even after the act was passed it remained more difficult for people with mental illness to register to vote than it did for other people.¹ Until recently, patients detained under the Mental Health Act had been assumed to be disenfranchised because they lacked a permanent address. Recently, the Home Office issued guidelines on the eligibility of people with mental illness to vote.²

The day after the general election we gave a questionnaire to 89 patients detained in a regional secure unit under the Mental Health Act. We wished to determine how many understood their right to vote in the general election, how many had wished to vote, and why they had not voted. Seventy three patients (82%) responded. Of these, 67 knew that the election had taken place, but none had voted. One patient had had a proxy vote but had been told he could not use it. Half of the patients said that they would have liked to vote; 46 did not know if they were entitled to vote. Fourteen had been told that they could vote; this information was correct for four patients. Of those who thought that they could vote, nine were correct. In total, 24 may have been eligible. The remainder were excluded because they had been in hospital

for more than a year or were prisoners serving sentences and thus ineligible to vote.

A large proportion of these patients would have been eligible to vote but for various reasons had not done so.³ They were poorly advised and unaware of their rights. Most of our patients were detained under the Mental Health Act and had often spent several months in hospital. Many continued to have places of residence outside the hospital but failed to satisfy conditions for registering to vote because of the length of their stay in hospital.

Current legislation is outdated and needs revising. Many people with mental illness, who would previously have been treated in hospital, are now managed in the community as a result of the reduction in the number of hospital beds.

Criteria for both eligibility to vote and registering to vote should be the same regardless of whether patients are detained under the Mental Health Act or whether they are informal patients. If a patient is resident in hospital for longer than a year, then use of the hospital's address is appropriate. Patients are likely to return to the hospital's local community during rehabilitation and to be affected by political change there; thus they should participate in the election of their local constituency's representative.

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2 Health Service Guidelines. *Electoral registration of patients detained under the Mental Health Act 1983*. London: Department of Health, 1996. (HSG(96) 43.)

3 Home Office Constitutional and Community Policy Directorate. Constitutional Unit. *Electoral registration of the homeless*. London: Home Office, 1996. (RPA 407.)

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