

Table 1—Students' choice of provider for different sexual health needs. Values are numbers (percentages)

Scenario	Family planning clinic	General practitioner	Sexual health clinic	Genitourinary medicine clinic	Other
You want advice on contraception (n = 960)	549 (57)	267 (28)	104 (11)	25 (3)	15 (2)
You want free condoms (n = 758)	536 (71)	59 (8)	112 (15)	42 (6)	9 (1)
You want advice on safer sex (n = 970)	481 (50)	233 (24)	198 (20)	32 (3)	26 (3)
You want an HIV test (n = 969)	85 (9)	357 (37)	418 (43)	97 (10)	12 (1)
You think you may have genital warts (n = 964)	81 (8)	444 (46)	265 (28)	168 (18)	6 (1)
You think you may have genital herpes (n = 959)	70 (7)	456 (48)	275 (29)	155 (16)	3 (1)
You are worried about discharge from your genitals (n = 943)	84 (9)	521 (55)	197 (21)	133 (14)	8 (1)
It hurts when you pass urine (n = 981)	24 (2)	750 (75)	72 (7)	130 (13)	5 (1)

harness their public image and work effectively towards the Health of the Nation's targets.⁵

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Teenagers can be helped to behave responsibly

EDITOR,—Sue Stuart-Smith's editorial on teenage sex contains several confusing statements.¹ Most of the editorial deals with underage sex, but conclusions are generalised to all teenagers. A prepubescent 13 year old is not the same as a physically mature 19 year old, yet they are both teenagers.

To explain the fact that young people fail to take preventive measures when they have intercourse Stuart-Smith suggests that they are cognitively immature, lacking in the capacity to reason abstractly or predict future consequences, and see things from a different perspective. While this may be the case for some younger adolescents, it has been shown that there is little or no difference in these respects between young people in mid and late adolescence and adults: for example, they reason equally well when it comes to making informed medical decisions.² In one study of perceived consequences of risky behaviour, which compared 12-18 year old adolescents with their parents, the authors concluded: "The strongest overall pattern in these results is how similarly the adolescents and adults responded."³ Furthermore, the suggestion in the editorial that late neural myelination in adolescence provides a biological basis for cognitive immaturity is controversial, with some studies that have used magnetic resonance imaging indicating that myelination is complete by early adolescence.⁴

The single most worrying feature of the editorial is the failure to recognise that teenagers can be helped to behave responsibly. Of course, some children, as they reach puberty, start sexual activity early because, for example, they are oversexualised after abuse or are seeking excitement to escape depressive feelings. But a controlled study has shown that many schoolchildren who are given adequate information and helped by older peers to

develop social skills delay sexual activity for longer than teenagers who do not receive such education.⁵ Surely the problem frequently lies not in cognitive immaturity but in the fact that responsible adults, parents, and teachers do not provide young people with the information they need and are capable of understanding, or with the relevant social skills so that they can make good life choices. In 1993 the abortion rate for 16-19 year olds was about a third of that for 20-34 year olds. Which is the irresponsible age?

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Screening to prevent renal failure in diabetic patients

Study's assumptions are unwarranted

EDITOR,—Bryce A Kiberd and Kailash K Jindal questioned the cost effectiveness of microalbuminuria surveillance in patients with insulin dependent diabetes mellitus¹ even though previous studies have shown that screening and intervention is likely to have cost benefits.² These were simulation studies based on a combination of epidemiological data and data from controlled clinical trials, and they were based on assumptions regarding incidence of complications, treatment effects, and the sensitivity and specificity of screening methods. In comparing screening for microalbuminuria with screening for hypertension and persistent proteinuria (both followed by treatment with an angiotensin converting enzyme inhibitor), Kiberd and Jindal made five critical assumptions that are not necessarily correct.

Firstly, they assume that diabetic patients with microalbuminuria usually develop hypertension before they develop nephropathy. However, blood pressure increases in parallel with increasing urinary albumin excretion rate,³ and hypertension is rare in the microalbuminuric stage, even on the basis of the 1993 WHO recommendations (140/90), and is not present in all patients with persistent proteinuria. Kiberd and Jindal did not define hypertension, so it is impossible to estimate its prevalence from the data.

Secondly, the low predictive value of microalbuminuria for development of nephropathy

claimed by the authors (0.3) is based on a Finnish study that included only patients with diabetes of very long duration, in whom the progression rate of microalbuminuria is low ("slow track patients").⁴ The subsequent correspondence showed that the group of patients was not representative of all patients with insulin dependent diabetes who develop nephropathy and that the follow up was too short.

Thirdly, Kiberd and Jindal assume that hypertension is an easy and unbiased diagnosis, resulting in no false positives or false negatives. We have shown, by comparing traditional outpatient blood pressure recording (repetitive readings) with 24 hour or daytime ambulatory recording, that systolic blood pressure recorded at outpatient clinics is 16.0 mm Hg higher than ambulatory daytime blood pressure and diastolic pressure is 8.7 mm Hg higher. Thus standard blood pressure reading would overdiagnose hypertension (false positive diagnoses).

Fourthly, contrary to the authors' assumption, prevention of nephropathy is not the only reason for surveillance and intervention. Suggesting that screening for microalbuminuria could be replaced by blood pressure recordings ignores the fact that patients with microalbuminuria are at high risk for developing other complications later in diabetes. Blood pressure reading is not as precise as microalbuminuria in "flagging" the person as being at high risk.

Kiberd and Jindal's fifth assumption is that treatment effect is measured optimally by quality adjusted life years. In their analysis, 17 health care workers were asked to score six conditions, which included only a few of the problems related to diabetes. The scores were not objective measures but represent the mean of 17 highly subjective evaluations (not those of patients or relatives). Quality adjusted life years is one of many ways of analysing data and should at least be combined with an analysis using real life years.

We find that screening for microalbuminuria in diabetic patients helps to identify those at high risk, as suggested by six professional organisations.⁵ We recommend that any surveillance system should be carefully monitored for effects on outcome related to health status, prognosis, and economics.

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