

Seventeen were resistant to isoniazid, three to rifampicin, two to ethambutol, 19 to streptomycin, and six to both isoniazid and streptomycin. Two patients had tuberculosis that was resistant to at least three drugs, of whom one repeatedly defaulted from the clinic while the other was a Nigerian with his first presentation of pulmonary tuberculosis. The pattern of drug resistance was similar to that in a previous study, but the incidence has more than doubled since that study.⁴

Mycobacteria were detectable on sputum examination in 159 patients. Thus within the local urban community there is great potential for transmission of *M tuberculosis* that is resistant to one drug. In addition, patients may well receive what is effectively two-drug treatment on diagnosis, which will accelerate the emergence of drug resistance. Since multidrug resistance is the result of the sequential acquisition of resistance to single drugs,⁵ treatment strategies must be altered as resistance to single drugs becomes more common and not when multidrug resistance is established. If our findings are confirmed elsewhere, British policies for treating tuberculosis will need to be revised soon. Four-drug empirical treatment of tuberculosis should then become normal practice, pending definitive results from drug sensitivity tests of the organism being treated.

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Strategic plans for vascular services have not been put into effect

EDITOR,—The media have recently focused on deaths resulting from the non-availability of intensive care. They see but the tip of the iceberg. The problem with paediatric intensive care beds, we are told, is "distribution rather than numbers."¹ The problem with accident and emergency services, we are told by the Audit Commission, is that they need to be centralised.² Advice such as this, however pertinent, is unlikely to be taken: the NHS is currently strangled by its own structure.

The need to rationalise those acute services that depend on round the clock availability of specialist staff and expensive resources becomes daily more obvious. The reorganisation of the NHS into independent trusts, the purchaser-provider split, and short term administrative contracts have placed road blocks in the way of strategic regional planning. Nowhere is this better shown than in the provision of vascular services.

In 1993 a report, *Vascular Surgery Services*, was prepared by a working party of the National Medical Advisory Committee.³ Taking into account a wide body of evidence, especially quality and economic issues, the report recommended that the 20 hospitals providing vascular surgery in Scotland

be centralised into six major and three intermediate units. Recommendations included that emergency services should be provided by surgeons specialising in vascular work, vascular surgeons should not work single handedly, on site intensive therapy units were essential and renal dialysis desirable, and the service should include specialist radiological and laboratory support.

What has happened in the intervening years? The distribution of vascular services has not changed. Singlehanded vascular surgeons continue to be appointed. Surgeons with no interest in vascular work are still obliged to participate in emergency rotas. Vascular services continue to lack the support of an intensive therapy unit. Renal failure, which is a common complication of vascular surgery, still necessitates interhospital transfer of ill patients. Radiology and laboratory support is deficient in many units, while elsewhere expensive diagnostic facilities are duplicated in adjacent hospitals.

Charters and guidelines are not the answer. Where are the administrative mechanisms, and what are the incentives to bring common sense, economy, efficiency, and quality into the acute services?

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Evidence for efficacy of topical acyclovir in recurrent herpes labialis is weak

EDITOR,—In a letter responding to my editorial about the value of acyclovir in recurrent herpes labialis¹ P-J Lamey says that the benefit of topical acyclovir has never been truly evaluated.² I agree. In my critical appraisal of the evidence for the efficacy of topical acyclovir I found that the trials that had been carried out had generally been of poor methodological quality and of weak power to detect treatment effects.³ Even if reliable thermographic methods have now been developed to confirm the prodromal stage of recurrent herpes labialis, properly conducted studies of efficacy and effectiveness still need to be done in primary care.

Shortly after the publication of my original review I approached the makers of topical acyclovir and suggested that they were the logical partners to produce placebo ointment for a randomised double blind trial in primary care, but they were unwilling to help. I also note that most of the papers supporting the use of topical acyclovir have come from departments of dentistry and oral medicine rather than from general practice. I still maintain that evidence for the efficacy of topical acyclovir in recurrent herpes labialis is weak.

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Neonatal circumcision and penile cancer

Evidence that circumcision is protective is overwhelming

EDITOR,—As chairman of the American Academy of Pediatrics' Task Force on Circumcision¹ and a reviewer on the topic for the American Cancer Society,² I am amazed at the claim by Paul M Fleiss and Frederick Hodges that no link exists between circumcision and penile cancer.³ In an incredible example of selective medical amnesia the authors ignore evidence that has accumulated in the past 64 years. They discredit Wolbarst's study in 1932 without mentioning the data.⁴ Wolbarst reviewed 1103 cases of penile cancer in the United States and found that all occurred in uncircumcised men and none in Jewish men, even though 33 cases would have been expected because Jewish men constituted 3% of the population. Wolbarst cited confirming figures from Europe and noted that Moslems, who also circumcise boys, are protected against cancer. This landmark study served as the stimulus for five future series that were published in refereed journals in the next 50 years⁵ but are apparently unknown to Fleiss and Hodges (although Hodges, a known lay anticircumcisionist, says that he is a medical historian).

In a classic review in 1935 Dean analysed 120 cases of penile cancer reviewed at what is now Memorial Sloan-Kettering Cancer Center in New York City.⁵ All of these cases occurred in uncircumcised men. None occurred in Jewish men, although more than a third of other inpatients with cancer at the facility were Jewish. Dean concluded that "prophylactic treatment of cancer of the penis consists in circumcising all male infants." In four later, separate series 139 cases in Illinois were reviewed in 1946; 100 in Roswell Park, New York, in 1972; 156 in Michigan in 1973; and 77 in Cleveland in 1986. Of these 592 cases at five institutions renowned for treating cancer, none occurred in men who had been circumcised as newborn infants, although most newborn male infants in the United States were circumcised.

Since 1935, about 50 000 cases of penile cancer have been reported in the United States (annually, about 750-1000 cases and 200 deaths), only 10 of which occurred in men who had been circumcised as newborn infants. This yields a ratio of 5000:1 for the incidence of penile cancer in uncircumcised to circumcised men—overwhelming evidence.

As Kochen and McCurdy pointed out, the low incidence of penile cancer in the United States is misleading because it has been calculated by combining circumcised men (in whom the incidence is essentially zero) with uncircumcised men (in whom it is 2.2/100 000).⁶

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