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Ureteric obstruction secondary to endometriosis

Ultrasonography is best method of detection

EDITOR,—R J Brough and K O'Flynn report a case of bilateral ureteric obstruction secondary to recurrent endometriosis in a patient receiving hormone replacement therapy.[1] This is a rare complication; even the 1.2% rate of ureteric obstruction that the authors quote is probably an overestimate, as a Medline search for 1966-96 shows fewer than 200 reported cases worldwide, with the largest modern series being just eight cases from the combined records of two large teaching hospitals.[2]

Ureteric obstruction can result in irretrievable renal loss, and early recognition is vital, as Brough and O'Flynn emphasise. Nevertheless, we believe that the authors' suggestion that "routine imaging, either intravenous urography or preferably isotope renography," should be used to assess any patient with endometriosis" is misleading; more importantly, we believe that this would be unsafe practice as it would expose women, many of whom will be of reproductive age, to harmful irradiation. Ultrasonography is a more appropriate investigation in assessing renal obstruction because it is sensitive in chronic obstruction, relatively inexpensive, and safe.

Ultrasonography will not identify non-obstructive ureteric endometriosis, but neither does urography lead to a confident diagnosis of ureteric involvement.[3] This is not to say that we advocate routine use of ultrasonography in all patients with endometriosis. Our view is that patients with loin pain, as in this case, merit renal assessment by ultrasonography. In women with a history of endometriosis (particularly if they have recently started hormone replacement therapy) or with a cyclical history of pain or haematuria, endometriosis should be suspected, looked for, and excluded.

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Authors' reply

EDITOR,—We disagree with several of N D P Marchbank and colleagues' statements. Firstly, although the number of reported cases in the literature is small, the number of patients at risk of ureteric obstruction is likely to increase considerably as hormone replacement therapy becomes more common. Secondly, although the use of ultrasonography to assess the dilated pelvicaliceal system provides static anatomical information, it is unreliable in diagnosing obstruction and has largely been replaced by diuresis renography,[1 2] which gives dynamic information on kidney drainage. Isotope renography exposes the patient to a small radiation dose of 0.5 mSv, which is smaller than that resulting from plain abdominal radiography; in these symptomatic postmenopausal women such a dose represents a minimal risk in comparison with the dangers of renal failure in patients in whom the obstruction remains undiagnosed.

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Rate of Creutzfeldt-Jakob disease in farmers is not significant

EDITOR,—After the death of four farmers from sporadic Creutzfeldt-Jakob disease Gore concluded that the probability of this occurring by chance was less than 1 in 10 000.[1]. Recently Will *et al* reported 10 cases of a new variant of Creutzfeldt-Jakob disease (two of the patients were still alive).[2] While bovine spongiform encephalopathy could not be proved to be responsible for these cases, it was considered to be the most plausible explanation. It might therefore be concluded that bovine spongiform encephalopathy has been responsible for two new diseases (sporadic Creutzfeldt-Jakob disease and the new variant)—a surprising result. I have checked the robustness of Gore's calculation of probability.

The existence of a new variant of Creutzfeldt-Jakob disease, different from sporadic Creutzfeldt-Jakob disease, seems established because of the unusual neuropathological profile and the young age distribution of the patients. Seven of the eight patients who died were aged 15-34, and I have calculated that the probability of this occurring by chance is 1 in 100 000 000. To check the robustness of this calculation, I increased the expected rate by 2 SD, when a probability of 1 in 1 000 000 was found. The result was thus robust.

My main worry about Gore's calculation of probability is the size chosen for the population at risk. This was taken to be 46 000 farmers (9% of the total of 500 000 farmers). These were only male, full time, lifelong farmers. There was an implied assumption that small and large herds of cattle are looked after by the same numbers of farmers and contain equal numbers of cows with bovine spongiform encephalopathy. If the number of farmers at risk had been regarded as 100 000 or 200 000 (20% and 40%, respectively, of the total number of farmworkers) then the probability of four farmers developing sporadic Creutzfeldt-Jakob disease over five years would be 1 in 500 or 1 in 30 respectively. The first figure is significant at the 3 SD level, but the second is not significant.

It has been assumed that the rate of sporadic Creutzfeldt-Jakob disease is one per million population per year. As recording improves, however, the rate is increasing with time in most countries—except in the United States, where Holman *et al* found a rate of 0.9 (range 0.8-1.1) cases during 1979-90 (total number of cases, 2614).[3] In Austria, where many necropsies are performed, the rate was 1.25 in 1995 (H Budka, personal communication).

I conclude that Gore's calculation is not robust and that bovine spongiform encephalopathy has plausibly caused only one disease, the new variant of Creutzfeldt-Jakob disease.

I thank Dr F James for helpful discussion.

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Performance procedures for seriously deficient professional performance are flawed

EDITOR,—The nuances of Stephen Brearley's editorial on seriously deficient professional performance show the flaw in the performance procedures that have been introduced, at least in so far as patients are concerned.[1] Patients who are on the receiving end of poor performance are more concerned with the accountability of those who were responsible than with the definition of seriously deficient performance. If a patient has suffered injury as a result of treatment by a doctor, or as a result of a failure to treat, then surely he or she must have been at risk. If the patient was at risk then there must be a danger that others will be at risk in the future.

The problem is that the new procedures are aimed solely at a pattern of behaviour. How many ureters must a surgeon divide before a pattern is established? How many babies must suffer asphyxia? What patients want to know is whom doctors will be held accountable to after the first occasion that they cause such a serious injury.

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Tuberculosis is important problem in children with HIV infection in sub-Saharan Africa

EDITOR,—The suggestion by Sebastian B Lucas and colleagues[1] and Charles Gilks[2] that tuberculosis is not an important problem in children with HIV infection in sub-Saharan Africa deserves further comment. In Lucas and colleagues' necropsy study of children with and without HIV infection in Abidjan, Côte d'Ivoire, only one of the 78 children with the infection had tuberculosis.[1] The suggested explanation—that "with an annual risk of tuberculosis infection of about 2% in many African countries, most children infected with HIV will die without having been exposed to *Mycobacterium tuberculosis*"—may not be valid. Firstly, the risk of

infection with *M tuberculosis* is greatest in childhood, so that the risk in children is greater than the 2% that they quote. Secondly, the likelihood that children with HIV infection in sub-Saharan Africa will be exposed to tuberculosis before they die is considerable in view of the high incidence of tuberculosis in adults in families with HIV infection and the often overcrowded living conditions.

Caution is necessary when drawing conclusions from a small and unrepresentative study sample. The estimated total number of deaths in children aged under 5 years in Abidjan in the eight months of Lucas and colleagues' study in 1992 was about 8060 (based on the assumption that the death rate in Abidjan was similar to that in the whole country; the population of Abidjan was two million and of Côte d'Ivoire 13.4 million; and the annual number of deaths of children aged under 5 years in Côte d'Ivoire was 81 000 (Unicef's estimate)). The study sample of 155 deaths therefore represented 1.9% of the 8060 deaths in this age group. An alternative explanation for the finding that only one of 78 children with HIV infection had tuberculosis is that children with HIV infection and tuberculosis may die at home and not be admitted to the mortuary.

Several studies, including studies from Abidjan,[3] Lusaka (Zambia)[4] and Blantyre (Malawi),[5] have shown that tuberculosis is an important problem in children with HIV infection in sub-Saharan African. There is an urgent need to strengthen national programmes aimed at controlling tuberculosis and to promote collaboration between such programmes and programmes aimed at controlling HIV infection and AIDS in sub-Saharan Africa.

The views expressed in this letter are those of the author only and not necessarily those of the World Health Organisation.

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Secondary prevention of coronary heart disease in primary care is cost effective

EDITOR,—Neither of two recent studies that estimated the cost of health checks in primary care was able to show cost effectiveness.[1 2] It has been suggested that larger trials with longer follow up are required to assess fully the long term effectiveness and overall cost effectiveness of population cardiovascular screening. The value of primary prevention of coronary heart disease remains doubtful.

We have reported a randomised controlled trial of health promotion for patients with angina. The intervention was shown to have a significant impact on lifestyle and survival[3] and on the self assessed quality of life of people with angina cared for in general practice.[4] Recently, the cost effectiveness of this personal health education, which is led by a nurse, has been investigated.[5] Health services—including the prescribing of drugs; visits to the general practitioner; visits to the hospital as either an inpatient or an outpatient; and all tests, investigations, and treatments carried out—were costed, as was the cost of the health promotion visits by the nurse.

The intervention was associated with a reduction in drug use, but no other significant difference was observed between the intervention and control groups in terms of their use of health services. The conclusion is therefore that this intervention is cost effective because it generated useful benefits at no detectable cost to health services. When benefits can be achieved without cost such services should be given top priority in the development of health services. We consider that, though debate may continue regarding the cost effectiveness of cardiovascular screening, secondary prevention of coronary heart disease in primary care should be encouraged.

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Risk of coronary heart disease in Hindus and Muslims from Indian subcontinent is similar

EDITOR,—Paul Wilkinson and colleagues report a study comparing the case fatality after acute myocardial infarction in Asians from the Indian subcontinent and white patients.[1] The increased susceptibility to coronary heart disease among Asians from the Indian subcontinent who live in Britain is well recognised but remains unexplained.

The population of Asians from the Indian subcontinent who live in Britain is heterogeneous, with major religious, cultural, and ethnic differences,[2] but this aspect has rarely been addressed in studies of coronary heart disease. We have shown that the susceptibility to both osteomalacia and tuberculosis in immigrant Asians from the Indian subcontinent is significantly greater in Hindu than Muslim subjects living in south London.[3 4] For both osteomalacia and tuberculosis the increased risk seems to be explained by the higher prevalence of vegetarianism among Hindus.

We examined whether dietary differences in risk between groups of Asians from the Indian subcontinent might also influence risks of ischaemic heart disease. We retrospectively analysed patients listed on the patient administration system at St George's Hospital over two years (April 1991 to March 1993) as having ischaemic heart disease, angina, unstable angina, or myocardial infarction (identified from the *International Classification of Diseases* (ninth revision) codes). With the help of an Asian dietitian we identified all Asian names and categorised them as probable Hindu, probable Muslim, or other. This method has been shown to be accurate.[4] Patients who were admitted more than once during the two years were counted only once. A total of 272 patients with Asian names were identified, of whom 117 were considered to be Hindu, 150 Muslim, and 5 "other." These were compared with 279 community Asian controls of a similar age range identified for our previous study of tuberculosis (113 Hindu, 153 Muslim, 13 "other").[4] The crude odds ratio of Hindus to Muslims was 1.06 (95% confidence interval 0.75 to 1.49). After adjustment for age (year of birth) and sex the odds ratio was 1.08 (0.62 to 1.87).

These results suggest that Hindus and Muslims from the Indian subcontinent do not differ greatly in their risk of coronary heart disease despite substantial differences in their consumption of meat and fish.[4]

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