

does not have an official policy on vaccination but considers it important that concerned parents should have access to full information on efficacy and adverse effects so that they can make an informed decision. A detailed search of the many papers published on this subject yields many short term studies but few comparing vaccinated and non-vaccinated populations over the longer term, such as that reported by Odent *et al.*²

The society receives many requests for information on vaccination from members of the public. The article by Moskowitz, an American paediatrician, cited by Simpson and colleagues is one of several listed in a leaflet published recently by the society in response to these requests.³ Among others listed are a booklet published by the Anthroposophical Medical Association⁴ and the Department of Health's *Immunisation against Infectious Disease*.⁵ Copies of the leaflet and the bibliography from which the references were selected may be obtained from the Society of Homoeopaths.

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1 Simpson N, Lenton S, Randall R. Parental refusal to have children immunised: extent and reasons. *BMJ* 1995;310:227. (28 January.)

2 Odent MR, Culpin EE, Kinnel T. Pertussis vaccination and asthma: is there a link? *JAMA* 1994;272:592-3.

3 Society of Homoeopaths. *Vaccination*. Northampton: SH, 1995.

4 Goebel W. *Should I have my child vaccinated?* London: Anthroposophical Association, 1991.

5 Department of Health. *Immunisation against infectious disease*. London: HMSO, 1990.

Book dispelling immunisation myths is available

EDITOR,—Neil Simpson and colleagues report that the rate of non-immunisation among children in their area is 0.33% and describe the reasons why some parents refused immunisation.¹ We wish to describe the situation in New Zealand.

Until recently the childhood immunisation rate in New Zealand was thought to be low relative to that in many other developed countries (New Zealand does not have a national immunisation register to give accurate overall figures). A small study in 1992 showed that less than 60% of children had received the immunisations appropriate for their age by 2 years of age and that 4.2% of parents believed that immunisations were unnecessary if children were healthy.² More recently, the rate of completed immunisation has been shown to have risen to around 80% by 2 years of age.³

Many local health professionals believe incorrectly that the childhood immunisation rate is appreciably affected by a sizeable lobby against immunisation. Although members of this lobby claim not to be against immunisation but, rather, to be in favour of giving parents information so that they can make an informed choice, virtually all their literature is against immunisation. At the age of 6 months, however, only 0.5% of infants in New Zealand's largest national childhood cohort study, of 4000 infants, had not been immunised because their parents were against immunisation.⁴

The flood of letters in the media suggests that some anti-immunisation groups have a disproportionately high profile, but we should not overestimate the size of their lobby. Conversely, we should not underestimate the pernicious effect of their specious arguments. We agree with Simpson and colleagues that health professionals should provide consistent, accurate, and up to date advice on immunisation. This in turn means that they must be given clear and readable information by the appropriate authorities. We have trawled the anti-immunisation literature and written a small book, with references, that attempts to answer the arguments, myths, and misinformation that health professionals are likely to meet.⁵ This has been

distributed to general practitioners, practice nurses, and Plunket nurses (equivalent to health visitors) in New Zealand (available in Britain from Dr C Essex, c/o 35 St Leonard's Court, Alfred Street, Lancaster LA1 1FD; price £2.50 (cheques should be made payable to C Essex)). We have found that many health professionals and parents have been helped by finding answers or explanations to specific claims made by the anti-immunisation lobby.

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1 Simpson N, Lenton S, Randall R. Parental refusal to have children immunised: extent and reasons. *BMJ* 1995;310:227. (28 January.)

2 Immunisation coverage in New Zealand: results of the regional immunisation coverage surveys. *Communicable Disease New Zealand* 1992;92(suppl 2):1-13.

3 McNicholas A, Baker M. Immunisation coverage in New Zealand: ongoing surveillance using benefit claim data. *New Zealand Public Health Report* 1995;2(1):1-3.

4 Essex C, Counsell AM, Geddis DC. Immunisation status and demographic characteristics of New Zealand infants in the first 6 months of life. *J Paediatr Child Health* 1993;29:379-83.

5 Essex C, Tuohy P. *Immunisation: questions and answers*. Dunedin: Royal New Zealand Plunket Society, 1993.

Measles and rubella immunisation

EDITOR,—The chief medical officer has stated that the recent measles and rubella immunisation campaign has been a success. Unfortunately, practices have been unable to record these immunisations systematically since no code has been issued for the Read 4 coding system, which most general practice systems use. Therefore, when patients move to another practice in the future there is a high chance that these data will not follow them. This information is important, particularly for rubella immunisation.

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Drug resistant tuberculosis

EDITOR,—P D O Davies highlights concern about drug resistant *Mycobacterium tuberculosis* and proposes a central laboratory for fast tracking molecular diagnostic tests for patients at risk.¹ The concern is shared by many, including the Public Health Laboratory Service, but Davies shows a lack of knowledge of the facilities available and the status of diagnostic methods that use the polymerase chain reaction.

The Public Health Laboratory Service Mycobacterium Reference Unit (currently in Cardiff) has provided a central focus of skill for many years and supports the diagnosis, treatment, and epidemiological monitoring of tuberculosis throughout England and Wales. The Mycobacterium Reference Unit, the network of Public Health Laboratory Service regional tuberculosis centres, and the Communicable Disease Surveillance Centre provide the backbone of the countries' laboratory and epidemiology services for mycobacteriology. It is true that most investi-

gations for *M tuberculosis* are still based on culture, although methods such as the BACTEC system for early detection of growth have reduced the traditional delays of such culture. The molecular approaches that Davies refers to offer exciting possibilities of more rapid primary detection and determination of drug resistance. They are not, however, ready for routine use and still need research and development, which is a high priority of the Public Health Laboratory Service.

Recognising the re-emergence of tuberculosis as a serious public health problem, the Public Health Laboratory Service initiated a review of its mycobacteriology services in 1991. As a result, the Mycobacterium Reference Unit will move to new facilities at Dulwich Public Health Laboratory/King's College Hospital this year and the post of director has been advertised. One principal area for development will be molecular approaches to diagnosis. The network of regional tuberculosis centres has also been streamlined, with Cardiff, Birmingham, and Newcastle Public Health Laboratories and the Dulwich Mycobacterium Reference Unit serving the south west and Wales, the midlands, the north, and the south east respectively. Molecular typing by restriction fragment length polymorphism has also been pioneered by the Central Public Health Laboratory, which, with the Communicable Disease Surveillance Centre, is using it to study the epidemiology of *M tuberculosis*.

It is disappointing that Davies does not recognise the priority that the Public Health Laboratory Service gives to mycobacteriology services. The laboratories that Davies desires already exist and will offer the methods Davies commends as soon as they become sufficiently reliable for routine application.

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1 Davies PDO. Drug resistant tuberculosis. *BMJ* 1995;310:400-1. (11 February.)

Asthma care in general practice

EDITOR,—Simon A Evans and colleagues surveyed general practitioners in the North West Regional Health Authority and used the drugs and equipment they carried as surrogate measures of their preparedness to manage acute severe asthma.¹ In early 1994 we repeated a study originally performed in 1989² to assess the change in use of peak flow measurements by general practitioners in Northern Ireland. Two questionnaire items are of interest, one asking whether general practitioners had a nebuliser available in their practice and the other asking whether they usually carried a peak flow meter on house calls.

The original study population was a 1 in 4 random sample of general practitioners in Northern Ireland. The same practitioners were surveyed in 1994, with replacements for those who had left the list being drawn randomly from doctors still practising at the same address. Of 232 doctors, 199 (86%) and 192 (83%) responded in 1989 and 1994 respectively. In 1994, 157 respondents were male and 173 were working full time. A maximum of 176 pairs of responses was possible, of which 84% were obtained. The table shows the proportions of general practitioners who had a nebuliser in their practice and took peak flow meters on house calls together with the change in behaviour of the general practitioners for whom paired responses were available. It is apparent that, in Northern Ireland, nebulisers are almost universally available in practices yet the proportion of general practitioners who carry peak flow meters on house calls is low and unchanged.