recommend, as S Field and colleagues do in their editorial,[2] that two views should be taken instead of one and that the screening interval should be reduced from three to two years, without even considering the possible adverse effects of repeated exposure to low doses of ionising radiation,[3] strikes me as foolhardy.

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1 Woodman CBJ, Threlfall AG, Baggis CRM, Prior P. Is the three year breast screening interval too long? Occurrence of interval cancers in NHS breast screening programme's north western region. *BMJ* 1995;310:224-6. (28 January.)
2 Field S, Michell MJ, Wallis MGW, Wilson ARM. What should be done about interval breast cancers? *BMJ* 1995;310:203-4. (28 January.)

Has increased the workload for primary care teams

EDITOR,—In his editorial on breast screening Paul A Creighton highlights the tendency of the government to raise patients' expectations but to expect those delivering care to absorb any extra work without complaint or extra resources.[1] The Cumbria Practice Research Group sought to document the extra workload for primary care teams that resulted from the national breast screening programme in the first few months after its introduction. Practice receptionists, nurses, and general practitioners completed time sheets.

The data collected showed that up to five hours of work in total was generated per 1000 patients on a general practitioner's list. Most of the time was spent on administrative tasks such as checking the prior notification list and filing results, but general practitioners reported extra consultations for counselling patients and inquiries related to different aspects of the screening process. These figures were almost certainly underestimates as the long period of the survey resulted in staff forgetting to record data.

We believe that if we are to provide new services to our patients the extra work entailed must be taken into account and costed appropriately. In this particular instance, as Creighton suggests, extra reimbursement for appropriately trained administrative staff and practice nurses should be made available.

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Uptake of breast screening

Accurate addresses will improve uptake rates

EDITOR,—R Rudiman and colleagues report no significant correlation between uptakes of breast screening and cervical screening in Grampian, which is an area with less deprivation than other Scottish health boards and high uptakes of screening.[1] We have compared uptakes of breast screening and cervical screening in 156 practices in east London, a highly deprived inner city area, in contract with City and East London Family Health Services Authority. The tables shows the data. Like Rudiman and colleagues, we found that the uptake of breast screening was consistently lower than the uptake of cervical screening. Unlike them, however, we did find a significant positive correlation between the two rates ($r=0{\cdot}51$ (95% confidence interval 0·38 to 0·62), $P<0{\cdot}01$).

Comparison of uptake of breast screening in prevalence round completed in 1992 and uptake of cervical screening in the 5·5 years before 30 June 1993 in 156 practices in east London. Figures are percentages

	Breast screening	Cervical screening
Mean (SD) uptake	44·1 (9·66)	63·0 (20·73)
Interquartile range	37·9-51·7	46·2-82·2
Minimum-maximum	7·1-64·0	2·2-98·8

East London is an area of high mobility. Practices with high rates of cervical screening have probably achieved these in part by more thorough completion of prior notification lists, correcting wrong addresses known to the practice and deleting patients no longer attending the practice. If the accuracy of the addresses are improved the uptakes of both cervical and breast screening will be improved. Practices in east London also have much greater variations in their uptakes of cervical screening (SD 20·73% compared with 4·20% in Grampian). These differences between Grampian and east London may explain why a correlation between uptakes of cervical and breast screening was found in east London but not in Grampian.

The more centralised delivery of mammography compared with cervical cytology screening argues against the introduction of target payments to general practitioners for breast screening. Extra payments for thorough completion of prior notification lists should, however, be evaluated in inner city areas with high mobility among patients.

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1 Rudiman R, Gilbert FJ, Ritchie LD. Comparison of uptake of breast screening, cervical screening, and childhood immunisation. *BMJ* 1995;310:229. (28 January.)

May be influenced by practice specific factors

EDITOR,—R Rudiman and colleages suggest that a financial incentive may be required to increase the participation of primary care staff in the management of breast screening.[1] Data from a study undertaken in 1990-1 of part of the prevalence round of breast screening in a health district in the then Northern region support this.

Almost 3500 women aged 50-64 who were registered with six general practices were invited for breast screening between 1 October 1990 and 31 January 1991. The overall uptake among these women was 75·8%. Decreasing age and increasing affluence, as determined by the Townsend score for ward of residence, were significantly associated with increasing uptake of the invitation ($P<0{\cdot}001$, $\chi^2=19{\cdot}7$, df=2 and $P<0{\cdot}001$, $\chi^2=46{\cdot}8$, df=3, respectively).[2] Uptake varied significantly among the practices, ranging from 65·3% to 81·0% ($P<0{\cdot}001$, $\chi^2=22{\cdot}78$, df=5). The distribution of age and ward of residence of the women, however, only partly explained the differences (table).

The uptakes of cervical cytology screening during the year ending 31 March 1991 among women aged 50-64 registered with the six practices were almost consistently higher than the uptakes of breast screening and ranged from 72·6% to 90·3%. The rank orders for the uptakes of cervical cytology and breast screening were similar from the six practices (table).

These data suggest that factors specific to the practices, such as willingness or ability to participate in population screening programmes without appropriate financial reward, in addition to population factors may have accounted for the differences in the uptake of breast screening among the practices.

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1 Rudiman R, Gilbert FJ, Ritchie LD. Comparison of breast screening, cervical screening, and childhood immunisation. *BMJ* 1995;310:229. (28 January.)
2 Townsend P, Phillimore P, Beattie A. *Inequalities in health in the Northern region: an interim report.* Newcastle upon Tyne and Bristol: Northern Regional Health Authority and University of Bristol, 1986.

Non-responders can be encouraged to attend

EDITOR,—As a general practitioner, I was particularly interested in R Rudiman and colleagues' comparison of uptake of breast screening, cervical screening, and immunisation in the Grampian region.[1] I have studied the uptake of breast screening in my practice (11 000 patients), where the response rate is 78% overall and 92% at my branch surgery. These rates exceed the target of 70% set in the Forrest report.

We are notified of women who do not respond, whose notes are then flagged so that the subject can be raised at subsequent consultations. Fears can be aired and education and reassurance given. Our nurses and attached staff are involved as well, and we have periodic poster campaigns. In this way we have encouraged about a third of women who did not respond initially to attend; these are in addition to the percentages given above.

In a study of women who did not respond I

Factors affecting uptake of breast screening and of cervical cytology screening by general practice in an English district, 1990-1. Figures are numbers (percentages) except where stated otherwise

	General practice					
	1	2	3	4	5	6
	Breast screening					
No of women	182	823	617	807	118	715
Distribution of age of target population:						
50-54	69 (37·9)	285 (34·6)	216 (35·0)	269 (33·3)	48 (40·7)	240 (33·6)
55-59	62 (34·1)	263 (32·0)	199 (32·3)	263 (32·6)	32 (27·1)	216 (30·2)
60-64	51 (28·0)	275 (33·4)	202 (32·7)	275 (34·1)	38 (32·2)	259 (36·2)
Distribution of ward of residence of target population:						
Group A	20 (11·0)	105 (12·8)	81 (13·1)	118 (14·6)	27 (22·9)	436 (61·0)
Group B	48 (26·4)	192 (23·3)	168 (27·2)	288 (35·7)	22 (18·6)	88 (12·3)
Group C	57 (31·3)	278 (33·8)	140 (22·7)	212 (26·3)	38 (32·2)	84 (11·7)
Group D	57 (31·3)	246 (29·9)	228 (37·0)	188 (23·3)	31 (26·3)	105 (14·7)
Uptake	138 (75·8)	596 (72·4)	470 (76·2)	612 (75·8)	77 (65·3)	579 (81·0)
Rank order of uptake	2	5	4	2	6	1
	Cervical cytology screening					
Uptake (%)	90·3	79	83·5	72·6	74·3	86·8
Rank order of uptake	1	4	3	6	5	2

Group A=most affluent wards.

Relation between various factors and response to mammographic screening 1991-2

Characteristic	Did not respond (n=34)	Responded (n=217)
Age range (average) (years)	52-65 (57)	50-65 (57)
Non-response for cervical screening	20**	16**
Not known personally to general practitioner	22*	77*
Marital status:		
Married	24	176
Widowed	5	29
Divorced	4	5
Single	1	7

*P=0·01, **P=0·001.

ascertained whether the following factors were associated with non-attendance: non-response for cervical screening, marital status, and whether the patient had personal knowledge of the general practitioner. The only factors that reached significance (table) were non-attendance for cervical screening ($P<0·001$) and no personal knowledge of the general practitioner ($P<0·01$).

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Acyclovir and post-herpetic neuralgia

Two other participating study centres report different results

EDITOR,—J I McGill and J E White report follow up data[1] on 57 of 74 patients from Southampton originally treated as part of a three centre study of acyclovir versus placebo in herpes zoster in elderly patients.[2,3] The original protocol required patients (mean age 71·7 years) to be followed up for six months or until pain free for one month. We are not clear about some of McGill and White's data. They state that 10 (37%) of the placebo group had pain "at each follow up" (at six months and five years by implication), compared wth two (7%) of those receiving acyclovir. The original data indicate, however, that 20 patients who received placebo in Southampton were followed up to six months and only two had pain. Clarification of this point is essential: have the authors included patients who still had pain at an earlier visit even though the protocol was violated and follow up was stopped? They surely cannot rely on the five year memory of patients for accurate assessment of when "the patient was finally pain free."

We have completed a late follow up (nine to 10 years) of 298 patients enrolled in the same study from Sheffield and Birmingham. A detailed search was performed for all patients. Of the 298 patients, 138 were lost to follow up as 99 had died, 35 were not traceable, and four were unable to participate (M W McKendrick *et al*, second international conference on varicella zoster virus, Paris, 1994). Altogether 160 patients (all over 60 when they acquired shingles) were visited and examined and had a structured questionnaire completed. Thirty four had experienced pain within the year before review; 33 of these had had moderate or severe pain at entry into the study, and 25 had prodromal symptoms lasting longer than 72 hours. Of 132 patients who reported absence of pain for at least one month when discharged from the original study, 16 reported pain "within the past year," which suggests that recurrence of pain may be more common than previously realised. Our analysis has shown no association between the presence or recurrence of longer term pain and the use of acyclovir and does not agree with the conclusions of McGill and White.

Although some studies[4,5] (but not the large British study[3]) have shown acyclovir to reduce pain in the first few months after herpes zoster, we believe that any conclusion regarding longer term benefits must be based on firm criteria. We await clarification of the above points.

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1 McGill JI, White JE. Acyclovir and post-herpetic neuralgia and ocular involvement. *BMJ* 1994;**309**:1124. (29 October.)
2 McKendrick WM, McGill JI, White JE, Wood MJ. Oral acyclovir in acute herpes zoster. *BMJ* 1986;**293**:1529-32.
3 McKendrick MW, Wood MJ, McGill J. Lack of effect of acyclovir in post-herpetic neuralgia. *BMJ* 1989;**298**:431.
4 Huff JC, Bean B, Balfour HH Jr, Laskin OL, Connor JD, Corey L, *et al*. Therapy of herpes zoster with oral acyclovir. *Am J Med* 1988;**85**(suppl 2A):84-9.
5 Morton P, Thomson AN. Oral acyclovir in the treatment of herpes zoster in general practice. *NZ Med J* 1989;**102**:93-5.

The balance of available evidence supports its use

EDITOR,—J I McGill and J E White's paper adds further to the debate on the efficacy of oral acyclovir in herpes zoster ophthalmicus.[1] It reports the long term follow up of a small sample of patients with ophthalmic complications from a study of 205 patients with herpes zoster in any dermatome.[2] Pain and ocular complications were significantly less frequent at six months and five years. The original paper failed to find a beneficial effect of acyclovir on pain between one and six months or on pain in the 53 patients with ophthalmic zoster.[2] McGill and White report on 74 original patients with ophthalmic zoster rather than 53, now with a significant difference at six months and five years, so it would be useful to know whether the two populations are the same and the source of the additional 21 patients.

McGill and White's paper agrees with a previous paper not referenced by them, which reported pain and ocular involvement after herpes zoster ophthalmicus in 46 patients randomly treated with either placebo or 800 mg acyclovir five times daily for 10 days, starting within 72 hours of the onset of the rash.[3] Active ocular disease was significantly less common in the acyclovir group ($P=0·01$). Pain was significantly less severe between two and six months and less common between two and three months. In this paper the rate of ocular involvement was 53% in the patients receiving placebo, which is similar to the figure reported by McGill and White; this suggests that the two study populations are similar and the results might be consistent. Two other papers have been published on the subject: one showed a beneficial effect on early ocular signs and pain[4] and the other detected no treatment effect in the eye.[5]

With conflicting results from several papers it is difficult for clinicians to make a clear judgment, but the balance of evidence currently favours the use of oral acyclovir in all patients with herpes zoster ophthalmicus.

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1 McGill JI, White JE. Acyclovir and post-herpetic neuralgia and ocular involvement. *BMJ* 1994;**309**:1124. (29 October.)
2 McKendrick WM, McGill JI, White JE, Wood MJ. Oral acyclovir in acute herpes zoster. *BMJ* 1986;**293**:1529-32.
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5 Aylward GW, Claoué CM, Marsh RJ, Yasseem N. Influence of oral acyclovir on ocular complications of herpes zoster ophthalmicus. *Eye* 1994;**8**:70-4.

Authors' reply

EDITOR,—In the part of the trial in Southampton independent analysis showed a significant difference in the duration of post-herpetic neuralgia between 38 patients treated with acyclovir (mean (median) duration 2·44 (2) months) and 36 patients treated with placebo (3·59 (4); P (two tailed)=0·01; Kaplan-Meier product limit method used to estimate duration of pain). The significance was lost, however, when the three centres' results were amalgamated.[1] This difference could have been due to the high number of patients from Southampton with trigeminal herpes zoster, which can be more severe and prolonged than other dermatome involvement[2]; thus the favourable effects of acyclovir would have been more pronounced in these cases.

M W McKendrick and M J Wood ask whether we relied on the patients' recollection of five years previously to determine when the post-herpetic neuralgia stopped. As we prophylactically followed up the patients monthly to six months and then at five years we avoided this pitfall and were able to detect late recurrences of pain, which occurred at five years in three patients who had not any such pain at six months.

We agree with Harding and Porter, whose study population was similar to ours, with a 53% rate of ocular involvement in placebo treated patients, that acyclovir lessens the risk of active ocular disease.[3] Our results also agree with those of others.[4] The failure of Aylward *et al* to find any such beneficial effect of acyclovir may have been because their analysis was retrospective on a selected group of patients.[5]

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2 Robinson PN, Fletcher N. Post herpetic neuralgia. *J R Coll Gen Pract* 1986;**36**:24-8.
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4 Cobo LM, Foulks GN, Leisegang T, Lass J, Sutphin JE, Wilhelmus K, *et al*. Oral acyclovir in the treatment of ocular herpes zoster ophthalmicus. *Ophthalmology* 1986;**93**:763-70.
5 Aylward GW, Claoue CM, Marsh RJ, Yasseem N. Influence of oral acyclovir on ocular complications of herpes zoster ophthalmicus. *Eye* 1994;**8**:70-4.

United Kingdom prospective diabetes study

Compliance with diet will affect results

EDITOR,—As a result of its comparison of the relative efficacy of diet and various drug treatments in patients with newly diagnosed diabetes the United Kingdom Prospective Diabetes Study Group concludes that chlorpropamide, glibenclamide, insulin, and metformin are more effective than diet alone.[1] The group does not present any evidence on what diets the subjects were given, what baseline diets were being consumed, whether diets changed during the study, or whether the subjects complied with the given dietary regimen. The authors did not consider whether there was any change in the dietary prescriptions over the 10 years of the study which might also have influenced the results. From figure 2 it is apparent that body weight did not change in any group, which suggests that, at least in obese subjects, those taking diet alone did not achieve the dietary