Thus most cancers detected were aggressive, and only a small number of men with prostate specific antigen concentrations >4·0 ng/ml would have a diagnosis of a non-aggressive cancer preceded by a long disease free interval. This was also true for the subset of men who were aged under 70 when the diagnosis was made. Compared with men with antigen concentrations of <1·0 ng/ml, those with concentrations of 2·0-3·0 ng/ml had a relative risk of all prostate cancer of 5·5 and a relative risk of aggressive cancer of 6·8.

It is important to note that this was a once only test, and the potential benefit of repeat screening or the addition of other screening modalities was not available. For men older than 70 watchful waiting may be appropriate management. This new study shows, however, that in this population of American doctors the mean age at diagnosis of prostate cancer was 68·7 years, most of the cancers detected were aggressive, and three quarters of deaths in the cases were directly related to the diagnosis. Thus in younger men screening for prostate specific antigens may be justified, particularly for those in higher risk groups, such as those with a family history of prostate cancer.[4,5]

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Methods are changing rapidly

EDITOR,—Fritz H Schröder discusses the controversies surrounding the early detection of prostate cancer and some differences in attitude between Europe and North America.[1] It is unfortunate that he emphasises screening rather than treatment. The uncertainty about the ability of treatment to modify the natural course of the disease should be resolved much more urgently than uncertainty about the value of screening, which can be addressed only when certain conditions are met—namely, that the natural course is understood, there is an agreed policy on whom to treat and by which method, and the cost of finding cases is economically balanced in relation to expenditure on medical care.[2] All these questions have yet to be answered in prostate cancer.

One flaw in screening studies is the rapidity with which methods of detection change. Testing for prostate specific antigen has been used routinely only in the past decade; already, different molecular forms of the antigen discovered recently suggest that newer assays may be more specific.[3] In the next five years a multiplicity of tests will probably emerge, with a higher detection rate than the 5·8% recently reported in a screening study.[4] The second problem with screening trials is that they do not specify the type of treatment for cancer provided. It is therefore essential and logical that the efficacy of treatment should be tested before the benefits of screening are assessed. Schröder refers to such studies being carried out in Scandinavia and Britain. These trials are unlikely to provide the answers required. In Scandinavia the randomisation protocol, which excludes high grade tumours, will prevent a clear resolution of the problem. In Britain the Medical Research Council's study, launched last year, will find it hard to recruit sufficient patients as no provision was made for finding cases, which is the only means of recruiting enough men for randomisation.

A valid and ethically justified study comparing radical surgery with watchful waiting could be conducted only by targeting a population of men who had been fully informed about the consequences of screening and understood that watchful waiting might be offered. Such a trial is currently being organised on a pan-European scale, and it is now the responsibility of governments, the Medical Research Council, and the European Commission to identify priorities and respond to the urgency of providing a definitive answer to the problem by giving adequate support where it is most needed.

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Evaluation of sexual health interventions

EDITOR,—Ann Oakley and colleagues rightly emphasise the need for rigorous evaluation of sexual health interventions.[1] Much early sex is unplanned, and, even though it is encouraging that many more young people now report using condoms,[2] there is a need to publicise the timing and availability of emergency contraception for those occasions when some form of failure occurs, be it failure to buy a condom, failure to use it, or its failure to remain intact.

Improving knowledge of the availability and appropriate use of emergency contraception has been identified as one of the relatively few opportunities for reducing the high incidence of unplanned pregnancy in Britain, a target in the *Health of the Nation.* Many women, however, while vaguely aware that a postcoital method exists, are unsure of when it can be used and where it is available.[3]

Last summer we undertook two surveys of publicity for emergency contraception. In one we visited a random sample of 30 general practices in Camden and Islington to see if there was anything in the waiting room to suggest that the service was obtainable there. Only a third of the practices had either specific leaflets or posters about emergency contraception. Their impact, however, varied considerably, from prominently displayed posters to out of date leaflets positioned at the back of a rack. A questionnaire survey of 113 young people's clinics and advice centres was conducted and achieved a response rate of 70% (n=79). Although leaflets were available in 70, 24 reported that they were displaying a leaflet published by the Family Planning Association in 1984, which refers to the "morning after pill" and should have long since been replaced.[4] There were isolated examples of well designed posters and reminders the size of a credit card.

Several commentators have drawn attention to the need for better publicity, and, as the Health Education Authority prepares to launch an initiative on emergency contraception, the opportunity to evaluate the impact should not be lost. The key indicators will be public knowledge of where and when emergency contraception is available, the proportion of women seeking terminations who remain unaware of or unable to access emergency contraception, and the impact on trends at district level in rates of emergency contraception and termination of pregnancy.[5]

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Who uses the *Cochrane Pregnancy and Childbirth Database*?

EDITOR,—The rationale for the Cochrane Collaboration's publication of systematic reviews electronically is that this medium facilitates updating of reviews in the light of new data and valid criticisms.[1] Dissemination by electronic publication is, however, novel, and the medium is still being developed. In 1993 a survey reported limited uptake of the *Oxford Database of Perinatal Trials* in English obstetric units.[2] Yet correspondence[3,4] suggested more widespread use of this database's successor, now produced by the Cochrane Collaboration.[5] I undertook a postal survey of all British subscribers to the *Cochrane Pregnancy and Childbirth Database* in May 1994.

The questionnaire elicited details about place of work, job, and uses made of the database. Three hundred and eighty seven people were sent the questionnaire, of whom 274 (71%) responded. Most worked in organisations providing care (140), all but 15 of them district general or teaching hospitals. Other sites included academic institutions (58) and purchasing authorities (42). The responses clearly identified 173 separate organisations in which at least one member subscribed to the database.

Three professional backgrounds predominated: midwives (83), doctors (81), and information specialists (56). Other respondents included managers, administrative staff, researchers, audit workers, and members of the National Childbirth Trust. Thirty five respondents were responsible for distributing a copy of the database to 68 further people; and 112 respondents made their copy of the database accessible to others, usually by installing it on a computer in a common area, often a library.

Most (239) of the respondents had viewed the information on the database, and most reported multiple uses. The database was most commonly used to improve personal knowledge and the knowledge of others but also for guiding research, developing clinical guidelines, and informing audit (table).

The most important findings about the *Cochrane*