H pylori is common,[6] this is not yet well established, and the article by Bytzer *et al* cannot be considered a serious evaluation of the cost effectiveness of such a policy. Studies to address this important question will also have to take into consideration some of the less tangible benefits of a "negative" result on endoscopy.[5]

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Treating myopia

Incisional keratotomy has a safer track record than photorefractive keratectomy

EDITOR,—David S Gartry's review restores some balance to the debate about photorefractive keratectomy, emphasising that such surgery must be predictable, effective, and safe with a low incidence of complications.[1] The excimer laser was introduced to treat myopia in the expectation that photoreactive keratectomy would surpass incisional keratotomy (microsurgery: the safer American development of Russian radial keratotomy) in predictability. This has not happened since a greater degree of remodelling is required after photoreactive keratectomy.

It cannot be overemphasised that the fact that "15% of patients lose one or two lines of Snellen acuity, a significant loss," is unacceptable for surgery on the healthy cornea. Furthermore, a recent study found that a tenth of patients treated with an excimer laser declined treatment of the other eye because of disturbances of night vision in the treated eye.[2]

Of greater concern are the possible long term complications. Gartry lists decompensation of the cornea "as unlikely though not impossible." This could occur from the shock waves in photoreactive keratectomy striking the corneal endothelium. Refractive surgeons remember that Sato's incisions in the posterior cornea eventually caused 85% of eyes to lose their vision, but only after 18 years, from decompensation (waterlogging) of the cornea.[3] Photoreactive keratectomy may also reduce corneal tensile strength by altering the corneal structure.[4] Complications in refractive surgery historically have been unexpected and emerged only after many years.

Meanwhile, incisional keratotomy causes far less loss of visual acuity (1-3%), has a long term safety record, and allows almost immediate return of vision. Initial fears that eyes would be more susceptible to traumatic rupture after incisional keratotomy were discounted by Robin's study of 750 000 eyes.[5] Refractive surgeons have learnt to be conservative to avoid secondary hypermetropia. Currently, the predictability of the result of fourth incision keratotomy is higher than that of any results reported in the same refractive groups after treatment with an excimer laser.[6]

Gartry reminds us that photoreactive keratectomy is an experimental, investigative procedure. It is astonishing that in a sophisticated country such as Britain there are minimal controls. It would seem reasonable to limit the numbers undergoing photoreactive keratectomy at approved research centres where independent assessment is done until results improve and more is known of possible long term complications. Whether it is ethical to charge for such experimental procedures for commercial gain is debatable.

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Elective procedures for normal conditions need high standards

EDITOR,—In his review of the treatment of myopia David S Gartry refers to the "inconvenience" of this condition.[1] Refractive myopia is a normal state resulting from the biological variation of several factors in what in most cases are normal tissues. It can convey many benefits, particularly in respect of the effects of presbyopia. Its "treatment" by methods that destroy normal tissues is akin to the approach of Proscrustes, the legendary Greek brigand, whose bed was offered to weary travellers but always proved to be either too long or too short, reflecting the similarly normal variation in height of ancient Greek travellers. Sir Frederick Treves, Edward VII's surgeon, enunciated the dictum that "all surgery is amputatory." The aphorism remains as relevant as ever.

An elective procedure on normal structures that results in 15% of subjects being dissatisfied with the outcome and a smaller percentage incurring important and even disabling consequences is not a procedure that one would advocate for oneself, one's family, or, least of all, one's best friends. If, in the terms of another item in the same issue of the *BMJ*,[2] this is rhetoric then so be it.

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Genetic testing for familial hypertrophic cardiomyopathy in newborn infants

Hypertrophic cardiomyopathy can be treated but not cured

EDITOR,—In the ethical debate on genetic testing for familial hypertrophic cardiomyopathy in newborn infants I agree in general with the views of Professor Celia M Oakley's group.[1]

I consider that the case for testing has been made, both for the welfare of the subject and the family and for the great need for further research. It is unfortunate that the myth of the untreatability of hypertrophic cardiomyopathy is being perpetuated. The disorder is certainly treatable: symptoms can be alleviated and the risk of sudden death reduced.[2] Neither is it true that prognosis cannot be altered. It is true that hypertrophic cardiomyopathy is not curable now, which makes continuing research essential. Diagnosis is vital because sudden death can strike without warning.

Counselling of sufferers and relatives is essential, as is greater awareness about the disease on the part of the public and of all who are concerned with the welfare of young people. The Hypertrophic Cardiomyopathy Association has been set up precisely to counsel sufferers and their relatives.

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A positive screening test for an untreatable condition provides psychological relief from uncertainty

EDITOR,—The recent ethical debate on the genetic testing of newborn infants for familial hypertrophic cardiomyopathy among parents, a cardiologist, a paediatrician, and two medical geneticists[1] shows the need for research based evidence in this area.

Their views differ in what defines benefit and how this might be achieved. Peter S Harper and Angus Clarke argue that parents' requests to test their children should be met only when there is clear medical benefit to the child. This, however, excludes the benefit of providing psychological relief from uncertainty. Yet the parents in the debate considered that reducing uncertainty was helpful in their care of their child, stating "knowledge can be a kind of cure." We found the same in a case study that formed part of an ongoing multicentred prospective study of young people undergoing DNA predictive testing for familial adenomatous polyposis.[2] The parents' request to test their two children was reluctantly agreed to by the clinician, given that they were aged under 5. One of the children received a positive result and the other a negative result. The parents firmly believed that the knowledge would benefit them as parents and increase their children's ability to adjust to information that they could gain gradually over the years. The mother in our study reported being less rather than more protective, in that she was anxious about insisting on early bowel screening for her children after receiving the results. Evidence from studies of adults undergoing genetic testing for Huntington's disease and breast cancer attest to the psychological relief that those requesting such tests experience when receiving test results, whether positive or negative.[3,4] The alternative to genetic testing suggested by Harper and Clarke is regular clinical monitoring of the child for signs of disease, and this may cause more anxiety and problems with self image than one off genetic testing and a preventive lifestyle in the 50% of children found to have the mutation.

We do not argue for clinicians to encourage parents to undergo predictive testing in their children. Rather we argue for respecting parents' wishes in the absence of evidence of harm and when there is potential for benefit. As with all new technology, it behoves all those offering unevaluated techniques to collect data on their outcomes—clinical, psychological, and social. One