determine the viruses' oncogenic potential.[2] Of 24 women in whom only human papillomavirus types 16 and 18 were detected, five progressed to cervical intraepithelial neoplasia grade III compared with none of the 12 women with only types 6 and 11, confirming previous studies.[3] Particularly interesting, however, were the 41 women who had clinical evidence of condylomata acuminata of the vulva or the perineum, or both. Human papillomavirus types 6 and 11 were identified using the in situ hybridisation test and were isolated from the cervix in 33 cases, either alone (in 25 cases) or combined with human papillomavirus types 16 and 18 (in eight cases). In a further eight cases cervical cells were positive for human papillomavirus types 16 and 18 alone.

It is this observation, that human papillomavirus types 6 and 11 and types 16 and 18 may coexist, which is so important. Indeed, it has even been suggested that types 6 and 11 may act as helper viruses for types 16 and 18.[4]

We have no simple or generally available method of screening specifically for human papillomavirus types 16 and 18. We must, therefore, rely on clinical indicators of risk. I would suggest that the presence of genital warts is one such indicator.

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Dyspepsia in general practice

SIR,—In their recent editorial[1] Dr C Brown and Dr W D W Rees have done a disservice to those who wish to see gastric cancer diagnosed early, when it can be cured. They have ignored the evidence from Japan, where endoscopy on demand, or in response to the most trivial dyspeptic symptom, has resulted in the proportion of gastric cancers that are diagnosed early rising from 10% to over 60%[2] while in this country it remains under 10%.[3] While the incidence of gastric cancer in the United Kingdom (30/10^5 population) is much lower than that in Japan (150/10^5 population), gastric cancer is none the less the fourth most common malignant disease in the United Kingdom and the incidence in this country in the past decade has not fallen significantly.[4]

The point which Drs Brown and Rees seem to have overlooked is that patients with early gastric cancer present without symptoms or with trivial symptoms which are often transient and responsive to treatment with an H_2 blocker. Such patients with minor symptoms, or with symptoms cured by an H_2 blocker, will rarely reattend six weeks later. These are the very patients who must be examined by endoscopy if gastric cancer is to be diagnosed early. We disagree that it is patients with weight loss and anorexia who clearly need urgent diagnosis. They show the features of late disease, and by the time weight has been lost a cure is unlikely.

Early endoscopy in patients over 40 presenting with dyspepsia has been shown clearly to increase the proportion of patients with gastric cancer diagnosed early to over 20% (J Fielding, personal communication). It was extraordinary to choose an American reference to support the statement that only 1% of all dyspeptic patients will be found to have oesophageal or gastric cancer, when the United States has one of the lowest incidences of gastric cancer in the world. Using open access endoscopy we found six patients per hundred examined to have gastro-oesophageal malignancy,[5] and Fielding found four per hundred. This compares with a yield of about four cases per 1000 for breast cancer screening.

Only with a policy of endoscopy for each patient over 40 who presents with dyspeptic symptoms, no matter how trivial or transient, will gastric cancer become a curable disease in the United Kingdom. The revenue implications are considerable but doctors and politicians must rise to the challenge.

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AUTHORS' REPLY,—We thank Mr I M C Macintyre and Mr D M Sedgwick for their interest in our editorial[1] but believe that some of their sentiments are misplaced and that many of their proposals are based on inadequate data.

Results from Japanese studies on early gastric cancer may be interesting, but their relevance to disease in the United Kingdom, where the natural course of early cancer may be different, remains debatable. Lesions differ in morphology and distribution, and with similar surgical procedures the outcome of the disease is much better in Japan.[2]

In a recent survey of endoscopy in Birmingham Fielding reported that of 2% of dyspeptic patients with gastric cancer about 20% had early cancer.[3] These results are slightly more optimistic than North American data[4] but are quite different from Japanese results. None of the patients in Birmingham screened when under 50 had gastric cancer. Even in Mr Macintyre's own study of 382 patients having "open access endoscopy" about 2% had gastric cancer.[5] None of the cancers occurred in patients younger than 59, and no cases of early cancer were detected.

A recent study in Leicester concluded that gastric cancer was rare below 45 and found that most of the younger patients with this disease over 6 years presented with "high risk" symptoms (weight loss, vomiting, anaemia, and gastrointestinal haemorrhage).[6] This information is compatible with an interim report by a group from the British Society of Gastroenterology that investigated early gastric cancer and dysplasia.[7] Of 132 patients with early gastric cancer, 91% were considered to be at high risk after the data were analysed by computer.

In the United Kingdom patients with trivial symptoms of dyspepsia resort to self medication and do not usually present until they have advanced disease. Mr Macintyre's and Mr Sedgwick's suggestion that all patients over 40 with trivial dyspepsia should be referred for immediate endoscopy is unrealistic. Without a campaign of public education and massive injection of funding and manpower such a policy will merely increase waiting time for endoscopy without improving the detection rate of treatable early gastric cancer. Clearer data are needed on the incidence and natural course of early gastric cancer in the United Kingdom before committing scarce resources to the mammoth task of screening dyspeptic patients on a large scale.

We regret the misguided and emotive response to our editorial by Drs M A Sampson and C Record.[8] Their comments are mostly irrelevant to the gist of our editorial and form a highly biased appraisal of the relative merits of endoscopy and double contrast barium meal examination.

The merits of upper gastrointestinal endoscopy in patients with dyspepsia are acknowledged widely by both hospital and general practitioners. Because of limited resources and manpower, however, barium meal examinations remain the most accessible form of investigation for general practitioners. The relative merits of the two techniques are grossly distorted by Drs Sampson and Record. We believe that the use and interpretation of both are observer dependent. Lesions may be photographed or filmed during endoscopy, thus providing visual evidence as well as a written report. We doubt the relevance of "some aspects of function, hiatal hernias, and extrinsic mass lesions" to the management of dyspepsia. Barium contrast studies do not provide an ideal setting for measuring gastric emptying, evaluating gastro-oesophageal motility, and documenting gastro-oesophageal reflux. As for "extrinsic mass lesions," these are so rare as to be superfluous to this discussion. The comments on gastric cancer are both naive and dangerous. To suggest that double contrast barium meal examination can approach the diagnostic accuracy of gastroscopy with biopsy and cytology is totally unacceptable.

We agree that audit will prove a valuable tool for evaluating certain aspects of clinical practice, and we hope that such information will soon confirm both the diagnostic merits and the cost effectiveness of endoscopy for investigating dyspepsia.

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Idiopathic dilated cardiomyopathy

SIR,—Several comments made by Dr A L P Caforio and colleagues in their recent editorial on dilated cardiomyopathy are more controversial than might be appreciated generally.[1]

The authors state that "idiopathic cardiomyopathy is a chronic heart muscle disease." The evidence for that statement is almost non-existent. Studies on isolated heart muscle from patients with cardiomyopathy[2] or heart failure[3] show that developed tension under resting conditions, or in the presence of a high extracellular calcium concentration, is normal. The time to reach peak tension is extended but this is a feature of hypertrophy and not necessarily of heart failure. Many factors may limit the function of the heart as a pump including cell slippage, ventricular shape and geometry, orientation of muscle fibres, and particularly fibrosis. These factors will contribute to reducing the function of the heart as a pump even if contraction of the myocyte is normal. This argument does not exclude the possibility that initiating

factors may affect the myocyte but challenges the idea that a chronic defect of the myocyte is a common feature.

The authors also state that mortality is greater than two fifths within two years of diagnosis of dilated cardiomyopathy. That figure depends critically on the time of referral and on the circumstances in which patients reach the attention of investigators. In the Framingham study[4] the mortality from heart failure of any cause was 50% at four years. In patients with heart failure due to viral myocarditis the prognosis is considerably better.[5,6]

Conventional treatment is said to make "very little difference to survival."[7] Conventional treatment is primarily with diuretics to prevent accumulation of fluid but is unlikely to be subjected to a clinical trial with an end point of survival. The report of the cooperative north Scandinavian enalapril survival study (CONSENSUS)[7] showed that angiotensin converting enzyme inhibitors were beneficial in severe heart failure, but only 15% of the patients studied had cardiomyopathy. Over 50% of patients studied in a Veterans Administration cooperative trial of vasodilator drugs in chronic congestive heart failure[8] lacked coronary artery disease, and statistical analysis did not confirm a differential effect in those with and those without coronary heart disease. These data suggest that angiotensin converting enzyme inhibitors are of some benefit in cardiomyopathy, even if the evidence falls short of definitive proof.

Arrhythmias are common in heart failure, and Dr Caforio and colleagues imply that treating ventricular tachycardia might be advantageous. The only controlled trial reported[9] studied patients taking amiodarone, which had no effect on mortality.[9] Furthermore, the terminal rhythm in most patients with severe heart failure due to idiopathic dilated cardiomyopathy appears to be asystole,[10] not ventricular tachycardia, in contrast to that in patients with atheromatous ischaemic heart disease.

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Disorders of the shoulder in elderly people

SIR,—The American Rheumatism Association's criteria for reporting and classifying osteoarthritis of the knee joint have been criticised at length in recent literature.[1,2] Strongest criticisms of the criteria concerned an inherent circularity in the methods by which they were derived, a strong bias to increasing age, and particularly their potential misuse as diagnostic, rather than classifying, criteria.

These concerns have materialised in the study by Drs K K Chakravarty and M Webley on shoulder problems in the elderly,[3] in which an ingenious and hitherto unforeseen misuse is illustrated—the criteria designed for classifying osteoarthritis of the knee are used to diagnose osteoarthritis in a markedly dissimilar joint (the shoulder) for which clinical criteria have not been developed.

The American Rheumatism Association has called for its criteria to be tried and tested before being abandoned,[4] but the use of the criteria in the diagnosis of osteoarthritis of the glenohumeral joint must represent a departure for which even the association cannot have hoped.

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Managing seizures in the casualty department

SIR,—Dr Paul J W McKee and his colleagues fail to comment on their most striking finding—namely, that 60% of those attending a casualty department after a seizure had alcohol abuse as a precipitating factor.[1] Head injury, the next commonest precipitant, is frequently associated with alcohol too. The large proportion of alcohol abusers may explain why over a third failed to attend follow up.

Although it is clearly important to exclude serious organic disease, it is worrying that such little emphasis seems to be placed on management of an underlying drink problem. The implication of this study is clear: anyone presenting to casualty following a seizure is more likely to be abusing alcohol than not. Therefore attention needs to be given to identifying and assessing alcohol related cases. The management of a possible withdrawal syndrome should be considered and an appropriate referral made to the local alcohol services. The timing of such intervention might be crucial. Such a dramatic physical complication, especially if occurring for the first time, can provide a valuable therapeutic "lever" to help convince the patient of the seriousness of the situation and hence encourage motivation to accept treatment.

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1 McKee PJW, Wilson EA, Dawson JA, Larkin JG, Brodie MJ. Managing seizures in the casualty department. *Br Med J* 1990;**300**:978-9. (14 April.)

SIR,—Dr Paul J W McKee and his colleagues have presented a useful paper on the management by accident and emergency departments of patients who have presented with seizures.[1] Among their 597 cases no fewer than 337 patients were known to have epilepsy, and of the other patients with seizures, some with presumably of unknown cause, 74 were discharged immediately or given a follow up appointment. The management of such patients should always include recording their status as a driver of a vehicle, and the authors make no mention of the responsibilities of casualty department medical staff to these patients.

Since 1960 several road traffic acts have determined epilepsy as a prescribed disability but have allowed for the issue of a licence for limited periods if certain conditions are satisfied.[2] Furthermore there is a responsibility placed on the subject of a first time seizure, "blackout," or attack of loss of consciousness to stop driving and notify the Driver and Vehicle Licensing Centre without delay.

Thus for the casualty department the management of this group of patients must include the following. Those patients who have had a recurrent epileptic seizure and those who have had a non-specific seizure and are being discharged without admission must be told in the most positive terms that they must not drive a car and must themselves notify the Driver and Vehicle Licensing Centre of the event. An urgent letter should be posted to the patient's general practitioner within 24 hours giving clinical details of the patient's condition and with particular emphasis on the general practitioner's role in encouraging the patient to report his or her disability, even if it is believed to be temporary, to the licensing authority.

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Acute otitis media

SIR,—Mr George G Browning and colleagues state that the otoscopic diagnosis of acute otitis media is not easy even when carried out by specialists.[1]

An examination technique which rarely fails is to have the mother hold the baby over her shoulder, holding his head so that his left cheek presses closely to her left cheek. The baby feels safe in his mother's arms, and in this position his head is stabilised so that his right ear drum can easily be examined. He is then moved to his mother's opposite shoulder to examine the other ear. If necessary, an assistant may hold the baby's arms, although this is not usually needed.

I was a house surgeon in Sunderland in 1943, in the days before penicillin, when we operated on more children for acute mastoiditis than for any other single childhood condition. Since the advent of antibiotics acute mastoiditis has become rare, as has the running ear from a chronic perforation. Among the more senior members of our profession, who practised in the 1940s and early 1950s, in that era of great therapeutic change, there is no doubt that the use of antibiotics is mandatory when treating ear infections.

A valuable research project would be the comparison of hospital records of admissions for acute mastoiditis in the years before the use of penicillin and sulphonamides and records today. Another subject of interest would be the vital statistics of deaths from acute mastoiditis before and after 1945, the year when penicillin first became available in civilian practice. Those who ignore history are doomed to repeat it.

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1 Browning GG, Bain J, Rubin P. Childhood otalgia: acute otitis media. *Br Med J* 1990;**300**:1005-7. (14 April.)

SIR,—Your otologist contributor to the Controversy in Therapeutics mentions that medical journals seem more likely to publish papers which