seems illogical and makes immunotherapy impractical.

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1 Committee on Safety of Medicines. *Statement on desensitisation*. *BMJ* 1986;**293**:948.
2 Varney VA, Gaga M, Frew AJ, Aber FR, Kay AB, Durham SR. Usefulness of immunotherapy in patients with severe summer hay fever uncontrolled by antiallergic drugs. *BMJ* 1991;**302**: 265-9. (2 February.)

Freeman Hospital

SIR,—Despite the optimism of Mr Jeremy Laurance,[1] if what is happening at the Freeman Hospital is what the NHS "reforms" are really about then the first signs are not good. One of Newcastle's two dermatology wards is at the Freeman Hospital, but dermatology is not included in its trust prospectus because all dermatology services are to be centralised at the Royal Victoria Infirmary when ward space becomes available in two or three years. Yet on 1 April this year dermatology will be discontinued by the new Freeman Trust—to be replaced, it is believed, by a private surgery ward for overseas visitors.

Dermatology is a subregional specialty in Newcastle, and the loss of over 40% of its beds will affect the whole of Northumberland. Surely the Freeman can and should be compelled to maintain this essential regional service until adequate facilities are found elsewhere. If this ejection of dermatology by the new Freeman Trust Hospital is permitted we can only conclude that it is a victim not so much of the stimulating "scent of opportunity... in the air" as of the sharp whiff of commerce.

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1 Laurance J. Freeman hospital: countdown to self government. *BMJ* 1991;**302**:580-2. (9 March.)

Child health computing

SIR,—The correspondence following our editorial on child health computing[1] has raised a number of important issues.

Drs Malcolm Aylett and Allan Colver are incorrect in suggesting that the national child health system is unable to provide rapid feedback of immunisation performance to practitioners.[2] Vaccine coverage data for individual general practitioners, health visitors, and child health clinics are available as a standard request from the statistics package of the system.[3] Not all districts that use the system routinely feed back this information[4]; failure to do so, however, is due not to a deficiency in the system but to failure to use an available resource.

Drs Aylett and Colver also advocate adopting the family health services authority's list as the basis for a community register. Other correspondents (Dr Sally Jefferies and colleagues[5]), however, draw attention to the inaccuracies that exist on both this list and child health computer lists. These discrepancies, which are due mainly to the lack of information flow between professionals,[6] can be eliminated only by collaboration between the two systems working towards a common register, thereby increasing the number of opportunities for updating information on the register. It has to be remembered that up to 15% of children in inner city districts are not registered with a general practitioner, and the health authority register thus remains necessary. The development of electronic links between the child health and family health services authorities' systems is now being piloted in Stockport (ICL version) and Avon (MUMPS version). This is only the first step, and future developments for the system will include direct linkage to general practitioners' microcomputers.

Dr D J Hewitt criticises the national system for being centralised and unresponsive to local needs.[7] Many health authorities do not, however, have the resources to develop their own system. The interactive ICL version of the child health system, which will be available from July, allows considerably increased local flexibility while retaining the financial advantage of sharing the heavy development costs among user districts. Compliance with data protection and confidentiality requirements are already proved, and staff can operate the system without additional training when they move between health authorities. For every health authority to develop its own system would lead to chaos and unnecessary expense.

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1 Ross E, Begg N. Child health computing. *BMJ* 1991;**302**:5-6. (5 January.)
2 Aylett M, Colver A. Child health computing. *BMJ* 1991;**302**:409. (16 February.)
3 Child Health Computing Committee. *The child health system—a statistical guide*. Cardiff: Welsh Health Common Services Authority, 1987.
4 Begg NT, White JM. A survey of pre-school vaccination programmes in England and Wales. *Community Med* 1988;**10**: 344-50.
5 Jefferies S, Victor C, Oerton J, McShane S, Beardow R. Child health computing. *BMJ* 1991;**302**:410. (16 February.)
6 Morris RW, Lakhani AD, Morgan M, Dale C, Vaile MSB. The role of information flow between health professionals and the child health computer system in the uptake of measles immunisation. *Community Med* 1988;**10**:40-7.
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Trials of homoeopathy

SIR,—The scoring system employed by Dr Jos Kleijnen and colleagues does not adequately reflect the credibility of publications.[1] No account is taken of peer review; indeed, it is biased against peer reviewed publications. A study by some of us that was published in the *BMJ* achieved a relatively low score—because it had not been possible to include full details of patient characteristics, randomisation, etc, in a 600 word *BMJ* short report.[2] A fuller version of the paper published in a less competitive and less rigorously reviewed journal would have scored higher. But would it really have been better?

Excessive weighting was given to trial size. The main reason cited was "worry about incomparability at baseline." This can be entirely obviated by cross over, yet the authors discriminated against cross over studies.

We wonder if Dr Kleijnen and colleagues have considered the methodological and logical problems raised by their call for checks on blinding. Presumably this would take the form of a question: "Do you think your medication is active or a placebo or don't you know?" If investigators can influence assessments, they can also influence patients to answer "don't know" to this question, which would be taken as indicating adequate blinding.

We believe that the questions surrounding homoeopathy will be resolved by the classical method: repetition of trials, with methodological improvement, at disinterested centres of excellence. This is the strategy that we are pursuing in several clinical trials at our two centres.

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1 Kleijnen J, Knipschild P, ter Riet G. Clinical trials of homoeopathy. *BMJ* 1991;**302**:316-23. (9 February.)
2 Fisher P, Greenwood A, Huskisson EC, Turner P, Belon P. Effect of homoeopathic treatment on fibrositis (primary fibromyalgia). *BMJ* 1989;**299**:365-6.

SIR,—A recent review of randomised trials of homoeopathy led the authors to the conclusion that: "in [our] opinion, the results do not provide acceptable evidence that homoeopathic treatments are effective."[1] To establish whether there is evidence of the efficacy of homoeopathy is not an easy task, and the methodology proposed by Dr Jos Kleijnen and colleagues is an important step forward.[2] However, some of their assertions seem debatable.

Firstly, is it true that "much evidence is available"? Perhaps, if the whole of homoeopathy is considered as a single medicine; surely not, if one counts the impressive number of ingredients, so that for some preparations positive results seem to be extremely scarce, whereas for the remaining preparations used in homoeopathy there are no results at all. Therefore the likelihood of a bias in reporting positive results is indeed tremendously high, probably higher than for other treatments.

Secondly, the indications given in table II were mostly for diseases the evolution of which is recognised to present huge fluctuations, making it difficult to assess the specific effect of a medical treatment. Thirdly, it seems (from the same table) that when homoeopathy had a more pronounced effect than placebo this was often on subjective symptoms (those assessed with a visual analogue scale), for which a psychological induction is likely: this must be emphasised because the authors have doubts about the blindness of most trials.

Finally, one can wonder whether the reported results, even when statistically significant, were *medically* important: is it very important to raise the percentage of recovery in influenza from 10·3% to 17·1%, or to wait for 4·0 days until first faeces rather than 4·9 (especially in view of the efficacy of laxatives when needed)?

I perfectly agree with Dr Kleijnen and colleagues that there is no reason to believe that the influence of bad methodology is much less in conventional medicine than in homoeopathy. But evidence that the assessment of allopathic treatments may be poor should be an incitement to become more demanding with our academic procedures, and by no means an encouragement to be less critical with alternative medicines.

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1 Hill C, Doyon F. Review of randomized trials in homeopathy. *Rev Epidemiol Sante Publique* 1990;**38**:139-47.
2 Kleijnen J, Knipschild P, ter Riet G. Clinical trials of homoeopathy. *BMJ* 1991;**302**:316-23. (9 February.)

Spontaneous pneumothorax

SIR,—Dr Douglas Seaton and colleagues present an interesting approach to the problem of managing patients with spontaneous pneumothoraces