clearly a need for more research in this area. The protective effects of vitamin B_{12} would similarly appear to be as yet unsubstantiated.—I am, etc.,

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*Both patients with schizophrenic symptoms had low folates.

SIR,—I was interested to read both the paper by Dr. C. Neubauer (27 June, p. 759) and also your leading article on the subject of serum folate and B_{12} levels and epilepsy (p. 744).

I have been involved in two recent research projects on this subject.[1] [2] I rather envy Dr. Neubauer's finding of therapeutic benefit from the administration of both folic acid and vitamin B_{12} to his patients. It was in the hope of arriving at just such a conclusion that we undertook the second piece of research mentioned above. Knowing full well the fallacies of personal assessments of behaviour improvement when undertaking a therapeutic programme, the efficacy of which one wishes to see established, we took the precaution of carrying out the drug trial under double-blind conditions, and also had a definite system of assessing behaviour. Dr. Neubauer appears to have overlooked these precautions, and perhaps therein lies the difference between his positive findings of therapeutic benefit, and our own less happy negative findings.

However, there is another important factor in that Dr. Neubauer administered both folic acid and vitamin B_{12}, whereas we confined ourselves to giving only the former; it may well be that the combined administration does confer some superiority, and certainly the analogy of precipitation of subacute combined degeneration of the spinal cord when folic acid alone is given to some patients with megaloblastic anaemia is interesting. However, I think more rigorous proof is required before allowing the conclusion to pass unchallenged.

In your leading article you refer to antagonistic effect between folic acid and vitamin B_{12} in epilepsy as well as subacute combined degeneration. I think this effect is not established either. For instance, in our research we did not find that the administration of folic acid alone to our epileptics led to any increase in the frequency or severity of their fits. Furthermore, there was no apparent tendency in our drug trial for serum vitamin B_{12} level to fall as folic acid therapy continued.

Although we found in the first of our research projects that there was a definite, though diagnostically indeterminate, relationship between low serum folate and mental illness in epileptic patients, there was no such relationship with lowered serum vitamin B_{12} levels. A lowered serum vitamin B_{12} level was very much less common than a low serum folate in mentally ill epileptics, and in only one patient was a finding of lowering of both levels recorded.—I am, etc,

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1 Snaith, R. P., Mehta, S., and Raby, A. H., *British Journal of Psychiatry*, 1970, **116**, 179.
2 Ralston, A. J., Snaith, R. P., and Hinley, J. B., *Lancet*, 1970, **1**, 867.

Burden of Cerebrovascular Disease

SIR,—I feel the article by Professor R. M. Acheson and Dr. A. S. Fairbairn (13 June, p. 621) is incorrectly titled. A better title would be "The Burden on the Hospital Service due to Cerebrovascular Disease." Total incidence of cerebrovascular disease is calculated by adding home deaths to hospital morbidity. This leads to an underestimate of incidence by the number of cases treated at home who either live for more than one year or who die within one year from some other cause. The authors state that "no information is at present available about this group [those treated at home who recover], so that it must be ignored."

I see no reason why this group should be ignored, and it is at present being studied in a defined community in South Wales by ordinary epidemiological methods. Our present results suggest that 60% of all "clinical" strokes never go to hospital, and that they are similar as regards severity and case fatality to those who are hospitalized. The indications for hospitalization in this area appear to be mainly social.

This means that there must be considerable error in Professor Acheson and Dr. Fairbairn's estimate of incidence. Their measurement of case fatality is similarly subject to error—both in the number of cases and in the number of deaths. Similarly their breakdown by marital status, if hospitalization is mainly for social reasons and those surviving at home are omitted, is very open to criticism. Their comparison with Middlesex County is surely inappropriate. Middlesex County is a correct study of total incidence. Any agreement must be coincidental.

Record linkage is a wonderful tool. When it covers general practice as well as hospitals it will be possible to use it for community epidemiology. Until then the usual methods seem safer.—I am, etc.,

A. L. COCHRANE.

Barry, Glam.

Costs of Screening Programmes

SIR,—Your leading article (6 June, p. 553) on phenylketonuria is timely, emphasizing as it does the need to review the organization which must be set up to deal with cases detected by screening programmes. We believe that it might be appropriate, too, for some central department at this time to review aspects of the screening programme itself, particularly those details relating to recording and reporting of results. The price of communication will be far from negligible in the final cost/benefit analysis which, surely, must soon be undertaken.

The cost of collection and reporting at this hospital is shown in the weekly figures which follow:

Costing of Guthrie Test (about 70 tests per week)

	£ s d
Cost of Collection of Specimens	15 14 10
Cost of Tests (laboratory cost)	1 19 6
Cost of Recording and Reporting	4 18 10
Cost of Instruction to Midwives and others	2 9 3
Total Cost + 10%	27 13 0

The cost of test materials and laboratory personnel is negligible in comparison with the costs of collection, recording, and reporting—tasks which fall largely on the nursing and secretarial staff. Our costing exercise, of course, does not take into account further expenditure on babies born at this hospital who for one reason or another (mainly early discharge) must be followed up by the medical officer of health.

Your leading article states that the result of the test, even if negative, should be given to the parents. While no doubt a courteous and humane gesture, this would add considerably to the expense, even if parents provide their own stamped addressed envelopes for the information. It has not been our practice here; nor is it customary for the results of laboratory procedures to be communicated directly to the patient, save at the discretion of the patient's own doctor. You also state that the laboratory should inform the midwife or health visitor as well as the medical officer of health, the family doctor, and the consultant paediatrician if two tests are positive. We cannot see what purpose is served by the laboratory directly informing the midwife or the health visitor, even when it is possible speedily to locate the originator of the test, and, again, this runs counter to ordinary practice. It too must add to the cost, although probably not greatly, as the numbers involved are small. By the time two positive tests have been reported it is most unlikely that the child will be under the care of a midwife, and we have little doubt that the medical officer of health would ensure that his staff were informed in any event. Costly duplication of information should be avoided, in our view.

If other screening programmes are to be introduced on a national scale, surely it is only wise to review critically the expenditure on this one, cutting it wherever possible by encouraging a truly national practice, and by discouraging unnecessary communications, be they reports, letters, or telephone calls?

We are indebted to Miss K. Kovari and to the Treasurer, Queen Charlotte's Maternity Hospital for calculations of cost.—We are, etc.,

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Cancer and the Pill

SIR,—I have seen over the last two years four cases of breast carcinoma where the disease *seems* to have started soon after the patient was launched on the contraceptive pill.

Many women are taking the pill for the first time at an age when the incidence of breast carcinoma starts to rise steeply. Much has been written about the thromboembolic risks, and the appropriate modifications in hormone dosage have been advised and largely heeded. But may it not be that the carcinoma risk is much more important? Our ignorance of the possible links between hormone imbalance and breast and uterine carcinoma is virtually complete. It is likely that there is a profound relationship in susceptible cases, and hints about this are only now coming