While personal protective measures against mosquito's are vitally important as a means of preventing malaria, I do not believe that current advice for travellers about chemoprophylaxis can be ignored.

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1 Cook GC. Prevention and treatment of malaria. *Lancet* 1988;i: 32-7.

The figures in the article by Dr C G Nevill and others on methods of preventing malaria can only lead to the conclusion that the mosquitoes of the Narok area of Kenya do not bite till after 2200 (6 August, p 401). All the mosquitoes I encountered in Malaya and west Africa started biting at sundown, while those in my garden in Kent start to get hungry after tea time. Even in a house with electric light in countries with malaria you can still get bitten before bedtime, and usually on the knees under the table. It was quite usual for me to get up from the dinner table with 10 bites on each knee despite wearing what might be regarded as adequately protective trousers. So how does merely sleeping under a mosquito net give 97% immunity from malaria?

A factor not mentioned in the article is that mosquitoes are gastronomes that will feast avidly on one person and avoid another in utter distaste. The most appetising subjects tend to be the greatest sufferers from malaria. I was clearly caviar with champagne for mosquitoes.

I had 18 attacks of malaria in five years despite my mosquito net.

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Primary health care for the single homeless

As the wrongly alleged author of a report (it was, in fact, the work of the Manchester and Salford health care team for homeless people[1]) quoted by Dr P V Powell (9 July, p 84), I must reply to his editorial.

The evidence relating to Manchester's use of a specialised singlehanded general practitioner is out of date.[2] Since 1985 all primary health care for single homeless people, homeless families, and travellers in Manchester has been provided by local general practitioners. The concentration of single homeless people in hostels led to the payment of sessional fees, but, as the city pursued an enlightened policy of dispersal, it has not been necessary to continue these special payments.

The provision of an integrated health service for homeless people requires not only local general practitioners who accept their responsibility conscientiously but also the provision of appropriate primary health care support and good liaison with many agencies. The greater health care needs of homeless people, who suffer from many conditions, often require primary health care workers to work intensively with them to help them to overcome their difficulties. Liaison with other agencies, particularly the local housing department and voluntary agencies providing shelter for homeless people, is also essential. In Manchester we have managed to provide a service that has enabled general practitioners to provide general medical care to all people within their locality.

The problems of having specialised general practitioners were listed by the response of Manchester's joint consultative committee to the green paper on primary health care.[3] They include the temporary nature of such posts, which leads to a lack of continuity and the recurring problem of finding another general practitioner to work solely with homeless people. Such posts are professionally isolating, and the pressure of having an exclusive caseload of homeless people often leads to "burnout." General practitioners in the community are encouraged to refer all homeless patients to a specialised general practitioner, thus reinforcing the segregation of services. Temporary absence of the general practitioner creates problems in covering the caseload. Homeless people using the specialist general practitioner experience problems of reintegration into generic services after rehousing.

As a result of these problems general practitioners of a high calibre are reluctant to apply for such posts, and in Manchester, while we accept that it may not be possible to provide an integrated health service for homeless people everywhere, we think that it should at least be given serious consideration.

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1 Manchester and Salford Health Care for Homeless People Team. *Manchester and Salford health care for homeless people project—interim report.* Manchester: Manchester and Salford Health Authorities, 1985.
2 Shanks NJ. Medical provision for the single homeless in Manchester. *J R Coll Gen Pract* 1983;**33**:40-3.
3 Manchester Joint Consultative Committee. *Homeless families, single people and travellers.* Manchester: DHSS, 1987.

Self examination of the breast

Dr David Hill and his colleagues report a meta-analysis of 12 studies to evaluate the possible benefit of breast self examination (23 July, p 271). The results on which they base this conclusion require comment.

They compare the proportion of cancers with positive nodes among women who practise breast self examination with the proportion among women who do not, using either premorbid practice or the circumstance of detection to define the two groups of women. They report an odds ratio favouring breast self examination of 0·66. This use of the distribution of tumour stage (or nodal state or size) as a measure of effect has long been emphasised by epidemiologists as potentially misleading.[1,2] More benign tumours may well grow more slowly and so present a greater opportunity of detection when small or before nodes are affected —the problem of so called length bias. The authors acknowledge in their final paragraph that length bias may have contributed to the association they report, but nevertheless contend that the data are encouraging. An example showing the potential magnitude of length bias is given by the results of the Swedish two county randomised trial for women aged 40-49 years at entry. Among women who developed breast cancer before the end of 1984 positive nodes were found in 27% of those allocated to screening and in 45% of those in the control group, an odds ratio of 0·46—considerably more than that reported by Dr Hill and others. At the end of 1986, nearly nine years after the start of the trial, no appreciable reduction either of mortality from breast cancer or of the rate of advanced disease (stage II or worse) had been seen.[3]

The Swedish results show clearly the danger of using stage distribution as an indication of effect. The results of Dr Hill and his colleagues do not provide good evidence that breast self examination will be of benefit, in terms of either mortality or the rate of advanced disease.

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1 Chamberlain J. Planning of screening programmes for evaluation and non-randomised approaches to evaluation. In: Prorok PC, Miller AB. *General principles on evaluation of screening for cancer and screening for lung, bladder, and oral cancer.* Vol 78. Geneva: International Union Against Cancer, 1984.
2 Sasco AJ, Day NE, Walkter SD. Case-control studies for the evaluation of screening. *J Chronic Dis* 1986;**39**:399-405.
3 Tabar L, Duffy SW, Fagerberg CJG, Day NE. The case for mammographic screening for breast cancer; recent results from the Swedish two county trial. *N Engl J Med* (in press).

Thromboses during cytotoxic chemotherapy

In their paper Dr Brian M J Cantwell and others suggest that intravenous cytotoxic chemotherapy can provoke life threatening venous thromboembolism in patients with lymphoma (16 July, p 179). Direct thrombogenic effects on vascular endothelium are plausible factors in the pathogenesis, particularly as axillary vein thrombosis was present in two patients. Patients with lymphoma may, however, possess other risk factors that contribute to a prethrombotic state.

We have found evidence of lupus-like anticoagulant activity in five out of 10 patients with lymphoma tested with sensitive methods for the detection of this potentially thrombogenic phospholipid antibody (dilute Russell's viper venom test and tissue thromboplastin inhibition test[1]). Severe thromboembolic events (portal vein thrombosis and pulmonary embolism) occurred in two of the patients positive for lupus-like anticoagulants. In four patients this activity disappeared during the course of effective anti-lymphoma treatment. Lupus-like inhibitors are antiphospholipid autoantibodies and may be a manifestation along with other antiself antibodies of the immune dysfunction of lymphoma. The steroid component of combination chemotherapy may suppress the activity, thus confining the risk to the initial course of intravenous agents, as in the series of Dr Cantwell and others.

If the association of thrombosis with lupus-like activity in lymphoma was confirmed in a large prospective study heparin cover for initial treatment in such patients would be indicated.

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1 Schleider MA, Nachman RL, Jaffe EA, Coleman M. A clinical study of the lupus anticoagulants. *Blood* 1976;**48**:499-509.

A process of denial

I suspect that in common with many non-medical relatives of doctors I am not alone in reading some of the non-technical medical articles in the *BMJ* when copies are left lying around. One of my favourites is the Personal View, that by W Reeve particularly catching my attention (30 July, p 367). The diary entries describing the development of acromegaly would have been almost identical with my own had I kept such a diary. The similarities are such that I also had difficulties in finding shoes to fit, which I attributed to a foot injury sustained while practising not karate but another of the martial arts, judo.

There is, however, one aspect of having this uncommon disease, not mentioned in the article, which I found more disconcerting than almost any other: that all patients with acromegaly tend to look alike. I was continually being told by friends and strangers alike that they had seen me (or my double) in places and situations that I had not even heard of let alone visited. Despite my denials many were absolutely convinced that it was me whom they had seen and that it was I who was mistaken, not them. Perhaps because I was a policeman and