and, frequently, by severe symptoms. Their uncertainty is not alleviated by prolonged investigations that delay palliation and generally fail to answer their questions about the origin of the tumour and the prognosis. Patients deserve prompt palliation, appropriate investigation, and adequate support and counselling through what is too often a terminal illness.

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SIR,—We were dismayed by Christopher Bradley and Peter Selby's implication that, in the search for an unknown primary, a biopsy specimen of a cervical node should be obtained, and if it is found to contain squamous cell carcinoma an otolaryngologist should be requested to evaluate the upper aerodigestive tract.[1]

It has long been taught in ear, nose, and throat surgery that a diligent search for a possible primary tumour should be undertaken when a patient presents with a neck mass thought to be metastatic in origin. Martin and Romieu wrote 30 years ago: "The immediate removal of a lymph node for diagnosis is never in the best interests of the patient."[2]

Premature open biopsy of a cervical lymph node leads to increased morbidity with a higher rate of fungation and wound sepsis[4] and may even result in reduced life expectancy.[4] Incisions used for open lymph node biopsy may compromise subsequent radical surgical excision if not planned to be readily incorporated into an incision suitable for radical neck dissection. Cytological examination of fine needle aspirates, on the other hand, can provide useful histological information and is free of the complications associated with open lymph node biopsy.[5]

We believe that lymph node biopsy (excluding cytological examination of fine needle aspirates) should be undertaken only after the aerodigestive tract has been examined thoroughly, including by rigid endoscopy and "blind biopsies," by an ear, nose, and throat surgeon. If this fails to detect a primary focus of carcinoma an open biopsy of the neck mass may be undertaken, but only by a surgeon who is able subsequently to perform a radical neck dissection if indicated.

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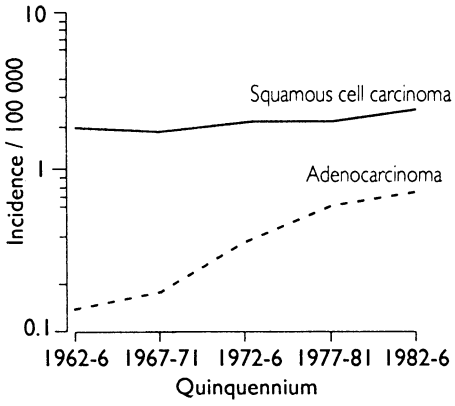
Oesophageal cancer in Britain

SIR,—We fully support the letter from K K Cheng and N E Day drawing attention to the increase in oesophageal cancer, particularly in Britain.[1] We recently showed that this increase is almost entirely due to an increase in adenocarcinoma since, in the west midlands, there has been little, if any, increase in squamous cell carcinoma (figure).[2] This analysis was based on cases registered in the west midlands regional cancer registry during 1962-86. Incidence data of this type include much more detailed information than is available from death certificates. In particular, we could examine trends by both histology and subsite.



Incidence of squamous cell carcinoma and adenocarcinoma per 100 000 in west midlands, 1962-86

Subsite analysis suggests that cancers of the lower third of the oesophagus increased fivefold from 1982 to 1986. Furthermore, the increase in oesophageal adenocarcinoma is paralleled by an increase in adenocarcinoma of the gastric cardia, which contrasts with a decrease in pyloric antral cancers.[3] Similar aetiological factors may therefore be operating for these two sites. Dietary factors reflecting socioeconomic factors may be important, as the west midlands data showed a relatively higher risk of adenocarcinoma of both the oesophagus and the cardia in social classes 1 and 2 compared with classes 3 and 4.

Mortality data are invaluable in comparing overall rates between countries. They can rarely, however, be analysed for subsites and almost never for histology. It is therefore vitally important that case-control and incidence studies include information on both histology and subsite. Only then can the differing aetiological factors be fully evaluated.

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Medical abortion

SIR,—R C Henshaw and colleagues claim to have costed surgical abortion in the NHS at £480 and medical abortion at £400.[1] For the past decade a day care surgical abortion unit has been operating in the Women's Hospital in Liverpool; it performed 1798 procedures in the year ended 31 March 1991 at a cost of £206 per procedure, which is similar to that charged for abortion by the charitable sector. This service includes specialised counselling and dedicated social work and is rapid and efficient, currently averaging 10 days between the first contact with the patient and the procedure. All women are under 12 weeks pregnant at the time of the procedure. Two per cent of the patients stay in overnight, not always for medical reasons; this is similar to the figure that I would estimate for those who fail to abort or have incomplete abortions with medical techniques.

Where an efficient and properly organised surgical abortion service is available, mifepristone can only add to the costs. When costing medical abortion account must be taken of the two additional visits required, although there has been some suggestion that mifepristone can be given on the day of counselling. At the Women's Hospital, however, 11·5% of women either cancel their appointment for the procedure or fail to attend for operation, and we regard this as a positive aspect of our counselling service. There is also the requirement for a follow up visit after a medical termination, and these visits I cost together at £35. In addition, the costs of mifepristone and the gemeprost vaginal pessary amount to £65.

The only saving that will be made with mifepristone is that of theatre time, which for a dedicated theatre using safe but low technology I cost at £55. Obviously the costs of counselling, laboratory tests, and nursing time for both types of procedure remain similar. Therefore, I estimate that abortion with mifepristone, rather than costing less than surgical abortion, will cost £45-50 more. This takes no cognisance of an increased requirement for ultrasound scanning, currently running at 19·8%, which will almost certainly occur owing to the constraints imposed on use of mifepristone.

I suggest that the issue of provision of abortion is being side tracked and that those districts that do not provide a dedicated service should consider this alternative rather than seeing medical abortion as a panacea for their problems.

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1 Henshaw RC, Templeton AA, Naji SA, Russell IT. Medical abortion. *BMJ* 1992;**302**:914. (4 April.)

Treatment of depression in primary care

SIR,—Allan I F Scott and Christopher P L Freeman[1] quote our controlled trial of amitriptyline versus placebo in general practice as having shown amitriptyline to be no better than placebo in milder forms of depression in primary care.[2] In doing so they omit the more important positive finding. What the study showed was highly significant superiority of the antidepressant over placebo in most cases of depression in primary care, extending well into the mild range but with a clear threshold in the mildest. Only patients scoring below 13 on the Hamilton scale or failing to satisfy criteria for probable major depression (a threshold well below that for major depression in the *Diagnostic and Statistical Manual of Mental Disorders Third Edition, Revised*) failed to show benefit. An American study in patients with mild depression treated by psychiatrists has given similar findings.[3]

Scott and Freeman found that patients with depression who received amitriptyline from the psychiatrist had improved significantly more at four weeks than those receiving antidepressant as part of routine general practitioner care. The distinguishing feature was the dose: the group treated by the psychiatrist received at least 150 mg daily while the group treated in general practice received a lower dose. Several studies in general practice have found antidepressant in the standard dose range of 125-150 mg daily for six weeks to be superior to placebo,[2,4,5] and several studies of doses of 50-75 mg daily[4,6] or a short treatment period[7] have not done so.

The conclusion is clear. Tricyclic antidepressants should be used in standard rather than low doses in general practice. They will then produce worthwhile benefit, at least in terms of more rapid emission, in patients with moderate to mild depression but not those with the mildest forms. Such treatment is entirely suitable for general practitioners and does not require psychiatric referral. The general practitioner, of course, must see the patient regularly during treatment.

The design of Scott and Freeman's study did not permit measurement of the benefits of combining

drug treatment with counselling, social work, or other psychological and social interventions. Good evidence from studies in psychiatric patients suggests that such psychosocial therapies combine well with drug treatment and are indicated for some psychological problems.[8]

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Measuring temperatures

SIR,—In his paper on using thermometers in general practice Steven Clarke shows the wide variation in the practice of temperature taking and identifies the problems associated with using the axillary temperature.[1] He and Duncan Keeley, in his editorial,[2] concentrate on the problem of detecting fever in children; another group in which measuring temperature may be difficult is elderly people.

We and colleagues have shown that the temperature of an afebrile elderly person varies according to the site of measurement.[3] Simultaneously measured rectal and axillary temperatures differed by a mean of 0·91°C (95% confidence interval 0·87 to 0·95°C). Whereas a rectal temperature of 37·6°C was outside our normal range and signified fever, the equivalent figure for an axillary temperature was 37·1°C. The picture is further confused by our finding that the difference in the temperature measured in the auditory canal and sublingually was increased if patients with confusion, previous stroke, parkinsonism, and micrognathia or patients who were not wearing their dentures were included in the normal afebrile population. Mouth breathing, difficulties in maintaining the position of the thermometer, and the ambient temperature may influence the measurement.

The environment in a patient's home is different from that in a warm hospital ward. In unselected elderly patients the mean change in rectal temperature in the 24 hours after admission to hospital was 0·4°C.[4] In our study 61% of patients who had a low or normal body temperature on admission had a raised temperature at one or more sites the next day.

The rectal temperature and temperature in the proximal auditory canal will detect fever in roughly 86% of febrile elderly patients, the sublingual temperature in 66%, and the axillary temperature in 32%.[5] If important clinical decisions are to be based on a patient's temperature the limitations of the various methods of measurement must be understood. Keeley's advice to forget the axilla is as important for elderly people as it is for the young.

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Ciprofloxacin in bacterial diarrhoea

SIR,—Y J Drabu and colleagues report on a patient infected with *Salmonella virchow* who displayed reduced susceptibility to ciprofloxacin after repeat dosing over 15 months.[1] The authors state, "Ciprofloxacin is not licensed for the treatment of bacterial diarrhoea." This is incorrect, as can be seen in the current datasheet, which indicates that ciprofloxacin may be used to treat enteric fever and infective diarrhoea. The datasheet also states that such organisms as *Salmonella* spp, *Campylobacter coli*, *C jejuni*, and *Escherichia coli* are fully sensitive to ciprofloxacin.

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Childhood mortality after a high dose of vitamin A

SIR,—Mike Lavender and Chris Vickery question whether vitamin A supplementation could be readily integrated into community health programmes, as colleagues and I suggested in our paper.[1,2] I acknowledge differences between our programme and the basic health services found elsewhere in Nepal, which were necessitated by the requirements of rigorous documentation. I wish, however, to highlight elements in our programme's design that enhance the possibility of replicating it.

In the more than two years since our study vitamin A supplementation in Jumla has been carried out every four months by intermittent mass coverage of all children at central points in their communities—similar to patterns established by the existing expanded programme on immunisation. Coverage has remained high. This does not rely on the two weekly household visiting regimen of our pneumonia case management programme, which has been running concurrently but separately. Each worker does about 100 children a day and could easily do more in more densely populated areas. Such routine periodic contacts are certainly operationally feasible and contrast with the difficulties cited by Lavender and Vickery in sustaining routine house visiting programmes.

The fact that no other nutritional services were available to our population is an argument for the programme being able to be replicated. Many primary health care programmes include elaborate components on nutrition education and growth monitoring, but, as Lavender and Vickery imply when they comment on the low levels of routine household contact with health personnel, such components are generally poorly executed. The programme we described has strength because it does not rely on this; we strongly disagree with Lavender and Vickery's claim that such an intervention should not be considered in the absence of a more comprehensive nutrition education programme, which adds great operational complexity. This is an appropriate long term goal, but first things first.

Our vital events monitoring system was entirely separate from the service delivery system, precisely to ensure that the intensity of monitoring would have no bearing on the delivery of services. The total cost of the programme per vitamin A dose delivered was under $0.20; in most places such a cost is affordable.

The reduction in mortality of 26% in our study is modest compared with reductions found in other, less extreme settings. In Sarlahi, Nepal, the protective effect of periodic vitamin A supplementation was 30%, and in southern India weekly supplementation resulted in a 54% decline in mortality.[3,4]

Our argument that this approach could be readily replicated does not imply that effort would not be required; our longstanding work with health services throughout Nepal and the proved effect on reducing deaths of children lead us to conclude, however, that this effort is feasible and worth while.

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Asthma in general practice

SIR,—Cedrick R Martys expresses disappointment at the inability of the Darley Dale asthma clinic[1] to show appreciable changes in morbidity compared with the Aylsham nurse run asthma clinic.[2,3] Several fundamental differences between the two clinics are worth highlighting.

Our clinic was for patients who were already receiving prophylactic treatment. They were judged to have more severe disease and hence most to gain. The Darley Dale patients were selected on the basis of having asthma and would have included patients with fairly mild asthma and perhaps little to gain from an intensive asthma programme.

Our study was based on those patients who actually attended the clinic whereas the Darley Dale clinic was judged on the total population with asthma regardless of whether they attended the clinic. It seems unfair to judge a clinic by patients who did not attend, just as it is unrealistic to expect general practitioners to use the clinic protocol (which may take 45 minutes) in their 5-10 minute consultations.

Hilton *et al* and Jenkinson *et al* have shown that providing patients with knowledge does little to alter morbidity.[4,5] Our behavioural approach, incorporating written self management plans, moves the control away from the doctor towards