findings can be applied to female genital mutilation occurring in a totally different cultural setting.

Finally, as paediatricians we condemn male circumcision; we were putting it into the context of the more extensive operations in females. It is now more than 46 years since Gairdner, in a classic paper, demolished the case for routine male circumcision.[5]

J A BLACK
Retired consultant paediatrician

Victoria Mill House,
Framlingham,
Suffolk IP13 9EG

G D DEBELLE
Consultant community paediatrician

Child Health Directorate,
Birmingham Children's Hospital NHS Trust,
Birmingham B29 6JB

1 Black JA, Debelle GD. Female genital mutilation in Britain. *BMJ* 1995;310:1590-2. (17 June.)
2 Female genital mutilation [letters.] *BMJ* 1995;311:1088-9. (21 October.)
3 Toubia N. Female genital mutilation and the responsibility of reproductive health professionals. *Int J Gynecol Obstet* 1994; 46:127-35.
4 Dorkenoo E. *Cutting the rose; female genital mutilation: the practice and its prevention.* London: Minority Rights Group, 1994:37.
5 Gairdner D. The fate of the foreskin. *BMJ* 1949;ii:1433-7.

Faecal incontinence in hospitals and residential and nursing homes for elderly people

EDITOR,—S M Peet and colleagues report a high prevalence of faecal incontinence in hospitals and residential and nursing homes for elderly people.[1] Faecal incontinence causes distress to patients and increases the amount of care they require. It also presents problems for infection control as it facilitates the spread of infectious intestinal disease to residents, patients, and their carers.

Between January 1992 and December 1994 the Public Health Laboratory Service Communicable Disease Surveillance Centre received detailed information on 1275 general outbreaks of infectious intestinal disease. Three hundred and sixty of these occurred in nursing or residential homes, geriatric or psychogeriatric hospitals, or wards for this subset of patients in general hospitals. The mean attack rate was 38%, with 7966 people affected and 37 deaths. There were 179 admissions to hospital from the 282 outbreaks that occurred outside hospital settings. Pathogens or toxins were identified in 306 of the 360 outbreaks: 186 outbreaks were due to small round structured virus, 56 to *Salmonella* sp, 24 to *Clostridium perfringens*, 18 to rotavirus, and 22 to other pathogens. Three quarters (271) of these outbreaks were reported to have been transmitted principally by the person to person route.

The duration of the outbreaks ranged from one to 71 (median seven) days in the 324 outbreaks for which duration was reported (fig 1). One hundred and twenty five outbreaks lasted 10 days or longer.

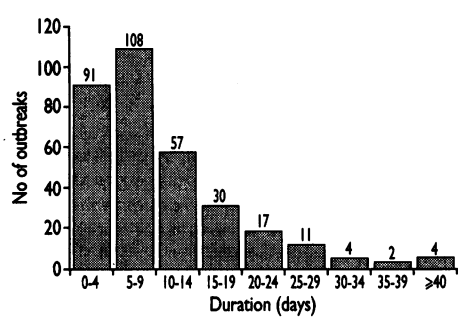

Fig 1—*Duration of outbreaks of infectious intestinal disease in nursing and residential homes and in hospitals or wards for elderly people reported to Communicable Disease Surveillance Centre, 1992-4 (n=324; 36 values are missing)*

The prolonged duration of many outbreaks with a foodborne component suggests that the initial cases were due to foodborne infection and that secondary spread maintained infection in the units.

Outbreaks in these settings are common because of the vulnerable populations that the units contain. Faecal incontinence is likely to be an important factor in these outbreaks, and adequate management of incontinence and the maintenance of good hygiene are essential if such outbreaks are to be avoided or rapidly controlled. Recently published guidelines on infection control in these settings should prove useful.[2,3]

PATRICK G WALL
Consultant epidemiologist
MICHAEL J RYAN
Senior registrar

Gastrointestinal Diseases Section,
PHLS Communicable Disease Surveillance Centre,
London NW9 5EQ

1 Peet SM, Castleden CM, McGrother CW. Prevalence of urinary and faecal incontinence in hospitals and residential and nursing homes for older people. *BMJ* 1995;311:1063-4. (21 October.)
2 Hospital Infection Working Group. *Hospital infection control. Guidance on the control of infection in hospitals.* London: Department of Health, 1995.
3 Public Health Medicine Environmental Group. *Guidelines on the control of infection in residential and nursing homes.* London: Department of Health, 1995.

Weightings for analysing general practices' prescribing

Pooling of data from practices was inappropriate

EDITOR,—In their paper presenting cost weightings based on patients' age and sex for general practice prescribing within therapeutic groups Lloyd and colleagues[1] use methods that they suggest are "slightly different" from those that colleagues and I used in a study.[2] In fact, the methodology is crucially different. Although Lloyd and colleagues obtained data separately for each practice, the prescribing costs and items by age, sex, and therapeutic group were then pooled across practices. This pooling does not allow any modelling of practice effects, which should certainly be taken into account, given the known variability in prescribing habits among practices. By contrast, statistical modelling to derive the weighting known as the ASTRO-PU (age, sex, and temporary resident originated prescribing units)[2] treated practices as fixed effects and derived estimates of relative rates of prescribing between the age-sex groups in practices, thus adjusting for interpractice variability. Given that data for individual practices were available, the pooled approach used by Lloyd and colleagues is inappropriate.

The differences between practices supplying data to the General Practice Research Database and those supplying data to the MediPlus database, as shown by figures 1 and 2 in the authors' study, are appreciable in view of the large numbers of patients. Nationally, about a tenth of women are aged 65-74, which means that about 150 000 and 38 000 patients are in this age-sex group in the practices supplying data to the General Practice Research Database and the MediPlus database, respectively. For drugs acting on the central nervous system the difference in rates is about 0·25 items per patient (4·38 as against 4·12, estimated from figure 1), and for endocrine drugs it is over 0·5 items (1·22 as against 0·68). No indication is given of the standard errors, but these differences are considerable and cast doubt on the typicality of participating practices and the completeness of the recording systems.

Finally, I note that in table III the headings "male" and "female" for ASTRO-PU weights have been incorrectly ascribed, and I wonder whether this also applies to the comparative columns for the IMS weights.

SARAH J ROBERTS
Lecturer in medical statistics

Wolfson Unit of Clinical Pharmacology,
University of Newcastle,
Newcastle upon Tyne NE2 4HH

1 Lloyd DCEF, Harris CM, Roberts DJ. Specific therapeutic group age-sex related prescribing units (STAR-PUs): weightings for analysing general practices' prescribing in England. *BMJ* 1995;311:991-4. (14 October.)
2 Roberts SJ, Harris CM. Age, sex, and temporary resident originated prescribing units (ASTRO-PUs): new weightings for analysing prescribing of general practices in England. *BMJ* 1993;307:485-8.

Authors' reply

EDITOR,—Sarah J Roberts is right in saying that the analysis that resulted in the ASTRO-PU weightings was more sophisticated, involving a log linear model, than that used to produce the STAR-PU weightings. We do not agree, however, that our simpler model, which used aggregated data, was inappropriate. We had a much larger sample than that available for the ASTRO-PU work, and the costs were direct rather than inferred from other data. Since we had these advantages we thought that the simpler analysis was appropriate.

The difference in items per patient for drugs acting on the central nervous system for women aged 65-74 (the rate mentioned by Roberts) is actually smaller than that suggested by the figures. The mean (SD) values are 4·30 (1·71) for the MediPlus database (n=112) and 4·41 (1·51) for the General Practice Research Database (n=510). A t test with unequal variances gives t=0·68 (620 df), which is not significant.

We thank Roberts for pointing out the typesetting error in table III: the headings "male" and "female" should be reversed for both pairs of columns in this table.

DAVID C E F LLOYD
Applied research statistician
C M HARRIS
Director
D J ROBERTS
Unit manager

Prescribing Research Unit,
University of Leeds Research School of Medicine,
Leeds LS2 1NZ

Early controlled clinical trials

EDITOR,—Carla L van der Wijden and John A Overbeke state that the publication of randomised clinical trials started in the late 1940s.[1] They cite a Dutch trial of paludrine in malaria and the Medical Research Council's first trial of streptomycin in pulmonary tuberculosis, carried out by the council's Tuberculosis Research Unit; both trials were reported in 1948. I wish to question this priority, favoured though it is by many authorities (for example, Cochrane[2]), and propose that the Medical Research Council's trial of patulin in the common cold, published four years previously,[3] deserves a place among the trials that initiated this new era of medical investigation and treatment.

The patulin trial was carried out in over 1000 British factory workers and civil servants. It was double blind and placebo controlled, and the controls were similar to the subjects in the intervention group on entry to the study and received similar instructions. A strict alternation scheme was devised by the clinical organisers (of whom I was one), which ensured an effectively random allocation of the subjects to patulin and placebo. Why has this trial been overlooked? Is it because attention to the validity of therapeutic trials was generally stimulated by the scheme based on random sampling numbers provided by Bradford Hill to Marc Daniels and me for our use in the