Table 1—*Number of laboratories (n = 103) making tests for H pylori available to gastroenterologists, other hospital doctors, and general practitioners (GPs)*

Test	Gastroenterologists	Other hospital doctors	GPs
Urea breath test only (^{13}C or ^{14}C, or both)	7	4	4
Urea breath test and serum assay	14	4	1
Serum assay only	53	57	59*
Near patient test only	1	1	1
Total offering service	75	66	65
No service offered	28	37	38

*Two further laboratories offered serum tests to fundholding GPs only.

all. Fourteen planned to introduce a non-invasive test within the next 12 months, though six would be restricting this service to hospital doctors.

Many of the guidelines on managing dyspepsia that emanate from secondary care advise that the success of eradication treatment should be confirmed by a laboratory test. However, the urea breath test, which is most suitable for this, was provided to gastroenterologists by only 20% of the laboratories and to general practitioners by only 8%. Some gastroenterology units have their own facilities for urea breath tests and make these available to general practitioners on an ad hoc basis. Near patient testing kits can also be bought by general practitioners. These alternative sources are unlikely to have an appreciable impact on the overall availability to general practitioners of tests for *H pylori*.

The restricted availability of non-invasive tests for *H pylori* limits both the effective use of gastroscopy services and the implementation of management guidelines for peptic ulcer disease. These tests, particularly urea breath tests, should be more widely available, and they should be as accessible to general practitioners, who manage 90% of peptic ulcer disease, as they are to gastroenterologists.

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Epidemiology of aortic aneurysm and peripheral vascular disease may show ethnic differences

EDITOR,—David Coggon and colleagues report the contrasting epidemiology of aortic aneurysm and peripheral vascular disease in England and Wales.[1] They conclude that, during the period studied, death rates from aneurysm were highest in the south and east of England and Wales whereas peripheral vascular disease was most common in the north and west, with an inverse relation with social class, and that there are other causes for aortic aneurysm besides the well established risk factors for atherosclerosis.

There are well established ethnic differences in the manifestation of atherosclerotic vascular disease—for example, the incidence of coronary artery disease is increased among Indo-Asians, while that of vascular complications related to hypertension, such as stroke, is higher in black or Afro-Caribbean patients.[2] Data on ethnic differences in the prevalence of aortic aneurysm and peripheral vascular disease in Britain are, however, limited. We therefore examined the computerised hospital admission diagnoses for patients admitted with aortic aneurysm and peripheral vascular disease to our city centre district general hospital, which serves a multiethnic population of 300 000, between 1976 and 1986.

Of the 66 patients admitted with aortic aneurysm, 56 (84.8%) were white, one (1.5%) was black, and five (7.6%) were Asian; of the 1466 patients admitted with peripheral vascular disease, 1282 (87.4%) were white, 52 (3.5%) black, and 46 (3.1%) Asian. The proportions of white, black, and Asian adults in the population served by this hospital during the period surveyed, however, were 83%, 10%, and 7% respectively.[3] When this was taken into account a significant excess of white patients was seen among those who presented with peripheral vascular disease ($\chi^2 = 13.14$, df = 2, $P<0.001$) and there were no trends for this to change over the years. There was no significant ethnic difference, however, among the patients who presented with aortic aneurysm ($\chi^2 = 4.26$, df = 2, $P = 0.19$).

We suggest that in addition to the contrasting epidemiology of aortic aneurysm and peripheral vascular disease in England and Wales[1] there may well be ethnic differences in the presentation of these manifestations of atherosclerotic vascular disease, which need to be considered in any detailed analysis. Further insight into the epidemiology of vascular disease in different ethnic groups is required.

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Drop out rate in medical schools seems reasonable

EDITOR,—James Parkhouse claims that the drop out rate from medical schools in the United Kingdom ranges "from 11.7% to 14.1%."[1] If true, this suggests serious problems. His figures, however, disagree with other estimates by a factor of two.

In a recent follow up of 2732 of the cohort of entrants to medical school in 1991, 133 (4.9%) had left during the preclinical (basic medical sciences) stage[2]; comparable figures for preclinical drop outs in the 1981 and 1986 cohorts were 35/502 (7.0%) and 60/876 (6.8%) respectively.[3 4] These figures are similar to the estimate of preclinical wastage in the survey of medical education by the General Medical Council for the five years to 1990 (1350/20 000 (6.8%)), with a small additional clinical wastage of 299/20 000 (1.5%) giving an overall wastage of 8.2%.[5] Parkhouse's indirect estimate of 11.7% to 14.1% is from 41% to 70% higher than the General Medical Council's estimate.

Parkhouse calculates drop out as the difference between input and output figures derived from two different sources. For the cohorts qualifying in 1989 to 1994 he compares two estimates of the average number of qualifiers (3648 (from the University Statistical Record) and 3576 (from the Higher Education Funding Council for England)) with the funding council's estimate of the number of entrants five years earlier of 4145, giving drop out rates of 12.0% and 13.7% respectively. Although the estimates of qualifiers agree with average provisional registrations with the General Medical Council of 3649, the estimate of entrants is much higher than that given by the Universities and Colleges Admission Service, which averages 3837. The source of the discrepancy is not clear, but double counting of students at Oxford and Cambridge Universities is possible; certainly the admission service's figures are likely to be more accurate since they are based on named individual students rather than aggregated statistics. When the admission service's and the General Medical Council's figures are used the drop out rate is 6.8%, which is compatible with the General Medical Council's rate of 8.2%[5] and almost half the rates based on Parkhouse's figures of 12.0% and 13.7%.

Both my colleagues and I[2] and the General Medical Council[5] found that about half of the students who drop out do so for non-academic reasons (probably most realise that medicine is an inappropriate career). Given this and that a non-zero drop out rate is presumably necessary to maintain academic standards, then an attrition rate of about 3.5% due to academic failure does not seem either unreasonable or unexpected.

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Correction

Neuroleptic prescribing in residents of nursing homes

Owing to an editorial error, only one author is given for the fifth letter in this cluster (29 June, pp 1667-9); there were in fact four authors. The complete list of authors should have read: Heather J Cameron (senior registrar in geriatric medicine), Gartnavel General Hospital, Glasgow G12 0YN; William Reid (consultant physician in geriatric medicine), Southern General Hospital, Glasgow G51 2TF; Carol Fisher (audit facilitator), Belvidere Hospital, Glasgow G31 4PG; and David J Stott (David Cargill professor of geriatric medicine), university department of geriatric medicine, Glasgow Royal Infirmary, Glasgow G4 0SF.