LETTERS

Cervical Smears

Sir,

I feel I must reply to your editorial on cervical cancer (February *Journal,* pp. 69-72). It comments that the starting point for cervical smear recall in general practice "must be the age/sex register. The cards can easily be marked to indicate the year in which the next smear should be taken." Unfortunately there is no further explanation of how to organize an adequate system. Using the age/sex register alone would not allow for "repeat in three months" reports and would require all the cards to be reviewed regularly. I would therefore like to describe a system which allows easy recall of all patients as and when necessary.

A second card index, the cervical cytology index, (CCI) is required, having cards for all female patients to be screened (e.g. over 35 years). The patient's name, address and date of birth are recorded on the card and the date and result of any previous smear. The card is then placed into a section within the index corresponding to the month that the patient is due for a recall. Their age/sex card is also tagged. Those patients who have not had a smear within the maximum recall time (e.g. five years) are recalled and again their age/sex cards are tagged, but their CCI cards are placed in a section marked "Sent for". If a patient responds positively to the recall their card is moved to a section "awaiting results" and then on to the appropriate 'monthly' section. Non-responding patients are recalled annually three times, after which their cards are placed in a section "not wishing to have smear", as are patients who respond negatively. The cards of patients who have had a hysterectomy other than for malignancy are placed in a section marked 'hysterectomy' and are not recalled.

When all the chosen group have been entered into the index, periodic review of the age/sex index to identify those newly registered and those now 35 years is required. (These have untagged cards). Those who have had three pregnancies or those of low socio-economic group could also be included.

The patients in each monthly group are recalled at the beginning of the corresponding month by means of a standard letter.

The system runs smoothly and I believe has more chance of being accurate than any operated via a distant impersonal family practitioner committee computer.

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Sir,

Professor Alwyn Smith (April *Journal* p. 256) suggests a practical solution to the dilemma of cervical cancer screening.

In 1970–1971 we attempted to screen 100 women aged 35 to 55, selected from our practice age-sex register, who had not had a hysterectomy and had no record of a cervical smear in the preceding 5 years. The response to a letter offering an appointment was 67 per cent. When we examined the records of those who did not reply, four had never seen a doctor since the introduction of the NHS in 1948. Attempts to visit and persuade the non-responders proved fruitless. Six had left the area, others could not be contacted or simply refused to discuss the matter. Most of the 67 women who were screened were in social classes I and II. The detection rate was one positive smear (carcinoma in-situ) and three patients with pelvic pathology (two fibroids, one sarcoma).

After this I worked for three years from 1972–1975 in a local authority cytology clinic which depended on a system of self-referral by the patients. The bulk of the work was carried out with highly educated middle-class patients. Although some working-class women attended the clinic and found it helpful and convenient, many were too busy with families or jobs, or too hard up, or too frightened to come. The community physician discussed this and we agreed that the screening programme was not reaching those in greatest need—parous women in social classes III, IV and V. We considered an attempt to contact them through the schools, or even bingo halls, but could not devise any practical method of doing this.

Perhaps Professor Alwyn Smith's suggestion of a single test for each woman at the age of 40, identified by her general practitioner from the age-sex register, will prove economical and fruitful. I intend to give this a trial in our own practice in the near future.

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Looking for the Fragile-X

Sir,

The College's (1981) report on health and prevention in primary care listed fourteen pre-natal 'target' conditions in which prevention, early detection or health education are, or may be, worthwhile.

Until very recently Down's syndrome has been the only chromosomal abnormality detectable by amniocentesis, but recent work in New York (Jenkins *et al.,* 1981; Shapiro *et al.,* 1982), Adelaide (Sutherland and Jaky, 1982), Bristol (Gardner *et al.,* 1982) and other centres now promises to add a second chromosomal abnormality of major importance to the list. This is the fragile-X syndrome, first described by Lubs (1969).

The disorder probably results from a defect in very few genes, or possibly even one. Affected individuals, who have mild to moderate mental retardation, will generally be found in ESN schools, sheltered work, subnormality hospitals or institutions. Female carriers may not be noticeably abnormal, but as in other X-linked abnormalities, half of their offspring are likely to be affected: 25 per cent normal boys, and 25 per cent affected; 25 per cent normal girls and 25 per cent carriers.

Apart from mental retardation, affected males are characterized by long faces, (high foreheads and prominent chins), often large ears, sometimes unusually blue irides and, after puberty, increased testicular size (macro-orchidism). In some there may be behavioural abnormalities, either psychotic-like or autistic. Generally they seem good pupils in special schools and good workers in workshops and have easy happy personalities. A particular quality of speech termed 'litany' speech has been described (Brown *et al.,* 1982)

Knowledge of this condition is now advancing rapidly. Professor J. Lejeune has postulated that the biochemical abnormalities resulting from the abnormal gene(s) may be correctable by the administration of folic acid, 5-formyl tetrahydrofolate or other donors of monocarbons (Turner and Frost, 1980). This suggestion is based on the observed reduction in the chromosome fragility *in vitro* in folic-acid-enriched cell-culture medium.

Eight patients in Lejeune's series of 16 have shown improvement in behavioural pattern following folic acid and adjuvant therapy. A further interesting possibility is the treatment of pregnant fragile-X women. A European co-operative study has been suggested (Lejeune, 1981).

Meanwhile there is an urgent need to