Use of ICHPPC as a nomenclature in order to retrieve medical records relating to specific conditions is very satisfactory if, as the authors indicate, 85.7 per cent of conditions can be retrieved without hand sorting. I cannot agree with their conclusion that "many of the problems forced into the residual category by the ICHPPC system were actually well-defined and highly prevalent diagnoses". In Table 2 they indicate that the maximum number of residuals in any class (other than class 16, which is by definition residual) was 952 or 1.1 per cent of all diagnoses. The maximum number of episodes of any individual problem recorded in a residual category must, therefore, have been well below 1 per cent of the total. This can hardly be called "highly prevalent".

C. BRIDGES-WEBB
Professor and Head of Department
Department of Community Medicine
University of Sydney
11 Croydon Avenue
Croydon
NSW 2132
Australia.

Is Peyronie's Disease Iatrogenic?

Sir,
We were interested to read Dr Owen's paper (August *Journal,* pp. 499–500) about the possible role of beta blockers in the pathogenesis of Peyronie's disease. Coupland (1977) also reported two cases, and seven of the 19 cases associated with beta-blocker therapy reported by Pryor and Khan (1979) had received practolol. We report four additional patients who developed Peyronie's disease in association with practolol treatment.

Case 1. A 44-year-old man was admitted to hospital for the investigation of angina pectoris in 1973. He was mildly hypertensive and whilst in hospital suffered a myocardial infarction. He recovered and was prescribed practolol 100 mg three times a day. After 14 months on this treatment he reported distortion of the penis on erection. He continued to take the drug and eventually indurated plaques appeared on the shaft of the penis. The practolol was stopped in May 1976.
Case 2. A 50-year-old man with hypertension was prescribed practolol 100 mg twice daily in August 1970. In January 1971 he noticed curvature and pain in the penis during erection. In April 1971 the treatment was changed to propranolol, but the penile deformity persisted and in April 1972 the diagnosis of Peyronie's disease was confirmed.
Case 3. A 46-year-old man was prescribed practolol 100 mg three times a day in February 1973 following a myocardial infarction. In April 1974 symptoms of Peyronie's disease appeared and progressed over the following year. Practolol was stopped in April 1975.
Case 4. A 65-year-old man developed angina pectoris and was prescribed practolol 100 mg three times day in January 1974. After three months the drug was withdrawn. In May 1975 penile symptoms developed and Peyronie's disease progressed rapidly during the following year.

Both patients described as cases 2 and 3 suffered from xerophthalmia.

Practolol has been accepted as the cause of fibrosing conditions in various parts of the body. The occurrence of Peyronie's disease in 11 people taking this drug seems a striking coincidence and strongly suggests that practolol was also involved in its pathogenesis.

G. HAMBLETON
Consultant Paediatrician

A. F. MACLEOD
General Practitioner

J. T. BINLESS
General Practitioner

Park Hospital
Moorside Road
Davyhulme M31 3SL.

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Chlamydia Trachomatis in General Practice

Sir,
With reference to your report (September *Journal,* pp. 562, 563) we would like to emphasize that chlamydial cervicitis is often asymptomatic. The at-risk criteria as given should only be taken as a guide. There is no evidence for claiming that most cases of chlamydial infection could be identified by these risk factors. The risk factor given last on the list, i.e. recent change of sexual partner, is obviously the most important. Many of the others that are suggested would be irrelevant to most women, considered insulting by some and not likely to be disclosed by those most at risk.

We think it should be pointed out that the culture method for the detection of *Chlamydia trachomatis* is very difficult to use in a general practice context; mainly because the specimen needs to be stored in liquid nitrogen unless it can be transported to a specialist laboratory within 48 hours (at + 4°C). An alternative method is to look for antibody to *Chlamydia trachomatis* in cervical secretion (Treharne *et al.,* 1978) which is absorbed onto a small sponge. This can be stored at room temperature for up to a week, and sent to the laboratory by post if necessary.

We have already carried out a study among all 200 women who had vaginal examinations in a Health Centre over a nine-month period. We failed to get any positive cultures, but local IgG antibody was detected in four women, probably indicating current infection. As yet, this antibody method is not widely used, but we feel it offers a cheap, sensitive method which is easy to use either for screening purposes or as a diagnostic procedure.

R. A. COPEMAN
General Practitioner
J. D. TREHARNE
Senior Lecturer—Virology
2A Forest Road
Edmonton
London N9.

Reference

Treharne, J. D., Darougar, S., Simmons, P. D. & Thin, R. N. (1978). Rapid diagnosis of chlamydial infection of the cervix. *British Journal of Venereal Disease,* **54,** 403–408.

Patient Movement and the Accuracy of the Age/Sex Register

Sir,
Dr Robin Fraser's excellent article (October *Journal,* p. 615) says that no information is available on the most efficient way of removing age/sex register cards when patients leave a practice or die. He kindly referred to my article of 1975, but I did describe the mechanism for ensuring that these cards are removed when a patient leaves the practice in an earlier paper. This describes the system which has been in use in this practice for 13 years and has proved eminently successful.

MERVYN GOODMAN
Netherley Health Centre
Middlemass Hey
Liverpool L27 7AF

Reference

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