tient held record is a step in the right direction.

Another area which was not mentioned in the review is the delay between patient discharge and the immediate discharge summary being sent from the hospital to the general practitioner. In a survey of discharge practice in the south east Thames region it was found that of 72 psychiatrists who responded, 22% did not send any early discharge summary. Sixteen per cent of psychiatrists gave seven days supply of medication on discharge and 78% gave enough medication for between seven and 14 days, yet they all estimated that it would take four to eight weeks for the final report to reach the general practitioner.[2]

There is an urgent need for general practitioners and psychiatrists to reach agreement on the need for early discharge summaries and to decide on what information should be provided. Until such basic communication problems have been tackled, there is little hope for improving the immediate follow-up care for this vulnerable group of patients.

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References

1. Essex BJ, Doig R, Renshaw J. Pilot study of records of shared care for people with mental illness. *BMJ* 1990; **300**: 1442-1446.
2. Essex BJ, Rosenthal J. Psychiatric discharge summaries in theory and practice. *Psychiatr Bull* 1991; **15**: 326-327.

Continuing medical education

Sir,

Dr Harding and colleagues from the Cardiff Postgraduate Medical Centre congratulate colleagues from the west of Scotland in attracting general practitioners to courses, but comment that their successes have not been experienced in other parts of the United Kingdom (letters, October *Journal*, p.443).

The Wessex GP Education Trust is now in its third year. It has a membership of nearly 1300, representing 70% of general practitioners in Wessex (excluding Bath, which has a different organization). The majority of postgraduate education within Wessex is covered financially, directly or indirectly, by the trust on behalf of its members. Members can attend an unlimited number of courses across the region without extra charge.

Income is generated from subscriptions, interest on investments and fees from non-members attending trust events. The subscription needed for the trust to break even is £150 per annum, but as a consequence of a surplus of funds, the subscription for existing members is at present £50 per annum. Members who wish to attend external courses can have a proportion of the course fee reimbursed up to £168.

As well as funding activity within postgraduate centres some of the trust's money is being utilized to develop innovative educational projects, such as focused small group learning, the development of higher professional education and courses that require a specific tutor or facilitator on a longer term basis than the usual study days or refresher courses.

The Wessex GP Education Trust is a registered charity and has an independent executive board to which the regional adviser is automatically co-opted. It has a small office in the headquarters of the regional health authority, and a part-time administrator and part-time secretary. The advantage of the trust is that it has a region-wide base and its size allows for administrative savings, together with the ability to invest surplus income. The trust would be delighted to develop reciprocal arrangements with other similar schemes where they exist.

The Wessex and west of Scotland regions have shown the way forward, and if similar regional schemes could be developed throughout the UK, they might address the fears for the long term future of postgraduate education.

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Cervical cytology

Sir,

We read with interest the comprehensive review relating to cervical cytology by Clare Wilkinson (August *Journal*, p.336).

In the guidelines published by the national coordinating network[1] it is recognized that in some women a minor cervical smear change may represent the only evidence of sexually transmitted disease and referral to a genitourinary medicine clinic should therefore be considered. The possibility that attending for routine cervical cytology may lead to information suggesting a transmissible condition caused concern both within the profession and among women receiving results relating to abnormal smears.

It therefore seems important to consider women with inflammatory smear results as potentially at risk of ascending infection which may lead to fallopian tube occlusion and infertility. The borderline cervical smear result is particularly challenging as the differential diagnosis would include all grades of cervical intraepithelial neoplasia, severe inflammatory changes, and changes owing to papillomavirus. *Chlamydia trachomatis* is considered to be the most important microorganism associated with ascending genital tract infection in women.[2] In women under the age of 25 years, the opportunity to use a minor cervical cytology abnormality to protect future reproductive function may be critical.

The department of genitourinary medicine at Doncaster Royal Infirmary has a commitment to training future general practitioners and has also offered an open access chlamydia culture service since 1980. Table 1 suggests that the peak recovery of *C trachomatis* in the mid-1980s included samples sent from primary care. These data provide an indication that early diagnosis and control may be achieved. These data may also demonstrate greater awareness of the risk of acute chlamydial infection in women compared with men outwith genitourinary medicine departments. However, it would be anticipated that a related increased incidence of tubal occlusion infertility and ectopic gestation might occur five to 10 years later.[3] Examination of the diagnosis at discharge from two adjacent south Yorkshire health districts showed the number of ectopic pregnancies in 1988–89 to be 81, in 1989–1990 to be 73 and in 1990–91 to be 102. Initial evidence does indeed suggest that a rise in ectopic pregnancy may be happening.

The relationship between minor smear abnormality and the presence of chlamydial disease is well recognized. Hicks and colleagues investigated women with inflammatory cervical cytology with detailed microbiology and found at least one sexually acquired infection in 74.9% of 215 patients.[4] This was in fact of greater statistical significance than in other women attending a department of genitourinary medicine where sexually transmitted disease was identified in 64.5% of patients.

It has been argued that genitourinary medicine populations may have epidemiological differences from other groups of young women seeking reproductive health care. This has not been our clinical experience. In 1982 Haworth and colleagues identified the possibility of diagnosing chlamydia within the general practice.[5]

Wilson and colleagues[6] assessed premenopausal women with inflammatory changes on cervical cytology for genital infections and cervical abnormalities and