This month • cervical cancer • otitis media • specialist training • alcohol and AIDS

Increasing risk of cervical cancer among younger women

THE Tayside region of Scotland introduced its highly regarded cervical screening programme in 1961. Dodgson and colleagues have reviewed the notes of 37 women aged less than 35 years who had a diagnosis of invasive cervical carcinoma between 1961 and 1987. The principal findings were that the younger patients now constitute a higher proportion of cervical cancer cases (5.7%) than in the earlier years when it was only 2.0%, and, as might be expected, 20 out of the 37 women had not had a cervical smear before presenting with post-coital or intermenstrual bleeding. More disturbingly, they found that for four out of five patients, previously reported 'normal' cervical smear results had been false negatives. This point is carefully discussed as the authors feel that their false negative rate is similar to that in other areas of the UK where quality control measures are used. They suggest that screening at three-yearly intervals instead of five-yearly would reduce the impact of this problem.

In the UK 90% of cervical cancer now presents in previously unscreened women. General practitioners should be moving ahead of the government in offering cervical smears to patients under 35 years of age as the incidence of the disease is rising in this group. If our local histopathology laboratories can take the strain we should also be reducing our screening interval from five to three years.

(F.S.)

Source: Dodgson J, Walker EM, Hussein KA, *et al.* The increasing problem in Tayside of cervical cancer in younger women. *Scott Med J* 1989; **34:** 403-405.

Epidemiology and management of otitis media

THERE have been a number of important studies of the epidemiology of acute otitis media which have led to a change in our understanding of this common condition as well as studies which have challenged the traditional management of acute otitis media in children. A review of this field in *Family Practice* is timely therefore.

Acute otitis media has a high recurrence rate and it is now known that recurrence is associated with a number of factors — the first attack in the first year of life; bilateral otitis media; and frequency of attacks. The incidence of acute otitis media is also associated with poor living conditions and attendance at day nursery. It appears from the work reviewed that while secretory otitis media is more prevalent in children who have had an episode of acute otitis media it is also associated with episodes of upper respiratory tract infection, rhinitis, and chronic but not acute tonsillitis. It is also clear that secretory otitis has a natural history of resolution within three months in 90% of cases. It appears likely that it is in the remaining 10% that the problems of persisting middle ear disease and learning difficulties occur. However, the authors urge caution in the interpretation of studies leading to this conclusion as there are methodological problems in the diagnosis of both secretory otitis media and of learning and speech difficulties, especially in younger children. The authors conclude that a causal relationship between otitis media and speech and learning difficulties remains unproven.

Four main areas of management are considered in the review. First, regarding antibiotics, the authors point out that studies have so far failed to prove conclusively that antibiotics are no better than symptomatic treatment though the benefit, if any, is small for the majority of cases. Secondly, in considering adenoidectomy, they refer to several other reviews which all indicate that the role of this procedure is likely to become more limited than it is now. Thirdly, they consider decongestants, which while used traditionally, have no proven value. Finally, they mention the place of health education in management though it is clear that further studies of this condition are needed before we can give clear health education messages.

This excellent review concludes with a list of practical guidelines for the management of acute otitis media and it is concluded that some cases of acute otitis media in children should be viewed as of greater significance than others. It is in 'otitis prone' children that we should use antibiotics selectively, carry out closer monitoring of hearing, and consider referral to ear, nose and throat surgeons.

(C.B.)

Source: De Melker RA, Burke PD. Epidemiology of otitis media and the role of the general practitioner in management. *Fam Pract* 1988; **5:** 307-313.

Specialist training in general practice

THE standard, and accepted, method of vocational training includes two years in suitable hospital posts and a year in a training practice. However, when added to six years at medical school, which is predominantly hospital based, and a year's pre-registration post, the imbalance in training for general practice is evident. In addition, there is little time for exposure to minor specialties such as ear, nose and throat and ophthalmology, and it is difficult for graduates to enter vocational training schemes later than after the intern year. Opportunities for the research-minded are limited by the present structure.

A pilot scheme in Sligo is attempting to address these issues and proposes an alternative model. The initial general professional training consists of 18 months at senior house officer level in approved hospital posts with regular day release for general practice topics. Candidates must show evidence of involvement and interest in general practice and when they feel that they are ready, they apply for the second phase, specialist training. A day-long interview assesses basic clinical competence and suitability. The specialist programme consists of two years attached primarily to a training practice, with sessional exposure to community care work and clinical areas where the trainee has perceived weaknesses. Ideally, at the end of the first year the candidate would sit the MICGP or MRCGP examination, and devote the second year to a PhD or MD project. Essential to this type of training is the philosophy of self-directed learning and continual trainee-centred assessment.

It is hoped that the Sligo experiment will be the first of many alternative models.

(C.D.)

Source: Money P. Specialist training in general practice: the Sligo experiment. *Forum (Journal of the Irish College of General Practitioners)* 1988; **4:** 158-161.

Alcohol and AIDS

GENERAL practitioners may feel unable to play a major part in the prevention of the acquired immune deficiency syndrome (AIDS) because their own embarrassment, prejudices and lack of knowledge about the homosexual

world (*J R Coll Gen Pract* 1988; **38:** 500-502) make it difficult for them to discuss sexual practices. In this paper an important risk factor in human immunodeficiency virus (HIV) infection is presented — alcohol. There are three main factors postulated: the immunosuppressive and behavioural effects of alcohol and its association with intravenous drug abuse.

In American studies of openly homosexual men 29% have been designated as having alcohol problems by the Michigan alcohol screening test. Although these figures are questionable, either because of self under-reporting or, over-reporting owing to the use of a population drawn from a club and pub social life, they are certainly disturbing.

The immunosuppressive effects of alcohol are well chronicled with both antibody and cell mediated immunity depressed, especially in the presence of liver disease (hepatitis B is also more common in this population). Lymphopenia of 1.5×10^9 cells per litre has been shown in 23% of people who have been recently intoxicated. The functional characteristics of the T-cells were also affected with a decreased rate of bacterial clearance by microphages.

Alcohol can destroy any thoughts of safe sex. People are less likely to use condoms when intoxicated and may go further in the sexual act than they might when sober. Early results from California suggest that homosexual men who have decreased their alcohol intake have also decreased or stopped anal intercourse. Since alcohol in pubs and discos is so much a part of the homosexual lifestyle then the commonsense conclusions drawn by this paper seem important. Those people most likely to be engaging in unsafe sex are most likely to be drinking excessive alcohol.

Many intravenous drug abusers also abuse alcohol in a package deal of substance abuse and HIV in drug abusers is emerging as one of the threats to the heterosexual population.

What does this mean to the general practitioner? General practitioners may find alcohol abuse an easier problem to broach than homosexual practices with the population most at risk, the heterosexual and homosexual men and women aged 16–35 years. A whole person approach to these people, looking at them physically, psychologically and socially, including both alcohol and risk behaviours, may break down the barriers between people at risk of HIV infection and their general practitioners.

(J.A.)

Source: Molgaard CA, Nakamura C, Hovell M, *et al.* Assessing alcoholism as a risk factor for acquired immunodeficiency syndrome (AIDS). *Soc Sci Med* 1988; **27:** 1147-1152.

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INFECTIOUS DISEASES UPDATE

Chemoprophylaxis against meningococcal infection

A working party has recently looked at the control of meningococcal disease.[1] The rationale for chemoprophylaxis is to try and eliminate carriage in household members and other close contacts thus reducing the likelihood of transmission of a strain which has shown itself to be virulent. It should be noted that the whole contact network should be treated simultaneously and this includes recent convalescent patients who may still be carriers. Rifampicin is the antibiotic of choice unless the responsible organism is known to be sensitive to sulphadiazine.

Chemoprophylaxis can also be used to treat asymptomatic infected individuals who may be about to get disseminated infection. This of course will only be effective while treatment is continuing. Penicillin is a more reliable drug than rifampicin in this case although rifampicin may have some effect. Protection is only afforded while treatment continues.

The third aim is to prevent susceptible contacts from becoming colonized with organisms. This can only be effective while prophylaxis continues.

Whenever chemoprophylaxis is used it is essential that it is given as soon as possible after the index case presents. The ideal target population is difficult to define. People who have been sleeping in the same household or dormitory as the case should be included but a few reports suggest extended family members, close neighbours, party guests or contacts in day care centres may also be at risk. The number of cases involved in an outbreak can also influence how widely prophylaxis is distributed. For example, in Scotland recently, a whole school with 600 pupils was given prophylaxis after six cases and one death had occurred over a short space of time. It is generally accepted that swabbing to identify carriers is of little value except to identify current local strains, and it may cause anxiety when the expected 5–10% or more of 'normal' carriers are identified and the exercise may delay instituting effective chemoprophylaxis.

Psittacosis

In some parts of the country there has recently been an increase in psittacosis which is a chlamydial infection commonly contracted from infected domestic pets. The contact history often leads to the diagnosis as when a recently purchased budgerigar dies with a diarrhoeal or coryzal illness. The presentation in humans is usually with pyrexia and little else in the way of other symptoms or signs. There may be a slight cough, usually unproductive, but rarely are there abnormalities on examination of the lungs. Radiography reveals consolidation commonly involving part of a lobe and perhaps with a circular rather than a lobar or lobular appearance. Oral erythromycin is effective treatment with tetracyclines as a second choice. Diagnosis is made serologically but it may be a week or two before the titres rise after the acute infection.

Glandular fever

Like many terms introduced before the responsible infecting agents were discovered this term sometimes serves only to confuse. The clinical syndrome of fever, generalized lymphadenopathy and perhaps hepatitis or splenomegaly can have a number of causes. Traditionally the three major infectious organisms to consider are Epstein-Barr virus, *Toxoplasma gondii* and cytomegalovirus. Serological diagnosis for toxoplasma and cytomegalovirus has long been available although its interpretation may need discussion with the reporting laboratory. It is not so widely known that reliable serology is available for Epstein-Barr virus infection and detecting immunoglobulin M antibody is now the diagnostic method of choice. The non-specific monospot or Paul Bunnel tests may be useful for preliminary screening but are becoming outdated.

Reference

1. Public Health Laboratory Service meningococcal infections working party, Communicable Diseases Surveillance Centre. The epidemiology and control of meningococcal disease. *Weekly Report* 24 February 1989/08.

Suggestions for topics to include in future updates are welcomed and should be passed to the contributor, Dr E. Walker, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB (041-946-7120), from whom further information about the current topics can be obtained.