tance of their children's symptoms.

R H JONES
S E LYDEARD

Primary Medical Care,
University of Southampton
Aldermoor Health Centre
Aldermoor Close, Southampton SO1 6ST

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The inflammatory cervical cancer

Sir,

The paper by Kelly and Black on the inflammatory cervical smear (June *Journal,* p.238) makes fascinating reading, since the investigation of these smears in the community always presents a problem.

It would have been interesting, however, to have had more details of their management of chlamydia infection. It is not clear if they treated only the infected women, or ensured that their partners (and all others in the chain of sexual contact) were also investigated and treated. Unless an infected woman is celibate at the time of the smear, she will have a partner from whom she caught the infection, or to whom she has passed it on. Unless he too is treated she will have been reinfected by the time of her repeat smear. Were follow-up chlamydia cultures performed?

Treatment with tetracycline in the absence of proof of infection must surely be open to question, if only because tetracycline is liable to provoke a further infection with candida, and cause more inflammation on the smear. If sexually transmitted cervicitis is suspected but not proven, it may be helpful to refer the couple to a department of genitourinary medicine, so that non-chlamydial non-specific urethritis can be detected by the presence of pus cells in the man's urethra and all contacts traced and treated as necessary.

As the human immunodeficiency virus epidemic spreads, our patients will become increasingly concerned that the presence of 'minor' sexually transmitted diseases may mean that they have also been exposed to far more dangerous pathogens. They will demand accurate diagnosis of infections, and blind treatment may obscure an extremely important medico-legal point.

LESLEY BACON

Department of Genitourinary Medicine
Homerton Hospital, Homerton Row
London E9 6SR

Sir,

Drs Kelly and Black (June *Journal,* p.238) are to be thanked for their study which complements larger community based studies carried out before[1] and after[2] theirs. I must, however, dissent strongly from their hesitancy about whether to treat a *Chlamydia trachomatis* infection, which they justify by citing 'the potential adverse effects of a lengthy course of tetracycline therapy'.

A week's course of tetracycline (preferably doxycycline), or of erythromycin if the patient may be pregnant, is sufficient to cure most chlamydial infections (Robinson AJ, manuscript in preparation), and has a low incidence of side-effects. The 'blind' use of metronidazole which they advocate is more likely to upset patients. The male partner(s) will also need to be treated, for their own benefit and to prevent reinfection of the female. The doctor who allows a proven chlamydial infection (probably asymptomatic) to persist in a female patient is laying her open to the risk of pelvic inflammatory disease and infertility, and laying himself open to a charge of negligence.

The authors are also uncommonly fortunate in having facilities for diagnosis of chlamydia, and for specimens to reach the laboratory within three hours. Most general practitioners with a patient in whom a sexually transmitted infection is suspected would do better to refer to a department of genitourinary medicine, which will offer their patient the advantages of immediate microscopy, comprehensive testing for possible pathogens, and discreet assistance in the tracing of contacts. I write as a general practitioner who is also a clinical assistant in genitourinary medicine.

W E GRIFFITHS

3 Ormond Road
Richmond, Surrey TW10 6TH

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Race, ethnicity and general practice

Sir,

The editorial 'Race, ethnicity and general practice by Ahmad and colleagues (June *Journal,* p.223) highlighted some important interactions between race and ethnicity and general practice. However, certain assertions were made which although they may be true in the narrow context of the United Kingdom are certainly not generally true.

The concept of race is described in negative terms but in other parts of the world, particularly in central Europe and Turkey, the perception of belonging to a particular race may be something that a person values. My experience is mainly in the context of Turkey where belonging to a certain race means that one has certain group and personal values, and that one conforms to certain cultural norms. This is a far more powerful perception than that defined by Ahmad and colleagues where race is referred to in terms of superiority and inferiority.

The problems of immigration in the UK are presented as relating to the fact that many of the immigrants in the post-war period came from ex-colonies and were therefore used to being of an inferior status to British people. This may be a contributory cause in the UK, but a very similar situation pertains in Saudi Arabia, where I and many of my colleagues have experienced blatant racial, financial and religious discrimination, and where neither side has had a colonial relationship with the other.

Discrimination in employment is also referred to in the editorial. It is true that many immigrants have come to the UK to do jobs that the native British population were unwilling to do. However, where there has been a shortage of skilled labour, immigrants have also filled jobs which are highly regarded by the native population, and where the income is significantly above the mean for the country, such as jobs in the nursing and medical profession. I would agree that within these professions there has been discrimination against immigrants, but in absolute terms people coming into these jobs are better off than many of the people of the native population.

Having lived in five countries and having experienced discrimination in at least two of these countries, I realize that in a rich, powerful community where there is work which the native population does not wish to do, workers are recruited from a less dominant poorer community and these people have a lower social, financial and cultural status. I would agree with the main thrust of the editorial that the care of these people anywhere in the world presents a challenge to the primary care