Physicians concerned about preventing the long-term sequelae of chlamydial infection in women (infertility, ectopic pregnancy, chronic pelvic pain) must welcome any expansion of screening into areas such as family planning clinics, termination clinics, well woman clinics and general practice. If chlamydial infection is diagnosed in these settings, however, we believe that referral to a department of genitourinary medicine should take place wherever possible. We recognize that a proportion of women will not accept referral, but control of chlamydial infection is more likely to be achieved by such a collaborative approach.

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Asthma care in general practice

Sir,

I read with interest the editorial by Kevin Jones (June *Journal,* p.224) on the British Thoracic Society's guidelines for the management of asthma in adults. I am concerned that it seems to have been written before the corrections were published.[1] I think Kevin Jones erred in suggesting that the role of oral theophylline be relegated to adjunctive therapy.

Much has been made of the relative merits of the various bronchodilator agents and the innumerable patentable devices in which they are presented. Discussion with colleagues confirms that there is widespread concern that recently the style of drug promotion has tended towards the needs of marketing rather than to the established practice of advertising sound information. The *Public eye* television programme (BBC 1991) found that prescribers had mistaken promotional material regarding salmeterol to mean that problematic evidence of a different anti-inflammatory action made it an important new advance. In fact the report concerned had concluded with the comment that further work would be required to determine whether any such effect existed.[2]

Drugs long out of patent, such as theophylline and ipratroprium, suffer from a sort of negative promotion in these circumstances. There is plenty of statistically validated evidence that theophylline is effective in chronic as well as acute asthma,[3] and the British Thoracic Society guidelines give recommendations of the quantities of the drug which are likely to prove safe and effective when given daily as two doses of a slow release oral preparation.

The problem is that asthma care does not seem to be improving. For 20 years or more this has been blamed on the general level of ignorance in the profession. The guidelines are a further effort to reduce this. But they make no difference, because young asthmatics still die in the hands of the most experienced experts. We need to use every treatment available, singly or in combination as needs dictate, and give up our pursuit of the simplistic idea that one drug should be enough. It is clear that the worse the asthma, the more general practitioners have to prescribe combinations of treatments.[4] At least we have stopped advising our patients to go away and live in a warmer climate, or in the mountains, as our predecessors did for patients with intractable respiratory problems.

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Curettage and cautery of skin conditions in general practice

Sir,

Dr Sundle's letter on curettage and cautery (August *Journal,* p.345), in response to my letter on the treatment of skin cancer in general practice (May *Journal,* p.213), was most useful.

Curettage and cautery are simple and inexpensive to undertake. While I agree with Dr Sundle that the procedure is very useful for the treatment of some benign and some potentially malignant skin lesions, it should be used selectively for the treatment of basal cell carcinoma. Dr Sundle alluded to this but perhaps further clarification would be helpful.

Curettage biopsy is useful if one wants to differentiate between an area of solar keratosis and a superficial basal cell carcinoma, or for confirming an area of Bowen's disease. The subsequent cautery is usually curative in treating all of these lesions. Experience and research have shown that the technique can also be used effectively for the treatment of well-defined basal cell carcinomas of up to 13 mm in diameter.[1] The curettage and cautery must be thorough and repeated at least once. The Volkmann spoon must have a good cutting edge — this is not always the case in my experience of hospital outpatient clinics. Satisfactory histopathology allows precise knowledge of the cell type, and one can decide whether the original curettage and cautery have been adequate, or whether further treatment, possibly using a different method, is required.

Curettage and cautery are not suitable methods for the treatment of invasive, morphoeic, sclerosing, ill-defined or larger basal cell carcinomas. When treating non-melanoma skin cancers, the best cure rates are achieved by ensuring a minimum tumour-free margin of 4 mm when employing excisional surgery[2] and a 5 mm tumour-free freeze margin when using liquid nitrogen cryosurgery.[3] It would be very interesting to know the recurrence rates in Dr Sundle's series when using curettage and cautery for the treatment of basal cell carcinoma.

Squamous cell carcinoma, which is potentially a much more invasive skin cancer, should not be treated with curettage and cautery by the inexperienced practitioner. The procedure may be useful in obtaining biopsy material in an unconfirmed squamous cell cancer, but only with a view to either complete excision or thorough cryosurgery. However, most histopathologists, in my experience, would prefer an incisional, full-thickness edge biopsy.

In summary, one has to be selective when treating non-melanoma skin cancers by curettage and cautery. While the procedure is simple and convenient to carry out in general practice, I feel that it should be regarded as complementary to surgical excision and cryosurgery if the patient is to receive the most effective treatment.

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