most women presenting for termination of pregnancy had heard of the 'morning after pill', they lacked information regarding its use and how to obtain it.[3]

The 12 trainees asked the first 12 women aged 16–19 years who presented to each practice for whatever reason (except a request for termination of pregnancy) to complete a questionnaire. A total of 138 women were asked to take part in the study and only one refused. The patients could complete the questionnaire in the trainee's presence or alone in a separate room. They returned the questionnaire to the receptionist in a sealed envelope. Data were therefore gathered from 137 women (mean age 18 years) and revealed serious deficiencies in their knowledge of postcoital contraception. Twenty five per cent of the women reported having no formal contraceptive advice, 92% had heard of the 'morning after pill', 42% did not know a prescription was necessary to obtain it, 86% did not know if it was an effective method, and of most concern, only 16% knew the postcoital pill could be used up to 72 hours after unprotected intercourse. Thirty three per cent of the women were not happy with their knowledge of contraception but a total of 68 women replied when asked about their preferred sources of information about contraception (Table 1). The highest proportion of women chose leaflets as a source of information.

Table 1. Sources of information about contraception chosen by the women.

Source of information	% of women choosing source[a] ($n = 68$)
Leaflets	68
General practice surgery	26
Practice nurse	21
Magazines	21
School nurse	13
School teacher	10
Parent	9
Other	4

[a]Women could choose more than one source of information.

These findings support the distribution of leaflets at school and in general practice to reinforce sexual health education received at school. Leaflets would provide a private source of information that can be kept for later reference. These results give cause for considerable concern and support the recommendations of the working party of the Royal College of Obstetricians and Gynaecologists on unwanted pregnancy.[4] Greater education about emergency contraception should be introduced and the results of this education audited to reduce unwanted pregnancy in this vulnerable group. Although undesirable as a regular method of contraception, as an emergency measure the postcoital pill is preferable to abortion and consultations for emergency contraception can be used to channel teenagers to appropriate contraceptive and sexual health counselling.

SWANSEA VOCATIONAL TRAINING SCHEME

Princess Street Surgery
Princess Street
Gorseinon
Swansea SA4 2US

References

1. Reader FC. Emergency contraception: a few days rather than a few hours to act [editorial]. *BMJ* 1991; **302:** 801.
2. Friedman EHI, Rowley DEM. Post-coital contraception — a two year evaluation of service. *Br J Fam Plann* 1987; **13:** 139-144.
3. Burton R, Savage W, Reader F. The 'morning after pill' is the wrong name for it: women's knowledge of post-coital contraception in Tower Hamlets. *Br J Fam Plann* 1990; **15:** 119-121.
4. Working party of the Royal College of Obstetricians and Gynaecologists. *Report on unplanned pregnancy.* London: RCOG, 1991.

Mood variability in asthmatic patients: a case report

Sir,

Although substantial emotional upset can reduce peak expiratory flow rate and thus precipitate an asthma attack, it has been suggested that day to day variation in mood is more likely to be caused by variation in peak flow rate rather than mood affecting peak flow rate.[1,2] In particular it has been suggested that poorly controlled asthma is associated with a correlation between mood and peak flow rate. If variations in peak flow rate do in fact cause changes in mood, these changes may be detected by friends and relatives, and thus, poorly controlled asthma could have emotional consequences not only for the patient but also for the patient's family.

Mrs B was a 40 year old asthmatic patient living in a rural area. She had had asthma since she was 11 years old. Mr B reported that Mrs B's behaviour had become more outgoing since she had been prescribed inhaled beclomethasone dipropionate, and he was concerned that the drug had altered her personality. We explained the alternative hypothesis that her change in disposition may have been because the drug had improved her peak flow rate, and we carried out a diary study using husband and wife. Mr B kept a daily diary rating overall how outgoing Mrs B was on a seven point scale from one (not outgoing) through to seven (outgoing). Mrs B recorded her peak flow rate in the morning and evening and her use of beclomethasone dipropionate. Mr and Mrs B kept their diaries independently and without cross reference for 29 days.

Mr B used only three of the rating levels on the seven point scale — three (on four days), four (on 20 days) and five (on five days). Mrs B's mean morning peak flow rate when she was rated as three was 240 l min^{-1}, 329 l min^{-1} when she was rated as four and 422 l min^{-1} when she was rated as five. Using analysis of variance, these data are significant at $P<0.001$, showing that Mr B rated Mrs B as more outgoing on days when she had a higher peak flow rate.

Mrs B's peak flow rate was quite variable, and this variability may be due, in part, to undermedication as she reported that she failed to take beclomethasone diproprionate on occasions when she fell asleep in the early evening. Inspection of the data shows that three consecutive ratings of three by Mr B coincide with a period of lower peak flow rate and follow a period of lower use of beclomethasone dipropionate. Mrs B would have benefited from instructions from her general practitioner about what she should do if she forgot to take her inhaler. This study shows that there is merit in devising patient management strategies which deal with possible patient error.

MICHAEL E HYLAND
C A PAUL KENYON

Department of Psychology
University of Plymouth
Plymouth PL4 8AA

References

1. Hyland ME. The mood-peak flow relationship in adult asthmatics: a pilot study of individual differences and direction of causality. *Br J Med Psychol* 1990; **63:** 379-384.
2. Brown S, Hyland ME. Mood and peak flow in asthma. *Lancet* 1992; **339:** 118-119.

Rare case of autoinoculation of orf

Sir,

A 16 year old farmer's daughter presented to her general practitioner with a four day history of painful blisters on the index and ring fingers of her right hand; the lesions had the characteristic appearance and distribution of orf nodules. She had recently been handling and feeding young lambs. Twenty days later she presented again with a two day history of a painful vaginal swelling. There was no history of trauma or new sexual contact or other urogenital symptoms. Examination revealed a small tender swelling in the region

of the urethral meatus, together with marked vulval oedema and a white vaginal discharge. Twenty four hours later the swelling had increased in size to approximately 2 × 2 × 1 cm and was extremely tender. The swelling was thought to be a periurethral abscess and she was admitted to hospital. Under anaesthetic the lesion was incised, but only a small amount of fluid was obtained. Bacterial and fungal cultures were negative. A small biopsy was taken, with the clinical summary of 'periurethral abscess'; microscopy showed a mild acute inflammatory infiltrate of neutrophils in the epithelium and underlying tissue, and was at this stage considered non-specific.

The diagnosis remained uncertain, and the lesion resolved over the next two days without further treatment. Following a practice meeting, the suspicion that this might be a case of orf was discussed with a histopathologist, and the biopsy material was reviewed. The sections showed ballooning and reticular degeneration of the superficial epithelium; some cells were vacuolated and few eosinophilic inclusion bodies were seen. Tissue was recovered from the paraffin block and processed for electron microscopy. Some particulate matter was seen, but the preservation was too poor to allow their definite identification as orf particles. Although the histopathological findings were consistent, and even strongly suggestive of orf, they were not definite enough to allow final confirmation. Nevertheless, these findings were analogous with those of orf in skin biopsies, and are therefore consistent with the clinical diagnosis of the same infection in the urethra.

Human infection was first reported in 1879,[1] and virological studies have confirmed the transmission of the disease from sheep to man.[2] The pox virus responsible for the infection is resistant to drying and freezing, and can remain viable for long periods on objects with which the infected animal has been in contact. This explains the reported cases of viral inoculation from inanimate objects such as farm buildings, wool and pastures.[3]

Infection from human to human is rare, and only three cases have been described — a nurse who had changed the dressings of a patient with orf,[4] the child of an infected mother,[5] and a farmer's wife who developed a lesion on her cheek.[6]

A literature review revealed only one report of autoinoculation with the orf virus: this was in a seven year old American girl who had perianal orf, and was later found to have a resolving digital lesion.[7] The case reported here is similar, but is the first description of orf infection in the urogenital tract, and is the first British report of autoinoculation of the orf virus.

J W Stead
C M T Henry

Wyndham House Surgery
Silverton
Devon EX5 4HZ

R H W Simpson

Postgraduate Medical School
University of Exeter
Barrack Road
Exeter
Devon EX2 5DW

References

1. Hansen G. Om enegen Sygdom (Kopper) hos Geden i Norge. *Tidsskr Ret* 1879; **9**: 298.
2. Lloyd GM, McDonald A, Glover RE. Human infection with the virus of contagious pustular dermatitis. *Lancet* 1951; **1**: 720.
3. Rees J, Marks JM. Two unusual cases of orf following trauma to the scalp. *Br J Dermatol* 1986; **118**: 445-447.
4. Westphal HO. Human to human transmission of orf. *Cutis* 1973; **11**: 202.
5. Kennedy CT, Lyell A. Perianal orf. *J Am Acad Dermatol* 1984; **11**: 72-74.
6. Stewart AC. Epidemiology of orf. *N Z Med J* 1983; **96**: 100-101.
7. Kennedy CT, Lyell A. Perianal orf. *J Am Acad Dermatol* 1984; **11**: 72-74.

Primary ciliary dyskinesia

Sir,

I am sure that many general practitioners are unfamiliar with the condition primary ciliary dyskinesia (also known as immotile-cilia syndrome)[1] as indeed I was myself until recently. As a cause of 'chestiness' in children, its diagnosis has therapeutic consequences and we should, therefore, be aware of its existence when a child presents with a recurrent, productive cough.

In primary ciliary dyskinesia the cilia of the respiratory tract move poorly or not at all, leading to accumulation of mucus which readily becomes infected. Unless prompt action is taken in the form of physiotherapy with postural drainage and treatment with bronchodilators and antibiotics, the child may enter adulthood with bronchiectasis. The effects of the poor mucociliary clearance thus resemble those of cystic fibrosis. In addition, there may be deafness and, in males, infertility (because the forward motility of the spermatozoa is impaired).

The incidence of the condition is thought to be about one in 20 000,[1] so that there may be approximately 3000 cases of primary ciliary dyskinesia in the United Kingdom. Only 37 cases are known (Polak C, personal communication), and the explanation for this discrepancy is probably that clinicians do not think of the condition. They do not, therefore, arrange the diagnostic test, which is electron microscopy of a nasal brush biopsy.

General practitioners should know that there is a primary ciliary dyskinesia family support group which is a source of information about research into, and the management of, this potentially disabling condition.

John Rawlinson

Hunters Way
Kimbolton
Huntingdon
Cambridgeshire PE18 0JF

Reference

1. Polmblad J, Mossberg B, Afzelius BA. Ultrastructural, cellular and clinical features of the immotile-cilia syndrome. *Annu Rev Med* 1984; **35**: 481-492.

Useful address

Mrs C Polak, PCD Family Support Group, 42 Burstow Road, Wimbledon, London SW20 8SX.

Journal publication times

Sir,

While it would be inaccurate to describe myself as an avid reader of the *Journal*, it is nevertheless true that I look at it at regular intervals. I always feel inferior when reading the correspondence columns since I can never remember the article to which the letter relates. It then occurred to me that this was because it took so long for letters to be published that any correspondence was outdated before a discussion could be generated.

Being of an enquiring mind, and well versed in audit I undertook a survey of the June 1991 and June 1992 issues of the *Journal* to examine publication times (Table 1). For the June 1991 issue, seven papers were published; the mean submission date was July 1990 and the mean acceptance date was November 1990. For the June 1992 issue, seven papers were published; the mean submission date was May 1991 and the mean acceptance date was October 1991. Thus, articles in the *Journal* reflect the state of general practice research some 13 months earlier, even if it is accepted that the research itself needed to be carried out and the paper written.

Regarding letters to the editor, 15 letters were published in June 1991; 11 were in reference to articles previously published in the *Journal*. Eight referred to articles published three months earlier, and one each to articles published four and five months earlier. One letter referred to papers published in both the February and March issues of the *Journal*. Nine letters were published in June 1992; two referred