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.

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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.

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Reference

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Useful address

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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

Table 1. Times between publication and submission and acceptance of papers[a] for the June 1991 and June 1992 issues of the *Journal*.

Paper	Times for June 1991 issue (months)		Times for June 1992 issue (months)	
	Between submission and publication	Between acceptance and publication	Between submission and publication	Between acceptance and publication
a	9	6	12	7
b	12	6	10	7
c	8	6	14	8
d	11	7	11	9
e	13	7	12	8
f	10	7	15	11
g	11	7	17	9
Mean	11	7	13	8

[a]Original papers, review articles and discussion papers.

to articles previously published in the *Journal* that had appeared in February 1992 (four months earlier).

Using *Statview* with the *Macintosh SE*, contingency tables were calculated to assess the significance of changes over the year. There was no significant difference between submission dates for the June 1991 and June 1992 issues of the *Journal*. The difference for dates of acceptance was also not significant. However, a significant difference was found in the number of letters published in the June 1991 and June 1992 issues that referred to previous articles (chi square = 27; 1 degree of freedom, $P<0.001$).

It would appear that the number of letters published referring to previous articles is significantly different to a year ago. It is not clear if this is editorial policy, or a feature of less doctors writing in to the *Journal*, but one possibility is that general practitioners see little point in writing to the *Journal* if their letter is going to be published so long after the article to which their letter applies. Although not a significant difference, it would seem that it is taking longer for papers to be published than it did 12 months ago. This means that the *Journal* is no longer able to provide the 'cutting edge' of general practice, but reflects what was happening some 12 to 15 months ago. Over the last 15 months enormous changes have taken place in general practice, which the *Journal* is unable to reflect in up to date research papers.

In the spirit of audit the following suggestions are made: the editor sets out standards for the time from submission to acceptance and publication for papers and letters; the editor publishes, at regular intervals, how successful the *Journal* has been in keeping to the standards; and the standards are regularly reviewed and new standards published.

Audit is, and should be, a routine part of modern general practice; it behoves the *Journal* to lead from the front by its own example of standard setting.

Finally, judging from the correspondence in the June 1992 *Journal*, I would hope to see this letter published in the October or November edition.

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Editor's reply

We are always pleased to have constructive criticism from readers, especially when it is based on the collection and thoughtful analysis of data and is accompanied by positive suggestions for change. Of course, we wish to remain part of the movement for regular audit and quality assessment which is becoming a routine part of modern general practice. You deal with several important points in your letter and I would like to reply to them in turn.

Delay between submission, acceptance and publication has always been of concern to the *Journal* team, and for this reason, data have been compiled on original papers since January 1984. Monitoring of papers through the system is a continuous process and any problems arising are discussed at the monthly *Journal* meetings.

Submitted papers are sent to two expert reviewers and to a statistician if appropriate. This peer review process takes time but is fundamental to maintaining the scientific quality and international reputation of the *Journal*. The detailed and thoughtful reports from our 900 reviewers are central to a decision to publish. Whether or not the paper is accepted, these reports are sent to authors who find this a valuable service. Most published papers are revised by the author before publication, this process adding some months to the delay before final acceptance. However, with the cooperation of reviewers, the time from submission to Editor's final decision for accepted papers has been cut from 21 weeks in 1990 to 16 weeks in 1991. The time taken from submission to Editor's decision for rejected papers was eight weeks in 1991. Since the end of April 1992, it has been *Journal* policy to send all papers which have received at least one set of encouraging comments from assessors to the *Journal's* statistical adviser. He then decides if the paper requires full statistical assessment, and chooses an appropriate referee to do so. This new procedure is likely to increase the delay between submission and Editor's final decision but the statistical input will enhance the scientific rigour of papers.

The delay between acceptance and publication remains much longer than we would like, so four extra pages are currently being added to the *Journal* to help clear the backlog of papers.

Letters to the Editor are selected and usually processed within the month of receipt. The content of our correspondence columns depends at least as much on which subjects interest readers and when they decide to take pen to paper as it does on editorial policy. Letters containing data are listed by *Index Medicus*. During the sub-editing process many letters are found to contain ambiguities, insufficient data or incomplete references, and proofs have to be reviewed by authors before publication.

Peer review, careful revision and sub-editing are essential to produce a journal of high quality as expected by members and subscribers in 40 countries of the world. Time and care are taken by the *Journal* team but, to be fair, some authors take much longer than others to revise and respond.

The *Journal* aims to serve the needs of thinking general practitioners, researchers and academic departments. While we strive to minimize delay, the *Journal* is not designed to respond as a medical newspaper might, but as a journal recording advances in the discipline and adding the results of sound research to the knowledge base of medicine. Journals do not decide what research is to be done or when. Some scientific journals have found that hasty publication has led to quick retraction and that the cutting edge of medicine can be uncomfortable for the ill prepared. Most new ideas need time to incubate and all need to be evaluated by others before their place is secure.