Table 1. *Chlamydia trachomatis* isolation over the period 1984–91.

	No. of cases of *C trachomatis* infection[a]			
	Isolated in GU department		Isolated elsewhere[b]	
	Male patients[c]	Female patients[d]	Male patients	Female patients
1984	175	199	0	25
1985	275	225	0	62
1986	302	220	2	120
1987	192	153	2	84
1988	153	146	2	99
1989	164	128	1	123
1990	126	163	2	141
1991	113	120	0	100

Source: Virology Department, Doncaster Royal Infirmary and Montagu Hospital NHS Trust. GU = genitourinary. [a]Proven by McCoy cell culture. [b]Hospital departments other than genitourinary medicine, including swabs taken by general practitioners. [c]Auterior urethra. [d]Cervix.

reported that 'inflammatory changes on cytology are often associated with the presence of a sexually acquired infection and premalignant disease of the cervix, particularly in younger, single women using non-barrier contraception'. This highlights the need to consider infectious diseases as well as pre-malignant disease in younger women with inflammatory cervical cytology. Wilson and colleagues conclude that inflammatory cervical cytology was often associated with cervicitis, which in turn was often indicative of a sexually transmitted disease, and that there was an interrelationship between risk of cervical intraepithelial neoplasia and risk of genitourinary infection. The management of both borderline and inflammatory smears therefore has to include the sexual history, where achieveable, and detailed microbiology. Where appropriate it should involve both the patient and her partner.

Chlamydial cervicitis is associated with sub-acute and chronic infection, with tubal occlusive infertility and with chronic pelvic pain. Much of this may lead to high cost surgical intervention with potentially severe psychological sequelae to both the patient and her partner. It seems a compelling preventive opportunity, at a time when sexual health is targeted[7] to utilize the association between minor cervical smear abnormality and the prevention of upper genital tract damage in women. This has to be based on accurate microbiological investigation and we would therefore urge that general practitioners either consider referral to genitourinary medicine departments, or that the general practitioner recognizes that the use of a high vaginal swab may be a dangerously misleading and incomplete investigation. Careful endocervical sampling with widely available chlamydia diagnostic technology should be considered essential.

Wilkinson, referring to cervical cancer, asked if the disease was different in younger women. Perhaps we should be asking if the management of a mildly abnormal smear in a younger woman should be different. In terms of risk of sexually transmitted disease, protection of future reproductive function, the avoidance of subsequent ectopic gestation and prevention of chronic pelvic pain, abnormal cervical cytology in a young, sexually active woman should be recognized as an opportunity to save the reproductive future for the individual woman and an opportunity to contain a high prevalence, dangerous endemic disease within human populations.

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Value of paediatric surveillance

Sir,

Demonstrable proficiency in paediatric surveillance has been made a requirement for the membership examination of the Royal College of General Practitioners. I would question whether the RCGP's enthusiasm for paediatric surveillance is justified.

I have long been sceptical of the value of paediatric surveillance, and have searched in vain for publications which have shown measurable benefits. I have talked to colleagues who are enthusiastic about the subject, but while describing subjective benefits such as an improved doctor–patient relationship, they are unable to give objective evidence of benefits.

It is interesting that the old term 'screening' has had to be dropped because so few of the procedures employed in paediatric surveillance fulfilled the criteria for screening.

There is no doubt that a small number of conditions are worth screening for, including congenital dislocation of the hip, heart murmur, undescended testis, and hearing and vision problems. Most of these can be carried out in a single postnatal assessment, with the hearing and vision assessments being done by a health visitor when the child is the appropriate age. This would all take considerably less time than a formal surveillance programme.

Even if we accept that paediatric surveillance is desirable for whatever reason, is it necessary that it should be performed by doctors? As the assessments are all straightforward and clearly written down in the various manuals they could be performed by a practice nurse or health visitor.[1,2]

If the quality of general practice is to be improved care must be taken not to sacrifice valuable consulting time in order to perform clinics of dubious value.

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