

Rubella antibody screening <i>K A Redhead, et al</i>	435	24-hour cover <i>Ian F M Saint-Yves</i>	437
Psychological consequences of hypercholesterolaemia <i>J Barlow</i>	435	Voluntary Service Overseas <i>Stephen Lonsdale; David Green</i>	437
Thyroxine prescription <i>Alan Jones</i>	436	Vestibular neuronitis <i>Robert Reid</i>	438
Formative and summative assessment <i>Lorna Tapper-Jones, et al</i>	437	History of general practice <i>Denis Pereira Gray</i>	438

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Rubella antibody screening

Sir,

There was an increase in the number of clinical and laboratory reports of rubella during the first few weeks of 1993.¹ This confirms the prediction that despite mass immunization periodic resurgences of rubella are to be expected, until disease elimination is achieved.²

What is the most appropriate policy for rubella antibody screening in general practice? In the United Kingdom pregnant women are repetitively screened for rubella antibody in every pregnancy. Ideally, however, every patient should be immune before embarking on a pregnancy. In its book *Immunization against infectious disease* the Department of Health states 'General practitioners are uniquely placed to ensure that all women of childbearing age have been screened for rubella antibody and immunized where necessary.'³ In the United States of America, the Immunization Practices Advisory Committee recommends that a documented history of rubella vaccination can be considered presumptive evidence of immunity.⁴

A study was performed to determine the prevalence of seronegativity by reviewing existing records and testing patients who did not have recorded serology results. Two groups of women were chosen from two King's Lynn practices (combined list size 23 800). The names of all those who reached the ages of 17 years and 25 years between January and December 1991 were obtained from the age-sex registers. Women who did not have serological proof of immunity were invited to attend for screening for rubella antibody. Notes were also tagged so that screening could take place opportunistically.

At the beginning of the study there were a total of 142 17-year-olds in the practices, five of whom had serological proof of immunity. Of the 164 25-year-olds 113 had serological proof of immunity. Thus, 137 women aged 17 years and 51 women aged 25 years were invited to attend for screening. After 10 months, 108 17-year-olds and 25 25-year-olds had attended for screening and their serum tested for immunity at the local hospital.

In the 17 years age group attendance was higher among those who had been vaccinated according to their medical records (94/115, 82%) than among those who had not (14/22, 64%). All 108 women were seropositive. In the 25 years age group, 10 out of 25 attended (40%) among those who had been vaccinated and 15 out of 26 (58%) among those who had not. Two of the 15 patients who had not been vaccinated were found to be seronegative and were subsequently vaccinated. The remaining patients were seropositive.

The results suggest that it is worthwhile screening patients who do not have evidence of serology or documentation of previous vaccination. The study would have been strengthened scientifically if there had been better attendance among those patients who had been vaccinated. It is possible that there were more susceptible patients in the remainder. This is unlikely, however, because it is estimated that there is a true vaccine failure rate of less than 2% if the vaccine is administered correctly (Morgan-Capner P, personal communication). Immunity should last up to 40 years.⁵

As a result of the study the practices have adopted the same pragmatic approach as in the USA. Patients who do not have a documented history of vaccination are given the choice of a serological test or vaccination with counselling that they must not become pregnant for one month after vaccination. All pregnant women should be tested for recent infection if they present with a rash or report contact with someone with a rash, because of the possibility of maternal reinfection.^{6,7}

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Psychological consequences of hypercholesterolaemia

Sir,

Between 1988 and 1989 the number of blood samples analysed for cholesterol level in the National Health Service laboratories in England and Wales increased by 30%,¹ and tests are now being carried out in a variety of settings, including the workplace. A pilot study was carried out between April 1989 and March 1990 to examine the psychological effects of a diagnosis of a raised cholesterol level.

Ninety patients were recruited from a hospital outpatient lipid clinic, a general practice and two occupational health departments. The group comprised 51 men and 39 women, 45 of whom had been diagnosed as having familial hypercholesterolaemia, and 45 of whom had a serum cholesterol level above 7.5 mmol l⁻¹. Interviews and questionnaires were used to collect the data and the main outcome measures assessed mood, anxiety and self-reported health.

Informing patients about a raised cholesterol level was associated with sleeplessness, worry, depression, feelings of a loss of control over health and an increased dependence on doctors (Table 1). Overall, significantly higher percentages ($P < 0.001$) on the main outcome measures were found among patients with familial hypercholesterolaemia than among the screened group, and the higher incidence of coronary heart disease among this group (23 patients, 51%) compared with the screened group (19 patients, 42%) may partly account for this.

Twenty one familial patients (48%) and eight screened patients (18%) were still