advise a mother who has a baby aged two months and wishes to discuss pertussis immunization if both she and her daughter aged five years suffer from idiopathic epilepsy?

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Reference

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Urinary tract infection in children

Sir,

In their letter, Kinmonth and Smellie state that further studies are required to determine the proportion of children with urinary tract infection at risk of renal damage (April *Journal*, p.219). I recently reviewed all cases of bacteriologically proven urinary tract infection in children aged under seven years on my personal list of approximately 2500 patients, occurring between 1989 and 1994. There were 16 cases (12 females and four males), with ages ranging from four weeks to six years. All were investigated by urinary tract imaging through direct access to the Imaging Department of the Luton and Dunstable Hospital. Abnormalities were found in 50% of the children (six females and two males). Vesico-ureteric reflux was found in two (12.5%), ureteric and/or pelvicalyceal dilatation in four (25%) and scarring in six (37.5%). All were managed conservatively, and in none was paediatric referral considered necessary. Management included prophylaxis with antibiotics (the duration of which depended on the nature of the abnormality), regular culture of the urine, and repeat imaging as appropriate to detect renal growth, new scars, and the persistence of cessation of reflux. The aim of management is to prevent avoidable renal damage and renal failure.

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Complementary medicine — a definition

Sir,

Medical professionals seem to talk more and more about complementary medicine these days, for example as in Paterson and Peacock's recent paper (May *Journal*, p.255), but what is really meant by the term? The abundance of publications on the subject sharply contrasts with the lack of a valid definition; this would account for the excessively large number of therapies (more than 100) falling under the umbrella term and for the fact that complementary medicine is more than just treatment. Exclusive negative definitions are prevalent, for example 'diagnosis, therapy and preventive procedures excluded from mainstream medicine'[1] or 'a system of health care which lies for the most part outside the mainstream of conventional medicine'.[2] However, an inclusive, positive approach, not defining what complementary medicine does not represent but what it actually means, would clearly be more constructive.

During a series of six staff meetings we (seven complementary health care professionals with medical and non-medical backgrounds) have attempted to define complementary medicine in this way. There were long, sometimes fascinating, discussions in which the four non-medical professionals (a herbalist, an acupuncturist, a chemist and a clinical psychologist) often deviated from the views of the medical professionals.

In spite of these difficulties, a consensus definition was finally found: complementary medicine is diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual frameworks of medicine.

We hope that this presents a step forward and will gradually phase out nonsensical definitions of complementary medicine[3,4] that so often obstruct our thinking.

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References

1. Ernst E. Complementary medicine — scrutinizing the alternatives [editorial]. *Lancet* 1993; **341:** 1626.
2. Downer SM, Cody MM, McCluskey P, *et al.* Pursuit and practice of complementary therapies by cancer patients receiving conventional treatment. *BMJ* 1994; **309:** 86-91.
3. Gravett P. *Making sense of alternative medicine.* Edinburgh: Chambers Harrap, 1994.
4. Stanway A. *Complementary medicine.* London: Penguin, 1994.

Teenage sexual health

Sir,

In defence of their belief that contraception provision and sex education at school do not increase teenage sexual activity, Jacobson and Wilkinson state 'there are several studies and reviews... which strongly suggest that no such increase occurs' (letter, May *Journal*, p.271). However, they cite only one such actual study,[1] from 1985, and fail to mention that it was commissioned by the Alan Guttmacher Institute, a wing of the International Planned Parenthood Federation which is heavily involved financially in the marketing and provision of contraceptives.

A recent review indicates that simply making contraceptives more readily available is associated with an increase in sexual activity in those aged under 16 years, and that sensitive abstinence education programmes are associated with a decrease in sexual activity.[2]

Jacobson and Wilkinson also refer to a conference which reported Dutch teenage pregnancy rates seven times lower than in the United Kingdom for all teenagers and 11 times lower for those aged under 16 years.[3] Their claim that these rates can only be attributable to 'successful contraception provision and sex education' is untenable. If that is so, why are the differential rates better for younger teenagers? Are we to believe that a 13-year-old is more proficient than an 18-year-old at putting on a condom or remembering to take a pill? I also attended the conference at which these data were presented, and the speaker pointed out that the greater differential rates for younger teenagers necessitated an explanation other than just contraception and sex education provision.

Finally, Jacobson and Wilkinson imply that those who disagree with their view automatically tend to be judgemental with sexually active teenagers. Well they may