diagnosis, as it represents the end stage of several skin diseases, including, rarely, cicatricial pemphigoid and lichen planus as well as lichen sclerosus.

Similar confusion has arisen in females whereby lichen sclerosus has been described by various now obsolete terms such as leucoplakia and kraurosis vulvae. The recognition of lichen sclerosus as a clear entity is a prerequisite for good management and follow up. Unfortunately, these aspects are relatively neglected in males, particularly boys,[3] as few surgeons seem to send the ablated foreskin for histological examination. Genital dermatoses are seen by specialists from disciplines other than dermatology, and the evolution of multidisciplinary teams running combined clinics for vulval diseases has led to improved diagnoses and management of patients with these problems. Perhaps similar clinics should be organised for penile problems.

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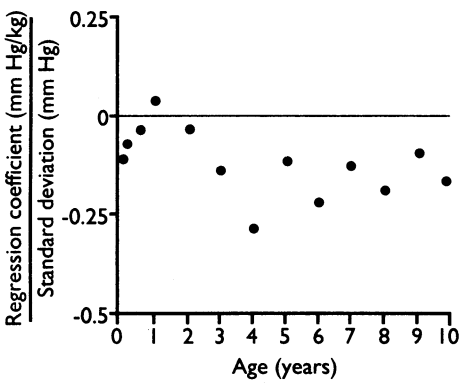
Initiation of hypertension in utero

EDITOR,—C M Law and colleagues, in their interesting paper on the initiation of hypertension, suggest that the relation between birth weight and blood pressure is amplified through life.[1] Although this assertion may be correct, the evidence that they present requires cautious interpretation. The four study populations reported on differ in their dates of birth as well as in their ages, with the oldest study populations being born earliest. Separating the effect of age from the effect of time of birth on the strength of the relation between birth weight and blood pressure is thus difficult.

To show conclusively that the association between birth weight and blood pressure is amplified with age, longitudinal study of individuals is needed. Only one of the four groups studied by Law and colleagues, the Farnborough (Brompton study) children, was followed over time. However, the regression coefficients relating birth weight and systolic pressure in those children, once adjusted for variation in the standard deviation of systolic pressure at different ages, do not become consistently stronger with age (figure). Moreover, within the Brompton study data, it is particularly difficult to interpret the regression coefficients (which are adjusted for concurrent weight throughout) in the youngest age groups. The relation between birth weight and blood pressure in the youngest age groups are thus being adjusted for measurements of weight only days or months after birth. Is it plausible that birth weight and weight four days after birth can be used to distinguish the effects of fetal and postnatal growth on blood pressure? The limited value of such an analysis is illustrated by the large standard error in the birth weight-blood pressure regression coefficient at 4 days, which reflects the high correlation of the two weight measures.



Regression coefficients relating birth weight and systolic pressure (mm Hg/kg) between 4 days and 10 years, divided by standard deviation of systolic pressure (mm Hg) at each age (the Brompton study)

We have recently produced direct evidence supporting the possibility of amplification of the birth weight-blood pressure relation in childhood. In a cohort of 540 children, the association between birth weight and blood pressure increased in strength almost twofold between 5-7 years and 9-11 years.[2] The absence of any relation between birth weight and change in blood pressure percentile rank between 5-7 and 9-11 years suggested that the relation between birth weight and blood pressure is established by 5-7 years and that the subsequent increase in the strength of the association is due to blood pressure tracking and to the increasing dispersion of the blood pressure distribution with age.[2]

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Primary prevention of neural tube defects with folic acid

EDITOR,—At Christmas we all received the HMSO circular dated 17 December from Dr Calnan and his colleagues at the Department of Health. We are exhorted to get all women planning a pregnancy to consume a supplement of 400 μg folic acid or folate daily and to continue through the first trimester. Unless you are addicted to Brussels sprouts and fortified cereals, you will find taking this amount of folic acid unachievable solely through eating the right food.[1]

Imagine our horror at the thought that we might now be held legally responsible for the tragic results of an inadequate diet. Add to this our initial difficulty in knowing what to recommend, when the very same paper said that there was no such folic acid supplement to give. What a relief when a second circular dated 18 December arrived, saying that 0·4 mg supplements are available singly or as B group tablets.

Keen to work proactively, we asked eight local pharmacists what they could provide for our patients. Three responded. We could prescribe approximately 0·4 mg folic acid by using one of several iron and folate combinations recommended for pregnancy anaemias. But they had no low dose folic acid supplements. One pharmacist belonging to a national firm contacted the head office, which said that a suitable product can be made by special order at £100 for 100. Another asked the National Pharmaceutical Association, which said that there is no medicinal product licensed for sale but referred to one small firm's product, a 400 μg folic acid tablet, licensed only as a food supplement.

It seems extraordinary that circulars should be issued with no public health promotional material and no infrastructure available for the delivery of the recommended supplements.

The obstacles to appropriate preconceptual and conceptual care of women in deprived urban areas such as ours are great; a pregnancy may be a welcome but unplanned event and many social and economic factors are beyond individual control. How can we help poor women to avoid neural tube defects when the appropriate supplements, even when they become available, are not going to be prescribable on FP10s but will have to compete with the rest of the family's needs?

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Lunchtime admissions

EDITOR,—Recently, as a trainee general practitioner, I went out on an urgent call at lunchtime on a weekday. It turned out that the patient had probably had an intracranial bleed. I contacted the local neurosurgical unit, and one of the team agreed to admission. When I asked where I should send the woman I was told to contact the neurosurgical bed manager, who would tell me which ward to send her to.

I eventually got back to the switchboard and asked for the neurosurgical bed manager. It was 1 45 pm by this time. I was told that the manager had gone to lunch, and when I asked for him to be bleeped I was told again that he had gone to lunch and that he had left his bleep at the switchboard—all in a tone that suggested that this was standard behaviour. I then asked to speak to his superior and was told that he didn't have one as he worked on his own and there was no way of contacting him. I spoke again to the neurosurgical surgeon and explained that I had no choice but to send the patient, who needed urgent admission, to casualty. He eventually suggested sending her to one of the wards and said that he would sort things out from there.

I find it indefensible that a bed manager—especially for neurosurgery, a specialty in which admissions are often urgent—is allowed to go to lunch without a bleep and that no one covers for him. I wonder whether eventually admissions will be possible only during working hours but not during lunch or coffee breaks.

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Radiology guidelines

EDITOR,—The paper from the Royal College of Radiologists Working Party would have had more impact if details of results of radiographs had been included.[1] The introduction of the guidelines appears to have led to around 1615 patients not being *x* rayed (we are not told whether there were confounding variables such as fundholding). Were these patients disadvantaged in any way? If not, one presumes that radiography would have either shown no lesion or not contributed to management of disease. If that is the case, the percentage of abnormalities should have increased in the reduced number who were referred.

This report is valuable, but incomplete. The suggestion that generation of referral data should be specified in contracts is welcome, but should be extended to feedback (through the medical audit network rather than through management) of the results of radiography referral in terms of