bronchial irritability syndrome be used as operational criteria for the diagnosis of asthma but believed not only that this was premature but that to do something so potentially controversial might obscure the message we primarily wished to convey. Because studies were planned and are now in progress to explore the value of the bronchial irritability syndrome in predicting potential responsiveness to treatment with sodium cromoglycate and steroids we preferred to await these further data.

J B L HOWELL
W E WATERS

Faculty of Medicine,
Southampton General Hospital,
Southampton SO9 4XY

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Clinical Algorithms: Infertility

SIR,—In her algorithm on infertility (4 April, p 887) Mrs T R Varma suggested that high dose steroid treatment might be considered for immunological infertility in men. This was enthusiastically supported and advocated by Dr J Houghton (9 May, p 1229), but we think that this approach to treatment cannot be left unchallenged.

Reports of a beneficial effect of short term high dose prednisolone treatment on fertility have been based on the results of small, uncontrolled studies in men with antisperm antibodies in the serum.^{1,4} Locally secreted antisperm antibodies, however, which probably have more relevance to sperm function and fertility, were not assessed in these studies. Patients were not categorised according to isotype of the antibodies, and pregnancy rates were not related to antibody titre or duration of treatment. In a small, also uncontrolled, study of similar treatment in men with antisperm antibodies in the semen Hendry *et al* reported a crude pregnancy rate of 31%, two of the pregnancies occurring in the absence of any reduction in antibody titre.⁵

High dose corticosteroid treatment carries the risk of serious side effects. Haemetemesia and avascular necrosis of the femoral head may occur in up to 6% of treated men, and less severe side effects of hip pain, dyspepsia, aggressive behaviour, and visual disturbance occur in a further 16-27%.^{4,5} We therefore do not consider that such a potentially hazardous form of treatment should be embarked on without the risks being clearly explained to recipients, especially when there is little objective evidence to support its effectiveness.

We believe that until large, controlled studies have established the efficacy of steroid treatment for immunological infertility in men the risk of these severe and debilitating side effects cannot be justified.

MAX ELSTEIN
C A VAUGHAN WILLIAMS
S M SHALET

Department of Obstetrics and Gynaecology,
University Hospital of South Manchester,
Manchester M20 8LR

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Irritable bowel syndrome as a cause of chronic pain in women attending a gynaecological clinic

SIR,—I am grateful to Dr Cynthia Farquhar and colleagues for their comments on my paper (9 May, p 1228) but am surprised at their reluctance to accept the irritable bowel syndrome as a common cause of chronic pain in women.

Firstly, the questionnaire used in our study is widely accepted as a useful aid to the diagnosis of the irritable bowel syndrome and is an accurate means of taking an adequate history. Furthermore, physical signs recognised as markers of an irritable bowel were sought and found in over 70% of our patients.

Secondly, Dr Farquhar and coworkers doubt that dyspareunia is a manifestation of the irritable bowel syndrome, yet this has been adequately documented by Fielding,^{1,2} and Whorwell *et al*³ have similarly shown that dyspareunia is significantly more common than other gynaecological symptoms in patients with the irritable bowel syndrome.

Though ours was a small study, Heaton has argued that the irritable bowel syndrome is likely to be a common cause of chronic pain in women referred to a gynaecologist.⁴ No previous study of chronic pelvic pain in women has given details of how the irritable bowel syndrome was excluded as a cause of pain, and the low incidence at St Mary's Hospital may reflect the pattern of referrals.

Even if 60% of the patients in my study now have an explanation for their pain many do not, and there is room for a lot more work.

PATRICK HOGSTON

Department of Human Reproduction and
Obstetrics,
Princess Anne Hospital,
Southampton SO9 4HA

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Unemployment and mortality

SIR,—Mr K A Moser and colleagues (10 January, p 86) provide the first evidence of high mortality among men seeking work in the early 1980s in Britain. Similar results are suggested by a longitudinal study that followed more than one million people resident in Turin, Italy, at the time of the general census in October 1981. The sources of the data and the methods used, as well as the main findings regarding mortality up to 1985, are being summarised in a report, which will be available at the end of 1987.

The study included 13 462 men, aged 15-59, who, having lost their job, were seeking a new one in the week before the 1981 census (4% of all men of working age). In the period 1981-5 these men experienced a higher mortality than expected from death rates in all the men in the study (standardised mortality ratio=202, 95% confidence limits 179 to 227). The excess was similar in different age groups (217 and 195, respectively, before and after age 45 at death). The distribution of some potential confounders (tenure, education, region of birth,

and marital state) differed between those seeking work and all men of working age. Standardisation for these characteristics, however, had little effect on mortality (table I).

According to the information on employment state in 1976, provided by the same census, overall mortality among men seeking work in both 1976 and 1981 was even higher (table II). Mortality by cause of death showed significant excesses for all major categories (table III); deaths from both suicide and murder were overrepresented (standardised mortality ratios=285, based on 15 suicides, and 677, based on nine murders).

Contrary to the findings in the Office of Population Censuses and Surveys' longitudinal study, our data are partially compatible with the possibility that men who were unemployed because of ill health had classified themselves as seeking work. Indeed, analysis by calendar year shows an excess mortality among the unemployed since the beginning of follow up, even if a definite unhealthy selection effect is evident only in the category of not active men, which includes the disabled (table IV). The overall mortality among unemployed, however, is still in excess after the exclusion of people receiving a disability pension (table V).

In conclusion, our preliminary results support

TABLE I—Mortality 1981-5 for all men and men seeking work in 1981 aged 15-59 by tenure

Tenure	Standardised mortality ratio (observed No) for all men	Men seeking work in 1981	
		Standardised mortality ratio (observed No)	Mortality ratio standardised by tenure
Owner	84 (1855)	219 (77)	258
Tenant	109 (2936)	188 (181)	173
Inadequately described	141 (340)	291 (26)	201
Total	100 (5131)	202 (284)	193

TABLE II—Mortality in 1981-5 for men aged 15-59 in 1981 according to employment state in 1976 and 1981

Employment state		Standardised mortality ratio (observed No)	95% Confidence limits
1976	1981		
Employed	Employed	81 (3002)	78 to 84
Unemployed	Employed	106 (56)	80 to 137
Employed	Unemployed	187 (143)	159 to 222
Unemployed	Unemployed	256 (107)	209 to 308

TABLE III—Mortality in 1981-5 of men seeking work in 1981 aged 15-59 by cause of death

Cause of death	Standardised mortality ratio (observed No)	95% Confidence limits
Malignant neoplasms	175 (78)	137 to 216
Circulatory diseases	168 (66)	125 to 205
Respiratory diseases	170 (6)	63 to 373
Digestive diseases	316 (38)	224 to 435
Accidents, poisonings, and violence	245 (61)	187 to 313
Other causes	220 (35)	153 to 306

TABLE IV—Standardised mortality ratio (observed No) in 1981-5 for men aged 15-59 in 1981 by economic position and year of death

Year of death	Economic position			
	Employed	Unemployed	Retired	Not active
1981	79 (128)	88 (5)	146 (46)	376 (16)
1982	81 (731)	158 (52)	155 (267)	349 (74)
1983	80 (799)	222 (79)	160 (305)	283 (65)
1984	86 (804)	186 (62)	132 (252)	246 (54)
1985	84 (776)	259 (86)	137 (251)	207 (44)