sexually transmitted disease, and it is well known that sexually transmitted diseases often coexist with cervical intraepithelial neoplasia.^{1,2} In our study each patient was investigated for evidence of various current infections, infectious agents, or infectious conditions, including gonorrhoea, syphilis, candidiasis, trichomoniasis, *Chlamydia trachomatis*, bacterial vaginosis, herpes simplex virus, and genital warts. Thirty four of the women were found to have one or more of these infections or agents; *C trachomatis* was the most prevalent, being detected in 15 of the women. On repeat cytology *T vaginalis* was identified in three smears and monilia in two. By contrast, however, 90% of the infections, including two cases of gonorrhoea and all the cases of *C trachomatis*, would have remained undetected if these patients had been managed by repeat cytology alone. Many of these infections are sexually acquired, and it is therefore mandatory to trace all sexual partners where possible and investigate and treat them.

Smears that are reported to show minor changes seem to be a marker of infection. We believe that the management of women with abnormal smears should include investigation for a range of specific genital tract infections, the prompt treatment of which may aid regression of low grade cervical disease.

MICHELINE BYRNE
DAVID TAYLOR-ROBINSON
J R W HARRIS

Jefferiss Research Wing,
Præd Street Clinic,
St Mary's Hospital,
London W2 1NY

1 Guijon FB, Paraskavas M, Brunham R. The association of sexually transmitted diseases with cervical intraepithelial neoplasia: a case-control study. *Am J Obstet Gynecol* 1985;151:185-90.

2 Cervical cytology screening in sexually transmitted diseases clinics in the United Kingdom. British Co-operative Clinical Group. *Gynaecological Medicine* 1987;63:40-3.

SIR,—There can be little doubt that the British Society for Clinical Cytology's document on terminology¹ is proving to be highly successful. The article by Professor H Fox (23 May, p 1307), however, was clearly written before the document's supplement, dealing with the management of abnormal smears, was published.² This is unfortunate as the supplement is contentious in both its content and medicolegal implications. The issuing of national recommendations on any aspect of medical management is unusual and by definition will quickly be established as desirable practice. The corollary is that any adverse clinical event resulting from failure to follow published directives could result in possible claims of negligence. Furthermore, as emphasised by Professor Fox, the accuracy of cervical cytology has suddenly become regarded as so low that colposcopy with directed biopsy is now the recommended management for persisting inflammatory and all borderline and dyskaryotic abnormalities. Indeed, the cynic could claim that the only necessary cytology reports are "negative" and "abnormalities present warranting biopsy." At a time when colposcopy services are increasingly stretched, it seems crucial that the assessment of minor abnormalities does not compromise the management of moderate and severe dyskaryosis. It is increasingly ignored that other countries have reduced the incidence of and mortality from cervical cancer by restricting treatment predominantly to major cytological abnormalities. The cases illustrated in the Lesson of the Week by Dr M J Campion and colleagues (23 May, p 1337) indicate, however, that, irrespective of current clinical facilities, cytopathologists now have no medicolegal option but to recommend management along the guidelines of the British

Society for Clinical Cytology. This will precipitate an era of colposcopy clinic chaos, which will extend to the histopathology laboratory if there is the recommended explosion in family practitioner colposcopic biopsies (23 May, p 1313 and 1326).

DAVID SLATER

Rotherham District General Hospital,
Rotherham S60 2UD

1 Evans DMD, Hudson EA, Brown CL, et al. Terminology in gynaecological cytopathology: report of the working party of the British Society for Clinical Cytology. *J Clin Pathol* 1986;39:933-44.

2 Evans DMD, Hudson EA, Brown CL, et al. Management of women with abnormal cervical smears: supplement to Terminology in Gynaecological Cytopathology. *J Clin Pathol* 1987;40:530-1.

Carcinoma of the cervix in young women

SIR,—It was interesting to note that a confidential inquiry into deaths of young women from cancer of the cervix is proposed and is supported by Minerva (18 April, p 1036). Two studies that are shortly to be published put forward a similar idea.

It has been stated that "it is the talk of the gynaecological world... that young women are faring poorly." Published data about this are sparse. The disease is often stated to have become "more aggressive"¹ in young women, but this aggressiveness is difficult to define and measure clinically, and various measures are proposed: stage or volume of the disease at presentation, histological type and degree of differentiation, incidence and timing of lymphatic and distant metastases, and survival. The epidemiological evidence of increased incidence of preinvasive and invasive disease and the more rapid transition from one to the other are undisputed, but the cause of the increased mortality is unresolved: is it just that more young women have developed the disease and hence are at risk of dying, or is the disease indeed "more aggressive"? In two studies from the Royal Marsden Hospital we collected data that suggest the need for caution in making such statements.²

Of 385 new patients with invasive carcinoma of the cervix (International Federation of Gynaecology and Obstetrics stages IB-IV) treated between 1970 and 1984, 43 (11%) were aged 35 years or under. During the period studied the proportion of young women gradually rose from 2% in 1970-2 to 18% in 1982-4. In women aged 35 or less early stage disease predominated, 72% presenting with stage IB disease compared with 29% in the older age group. For stage IB there was no significant difference in actuarial survival between younger and older patients ($p>0.1$), both groups having a five year survival rate of 81%. Similarly, for stage II there was no difference in actuarial survival ($p>0.1$) between younger and older patients, who had five year survival rates of 66% and 63% respectively.

Between 1970 and 1984, 191 women aged 35 years and under presented to the Royal Marsden Hospital (London and Surrey branches) with invasive carcinoma of the cervix out of a total of 1799 cases registered (10.6%). Retrospective case record analysis of this larger number of young cases showed that 32 (17%) presented as a result of screening, but early stage disease predominated: stage IB, 122 (61%); stage II, 45 (22%); and stages III and IV, 24 (12%). Clearly retrospective non-epidemiological hospital based data cannot be used to evaluate cytological screening and the purpose of such screening is to pick up preinvasive and not invasive disease. The overall five year survival was 64%; stage IB, 71%; stage II, 59%; and stages III and IV, 32%. Adverse prognostic factors observed were: stage and bulk of the primary tumour, the presence of lymph node metastases as shown by lymphography, and grade of histological differentiation.

In our experience, the incidence of invasive carcinoma of the cervix in young women is rising, but stage for stage their survival is similar to that of older women. A more recent change in the biology of the disease might have been disguised by our

long surveillance interval, and some young patients do indeed fare badly. Our evidence suggests, however, that most have early stage disease and do well with existing treatment strategies, so until more data are presented to contradict this changes in treatment policy should not be based on age alone. A national database for young patients with invasive carcinoma of the cervix is proposed and should not restrict itself to a confidential inquiry into deaths. In this way data on the cytological and clinical history of preinvasive disease could be correlated with the clinical course of the invasive disease phase, and fresh biopsy material could be submitted for biological study to gain further understanding of the pathology, virology, and molecular biology of carcinoma of the cervix.

MICHAEL ASHBY

Peter MacCallum Cancer Institute,
Melbourne 3000

1 Coppleson M, Elliott P, Reid BL. Puzzling changes in cervical cancer in young women. *Med J Aus* 1987;146:405-6.

2 Smales E, Perry CM, Ashby MA, Baker JW. The influence of age on prognosis in carcinoma of the cervix. *Br J Obs Gynaecol* (in press).

Surrogacy

SIR,—I note that motion 157 of the annual representative meeting refers to surrogacy.

I wonder whether the members of Ayrshire and Arran Local Medical Committee have made any studies at all of surrogacy in relation to the surrogate mother, the commissioning parents, the child, and the surrogate mother's husband and children. I wonder if they have indeed made any attempt at all to find out about surveys that have, or have not, been carried out.

About 150 babies have now been born by surrogacy arrangements in the United States, and the only authoritative survey that I am aware of was conducted by Dr Stanley Friedman of the Tyler Medical Clinic in Los Angeles.¹

I think a distinction should be made between surrogacy of the kind arranged commercially, in which the ovum is contributed by the surrogate, and surrogacy induced by in vitro fertilisation using the commissioning parents' ovum and sperm. The outcome of the second procedure is that the child is the genetic offspring of the commissioning parents, which eases doubts about the status of the child and, probably, the question of the surrogate mother giving up the child.

There are some couples who need surrogacy on very strong medical indications. If a young, healthy surrogate mother within the family volunteers to give this service to the infertile couple then I do not think it should be condemned out of hand. Every couple, of course, would need careful counselling by an expert counsellor, who should visit the couple at home, and recommendations should be made to the ethical committee of the in vitro fertilisation unit about the desirability of carrying out in vitro fertilisation surrogacy in each particular case.

Some of the medical indications are indeed very strong, but they do not necessarily overcome all of the problems, the most obvious being the contractual arrangements and the status of the child and the full responsibilities of the surrogate mother and her family and the commissioning couple.

I do not think that it will be appropriate for the annual representative meeting to advocate condemnation of surrogacy without the support of scientific evidence of properly conducted surveys. Nor is it appropriate that gynaecologists alone should be asked to decide whether or not a particular couple will make good parents.² Ob-

viously, this cannot be done at the present time in Britain to give any useful data, but inquiries to the American Fertility Society would be helpful to the annual representative meeting in this respect.

PATRICK STEPTOE

Bourn Hall Clinic,
Cambridge CB3 7TR

- 1 Friedman S. *Surrogate parenting*. Los Angeles: Tyler Medical Clinic, 1984.
- 2 Warnock M. *Progress in obstetrics and gynaecology*. London: Churchill Livingstone, 1987:243.

Ruptured abdominal aortic aneurysm presenting with ureteric colic

SIR,—The article by Mr C G Moran and colleagues (16 May, p 1279) acknowledges the difficulty of establishing the diagnosis of ruptured aortic aneurysm and highlights the trap of ureteric colic. Experience at Royal Perth Hospital supports this.

This hospital's experience of patients with acute renal failure requiring dialysis after repair of abdominal aortic aneurysm has recently been examined. In 29 of 33 such patients surgery followed emergency presentation. Seven of these patients reported symptoms that suggested a diagnosis of ureteric colic, and in four cases pain in or radiating to the testis indicated a ureteric origin. The finding of microscopic haematuria was considered further evidence for this. Back pain was a major symptom in seven other patients, and three patients were being investigated for renal or spinal disease when sudden hypotension or severe abdominal pain, or both, redirected the investigation.

Ruptured abdominal aortic aneurysm merits a prominent position in the differential diagnosis of ureteric colic in older patients. For the reasons outlined by Mr Moran and colleagues, the finding of microscopic haematuria should not exclude rupture of an aneurysm from consideration.

DAN O'DONNELL

Royal Perth Hospital,
Perth 6001,
West Australia

Evaluation of portable haemoglobinometer in general practice

SIR,—Dr R G Neville's report of excellent results with the HemoCue system for haemoglobinometry when used in the laboratory and disappointing ones when it was evaluated by practice nurses (16 May, p 1263) is not surprising. Substantial analytical inaccuracies, financial waste, and other difficulties are reported in relation to the uncontrolled use of equipment in clinical areas outside the laboratory.¹ We firmly believe that the laboratory is the best place for equipment, however simple it may be, and that the medical laboratory scientific officer is the best operator. The stringent quality control procedures undertaken in the laboratory could not be matched elsewhere.

There are very few indications for estimating a patient's haemoglobin concentration alone. If what general practitioners need is a simple screen for anaemia we suggest the copper sulphate method currently used for screening blood donors on site.² An immediate result is obtained, no equipment is needed, the cost is very small, and the skill required could easily be achieved by practice nurses. The result obtained is qualitative rather than quantitative. The cost of purchasing, maintaining, calibrating, and controlling even the simplest of machines may not be justified in view of

the fact that a quantitative result is unlikely to alter the action taken by the general practitioner in managing his patient. After all, if a patient is found to be anaemic a full blood count at the local laboratory is necessary to determine the type of anaemia.

CATHY WHITE
DAISY OBEID

Department of Haematology,
Alexandra Hospital,
Redditch B98 7UB

- 1 Browning DM, Cowell DC, Kilshaw D, Knowles D, Randall J, Singer R. Clinical chemistry equipment outside laboratories. *Med Lab Sci* 1984;41:99-107.
- 2 Mollison PL. Screening test to detect anaemia. In: *Blood transfusion in clinical practice*. 7th ed. Oxford: Blackwell Scientific Publications, 1983.

Early versus late induction of labour in post-term pregnancy

SIR,—A serious deficiency in the paper by Dr Kåre Augensen and colleagues (9 May, p 1192) on induction of labour in prolonged pregnancy is their failure to confirm dating by early ultrasonography. They compare their results with those of Cardozo *et al*,¹ but these authors used ultrasound dating, which is generally agreed to be more accurate. We found that in 5% of 626 women with certain menstrual dates (by the same criteria used by Dr Augensen and colleagues) an ultrasound scan in the first half of pregnancy altered dates by more than 14 days (unpublished findings).

We found the incidence of prolonged pregnancy (>42 weeks) to be 3.4% by ultrasound scan dates, and we confirmed the findings of Grennert *et al* and Warsof *et al* that ultrasound scanning for pregnancy dating reduces the incidence of prolonged pregnancy.^{2,3} Dr Augensen and coworkers do not state their incidence of prolonged pregnancy, making it impossible to assess the validity of their numbers.

Doubt about the accuracy of pregnancy dating in their study is reinforced by the large number (27%) in their group 2 (not induced) who did not go into labour spontaneously in the 43rd week of pregnancy and by the large number of "failed" inductions. They do not, however, state their method of induction, and we are left to presume that it did not include amniotomy. Many would argue that induction without amniotomy hardly constitutes an adequate procedure.

CHRISTOPHER E LENNOX
NAREN B PATEL

University of Dundee,
Dundee DD2 1UD

- 1 Cardozo L, Fysh J, Pearce JM. Prolonged pregnancy: the management debate. *Br Med J* 1986;293:1059-63.
- 2 Grennert L, Persson PH, Gennser G. Benefits of ultrasonic screening of a pregnant population. *Acta Obstet Gynecol Scand [Suppl]* 1978;78:5-14.
- 3 Warsof SL, Pearce JM, Campbell S. The present place of routine ultrasound screening. *Clin Obstet Gynaecol* 1986;10:445-57.

AUTHORS' REPLY—We acknowledge that routine early ultrasound was not in regular use when our trial started. With scrutiny of the case histories, however, including early human chorionic gonadotrophin tests and ultrasound when available, we managed to sort out 373, or 39.5%, of these 944 referred for suspected post-term pregnancy. During the study there were 12 265 deliveries in our department; of these, our study population of 409 plus 143 cases that were excluded for reasons unrelated to pregnancy duration constituted 4.5%.

We would emphasise how helpful thorough history taking can be. Let us remind our critics of the easily forgotten fact that all ultrasound nomograms are based on measurements of limited

numbers of fetuses of so called normal pregnancies with certain dates. Previous studies of pregnancy duration, based on certain menstrual dates, known date of conception, or known date of ovulation have concluded that the proportion going beyond 42 weeks is about 10%, or slightly less. Cardozo *et al* reported 6.6% and 6.3% in two series,¹ and Warsof *et al* 6.3% when ultrasound correction was used,² and so we are in good company. Grennert *et al* claimed that only 1.5% went beyond that limit after ultrasound correction, but they had excluded 152 of the 1000 consecutive cases, 148 of them because birth was induced.³

The fact that 27% of our non-induced study subjects did not go into labour spontaneously in the 43rd week is not at all surprising. Being a representative sample, they constituted 0.9% of the total birth population in the hospital. It is reasonable to expect a fraction of pregnancies of a sample of this size to pass the 43 week limit.

With regard to the method of induction, we believe that it was adequately described. Amniotomy was not performed before labour was clearly established, which is the usual practice in Norway. We would argue that a more aggressive approach in the face of a debatable medical indication may do more harm than good and lead to more unnecessary caesarean sections.

Finally, these points of debate do not seem to us to detract from the validity of the results, nor do they compel us to alter our conclusions.

KÅRE AUGENSEN
PER BERGSJØ
TORUNN EIKELAND
KJELL ASKVIK
JOHANNES CARLSEN

Department of Obstetrics and Gynaecology,
University of Bergen,
Kvinnekliviken,
Haukeland Sykehus,
N-5021 Bergen,
Norway

- 1 Cardozo L, Fysh J, Pearce JM. Prolonged pregnancy: the management debate. *Br Med J* 1986;293:1059-63.
- 2 Warsof SL, Pearce JM, Campbell S. The present place of routine ultrasound screening. *Clin Obstet Gynaecol* 1986;10:445-57.
- 3 Grennert L, Persson PH, Gennser G. Benefits of ultrasonic screening of a pregnant population. *Acta Obstet Gynecol Scand [Suppl]* 1978;78:5-14.

Ethics committees and research

SIR,—Professor Roger J Robinson (16 May, p 1243) discusses the membership of ethical committees and considerations with regard to research in children that are also relevant to research in adults. Guidelines that we have devised over five years may be helpful to other committees. A protocol is circulated in advance and talked through by the investigator at the meeting, and the guidelines remind the chairman of issues to raise.

Firstly, the ethical committee should consist of a clinical tutor, an undergraduate tutor, a vicar or priest, a member of the administrative staff, a member of the secretarial staff, and two consultants—preferably with some experience in the project under discussion. A consultant from a different firm or different hospital is probably most advisable, and a senior nursing officer should be present when needed.

With regard to the research itself: the project should not withhold essential treatment from patients; it should be of a good standard so that the result will be of some value, whether positive or negative; and it should not put the patients at unreasonable risk. A project designed merely to promote the use of a drug should not be passed by the ethical committee. The project should be explained to the patients and consent should be