producing it. Sunflower and safflower oils, which are the main source of unsaturated cooking oils and margarines, are produced outside the community and bear a heavy import tariff. At the current meeting of ministers the proposal is to prop up the dairy industry (which is suffering a decline in volume of sales with no decline in output) by still further increasing the tariff on imported oils so that in due course soft margarine will be dearer than butter.

Prognosis in asthma

Dr C K CONNOLLY (Memorial Hospital, Darlington DL3 6HX) writes: Recent work, including that from the British Thoracic Society[1] and New Zealand,[2] has highlighted acute mortality in asthma and suggested that some deaths may be avoidable. Dr H L J Markowe and his colleagues (17 October, p 949) suggest that the deaths which are regarded as directly attributable to asthma represent at most half the deaths from the condition. Even allowing for difficulties in diagnosis, it is likely that the 37 deaths attributed to chronic obstructive airways disease were related to the same process that produced the asthma. There were only four deaths among the controls from chronic obstructive airways disease. The importance of the development of failure to respond to treatment in at least some asthmatics is being increasingly appreciated. Cross sectional studies have shown secondary resistance to corticosteroid therapy[3] and an association between persistent obstruction and duration of asthma[4] which is independent of the age of the patient.[5,6] A proper longitudinal study on this aspect of asthma is urgently needed. Improving treatment so as to reduce the development of persistent obstruction might be even more fruitful in the long term than improving the treatment of acute attacks, a proportion of which are so catastrophically unpredictable, rapid in onset, and severe as to be inevitably fatal.

1 British Thoracic Association. Death from asthma in two regions of England. *Br Med J* 1987;285:1251-5.
2 Jackson RT, Beaglehole R, Rea HH, *et al.* Mortality from asthma: a new epidemic in New Zealand. *Br Med J* 1982;285: 771-4.
3 Carmichael J, Paterson IC, Diaz P, Compton GK, Kay AB, Grant IWB. Corticosteroid resistance in chronic asthma. *Br Med J* 1981;282:1419-22.
4 Brown PJ, Greville HW, Finnicatine KE. Asthma and irreversible airflow obstruction. *Thorax* 1984;39:131-6.
5 Connolly CK. Persistent obstruction in asthmatics; time and social factors. *Eur J Respir Dis* 1986;69:(suppl 146):A39.
6 Connolly CK. The relationship between age and duration of asthma and the presence of persistent obstruction in asthma. *Postgrad Med J* (in press).

Familial adenomatous polyposis

Mr JAMES P S THOMPSON (Polyposis Registry, St Mark's Hospital, London EC1V 2PS) writes: In the section on bowel cancer in your report of the BMA's clinical congress in Kuala Lumpur (31 October, p 1126) you refer to familial polyposis coli. At a recent meeting of an informal international group known as the Leeds Castle Polyposis Group we considered that the most appropriate name for this disease would be "familial adenomatous polyposis." This defines the type of polyp but does not restrict the disease to the colon.

Alzheimer's disease: ignoring achievements

Professor RAYMOND LEVY (Institute of Psychiatry, London SE5 8AF) writes: Dr Colin Currie's review of the Channel 4 programme *Alzheimer's Disease—The Silent Epidemic* (14 November, p 1268) was as one sided as the programme itself in ignoring the achievements of research in advancing our understanding of the condition to the stage where effective treatment has become an achievable goal. Since the TV piece was part of a consumer series it is not surprising that it should have dealt almost exclusively with the devastating effects of the disease on patients and carers. There was nevertheless a note of distinct pessimism about possible progress in the comments made by the presenter, Penny Junor. It is sad to find this view echoed in the columns of your journal. Words like "the costly impotence of science was on display" and "the response of science was a smooth man . . . asking for more money" are cheap jibes, particularly from a senior lecturer in geriatric medicine at one of our major universities. Bearing in mind how little is spent on research in Alzheimer's disease in Britain, the not so smooth man (Dr Martin Rossor) and many rougher men and women have not done badly in advancing our knowledge of the neurochemistry of the condition. It is a pity that the exploitation of these advances should now be left to other countries. Far from displaying costly impotence, science in this context has made remarkable studies on very little money.

Access to personal health data held on computers

Professor F V FLYNN (Department of Chemical Pathology, King's College Hospital, London WC1E 6AU) writes: "What every doctor needs to know about 11 November" (7 November, p 1160) needs to be updated. The draft order on access to personal health information under the Data Protection Act 1984, referred to in the leading article, proposed that data users could withhold or modify information where disclosure was considered likely to cause serious harm to the physical or mental health of the data subject or any other person. In the final order approved by the House of Commons on 3 November the words "or any other person" were omitted and cannot therefore form the basis on which disclosure of data under the act is withheld or modified. Revised guidance has been issued by the Department of Health and Social Security.[1]

1 Department of Health and Social Security. *Data Protection Act 1984: modified access to personal health information.* London: Department of Health and Social Security, 1987. (HC(87)26/HC(FP)(87)9.)

Walking through labour

Ms SHEILA KITZINGER (Standlake, Oxfordshire) writes: I was intrigued to read Professor Geoffrey Chamberlain's and Mr Malcolm Stewart's (3 October, p 802) assertion that "traditional birth attendants in primitive tribes have for centuries nursed women horizontally." In my records of birth positions taken from anthropological field reports in 93 different cultures all over the world I found only two descriptions of horizontal positions, both in accounts written by men. The most common are supported, squatting, or kneeling postures. The authors also claim that "most obstetricians allow a woman to adopt any position she wants during labour." How many obstetricians? In recent research of my own 705 women in Britain were asked, "Were you able to give birth in the position of your choice?" While 6% of the respondents did not answer this question because they had had caesarean sections, 39% said they had been able to choose and 55% said they had been given no choice.

Diagnosis of deep vein thrombosis

Drs JOHN MARTIN and ERIK CAMERON (King's College Hospital, London SE5 9RS) write: Professor Graham Whitehouse's leading article (3 October, p 801) on the radiological diagnosis of deep vein thrombosis rightly concludes that *x* ray venography is still the gold standard. However, venography and other useful techniques require expensive equipment, are time consuming, and require the transport of patients away from the ward. What is needed is a screening test that can be applied widely, regularly, cheaply, and with minimum inconvenience to the patient. Professor Whitehouse fails to mention liquid crystal thermography, which when compared to *x* ray venography was found to be a useful screening test to exclude deep vein thrombosis.[1] Although it gives false positive results, with a specificity of 62·2% (which indicates further investigation by the other methods described in the leading article), a negative thermographic result gives a 96·5% confidence of clot not being present in the leg veins. Venous thrombosis may cause fatal pulmonary embolism, yet it is treatable by anticoagulation. Wide and regular use of a screening test like liquid crystal thermography may be a cheap and non-invasive way of identifying deep vein thrombosis as early as possible in the hospital population.

1 Sandler DA, Martin JF. Liquid crystal thermography as a screening test for deep vein thrombosis. *Lancet* 1985;i:665-8.

Medicine and the media

Mr S DICKENS (South Birmingham Health Authority, Selly Oak, Birmingham B29 6JF) writes: To set the record straight I need to follow up Ms Debbie Newton's article (7 November, p 1199). South Birmingham's quarterly newspaper actually costs £26 000 per year for the four editions not £26 000 per print as Ms Newton reported. While I agree that the broader questions of cost effectiveness were not discussed in detail, our market research survey showed quite clearly the positive health image of the newspaper. Information which is now available indicates that there is a good return for the authority's investment. Our readers are getting advice on key health issues and information about the range of health services being provided across the district. Also I need to correct Ms Newton's statement that I described the function of the health authority as transmitting positive health messages, and not the running of hospitals. I believe I said that the health authority's function was the delivery of health care and that as part of that process the transmission of positive health messages was clearly an important dimension. My concern has always been to promote the wider role of health authorities beyond notions of institutional management.

Obstetricians on the labour ward

Dr D J HOUGHTON (All Saints' Hospital, Chatham, Kent ME4 5NG) writes: It is hardly surprising that the consultants in the two tier hospital in the study by Ms V A Coupland and colleagues (24 October, p 1077) made every effort to extend their midwives' role and limit medical intervention, since this obviously reduced their own workload. Of all the consultants in the two tier hospitals only one chose to sleep in the hospital. I would have thought that in order to provide cover equally as good as, if not better than, that in the three tier system the person who is doing the work of a registrar should be equally as available as the registrars. Obstetrics is one of the specialties where urgent action often needs to be taken by the man or woman on the spot. If the system suggested by Ms V A Coupland and her group (October 24, p 1077) were to be implemented then the role of the consultant would certainly have to be downgraded and the consultant would become a highly skilled technician, not a person who would be "consulted" in cases of difficulty. I believe that the writers aptly sum up the problem in their conclusion where they say that additional consultants "may not be appointed to compensate for missing registrars." In the present economic climate "will not" ought to be substituted for "may not."

The Isle of Wight's new hospital

Dr PETER BRAND (Brading, Isle of Wight) writes: It was good to see your plug for the healing arts (17 November, p 1212). We are proud of the local and national support we had in humanising our old institutions and the imaginative planning for the new St Mary's Hospital. I must, however, take issue with your last paragraph. The Isle of Wight is not part of wealthy Hampshire: we are an independent district, the smallest and poorest in Wessex. Our adult unemployment last winter reached 17%, we have the highest proportion of elderly in Wessex, and we have suffered from chronic underfunding for many years. The Isle of Wight Health Authority has worked hard to bring island medicine into the 1980s. We welcome the new hospital despite having had to contribute some £2m from district resources. I hope that we can open the hospital with the services for which it was designed, but unless our share of the Wessex cake is improved we may well have to restrict ourselves to carrying out workhouse medicine in an attractive high tech shell.