reports to be produced in the format of the required classification. It is well suited to cope with "fuzzy" and non-medical problems, permitting the doctor to be as precise or as vague as he thinks appropriate.

The Read clinical classification has been selected by the Scottish Home and Health Department for use in the NHS in Scotland and merits widespread consideration and acceptance in the rest of Britain and internationally.

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1 Read JD, Benson TJR. Comprehensive coding. *British Journal of Health Care Computing* 1986;3:22-5.
2 Anonymous. *The Read clinical classification*. 2nd ed. Loughborough: Computed Aided Medical Systems Ltd, 1988.

Points

Lethality of AIDS

Professor NORMAN R GRIST (Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB) writes: My answer to Minerva's question whether AIDS will become less lethal in a few generations (19 March, p 866) is, "No—not within the foreseeable future." The natural trend towards mutually tolerable equilibrium between host and parasite results from selection pressures on both, in this case between ourselves and HIV, the parasite of which AIDS is merely a late complication. The virulence of HIV for our species is already so low as to produce minimal damage and permit our survival in infectious and breeding condition for years and thus provide little advantage to the parasite from even lower virulence. The limited penetration of our population by the virus is another factor which reduces selection pressure for a more resistant race of humans, and our slow breeding rate means that even under intense pressure comparable with that of myxomatosis in rabbits it would take centuries to evolve such a change.[1] We must therefore learn to live henceforth with this new problem, which is provoking a dramatic upsurge of infections as well as major social and economic challenges, but our species will surely survive.[1]

1 Grist NR. Human AIDS and rabbit myxomatosis. *J Infect* 1988;16:117-9.

Young age as a prognostic factor in cervical cancer

Drs E SUGDEN, R KALRA, and C J ALCOCK (Department of Radiotherapy and Oncology, Churchill Hospital, Oxford OX3 7LJ) write: Two recent studies (6 February, p 386) have investigated young age as a prognostic factor for invasive cervical cancer. Our own work supports these studies, albeit with smaller numbers of patients, but we remain concerned that the emphasis of both papers tends to obscure the fact that more young women (under 40) are developing cervical cancer than before. While young age alone may not be an adverse prognostic factor, there is increasing evidence that these patients show other adverse prognostic factors, the net result being an increasing number of young women dying of cervical cancer. Both reported studies point out that, whereas the total number of patients presenting with invasive cervical carcinoma annually has remained constant, there has been an increasing contribution of younger patients since the mid-1970s. Figures from the West Midlands study show that in the late 1960s and early 1970s about 50 women (12%) aged under 40 presented each year. Between 1977 and 1981 over 100 women (25%) were under 40. In Oxford in 1986, 40% of all those presenting with cervical cancer were under 40.

Although detailed survival figures have yet to be published, others have suggested that the prognosis in young women is poor.[2,3] Our own data show that in spite of presenting at earlier stage (under 40, 91% stage I and II; over 40, 72% stage I and II) young women who presented in 1981-5 had a significantly higher incidence of pelvic lymph node metastases when surgical specimens were assessed pathologically. Previous studies have shown affected lymph nodes to be a particularly poor prognostic factor.[4] Consideration should be given to the effect on current management practice of the increasing number of young women presenting with aggressive cervical cancer.

1 Russell JM, Blair V, Hunter RD. Cervical carcinoma: prognosis in younger patients. *Br Med J* 1987;295:300-3.
2 Hall SW, Monaghan JM. Invasive carcinoma of the cervix in younger women. *Lancet* 1983;ii:731.
3 Ward BG, Shepherd JH, Monaghan JM. Occult advanced cervical cancer. *Br Med J* 1985;290:1301-2.
4 Alcock CJ, Toplis PJ. The influence of pelvic lymph node disease on survival for stage I and II carcinoma of the cervix. *Clin Radiol* 1987;38:13-6.

Management response to childhood accidents

Dr PATRICK J MORRISON (Belfast City Hospital, Belfast BT9 7AB) writes: Mr R H Jackson (13 February, p 448) states that the most comprehensive data on accidents are collected by the police and by the Department of Trade and Industry's home accident surveillance system, and not by the health services. The opposite seems to be true in New Zealand. Our survey, comparing hospital admissions data and official government statistics from police records of serious traffic accident injuries in New Zealand,[1] showed that on average only 56% of cases of serious traffic accident injury were reported during 1973-82 by the Ministry of Transport compared with the Department of Health's hospital admission statistics. These were comparable with results in several other countries. Extremely low reporting rates for children falling out of cars or run over in driveways (virtually 0%) or concerning bicyclists (15%) were understandable as there is no legal obligation to report these, although they constitute a significant proportion of all injuries and will be neglected if police statistics are used. The difference between reporting rates for two car collisions (84%) and one car collisions (52%) shows that a traffic officer is more likely to be called to the former as there is a higher incidence of personal injury and damage to the vehicle. We concluded that the Department of Health, the Ministry of Transport, and local accident compensation statistics should ideally be merged to give more accurate figures, thus allowing a more effective approach to prevention.

1 Morrison P, Kjellstrom T. A comparison of hospital admissions data and official government statistics of serious traffic accident injuries. *NZ Med J* 1987;100:517-20.

Fear of HIV infection and reduction in heterosexual gonorrhoea

Drs P D WOOLLEY, C B BOWMAN, and G R KINGHORN (Department of Genitourinary Medicine, Royal Hallamshire Hospital, Sheffield) write: We are surprised at the statement by Dr Brian Evans and others that the national campaign encouraging individuals not to engage in unprotected intercourse with casual consorts has had little effect because less than half of the women in their study used condoms (13 February, p 473). Unfortunately there is no indication on condom use before the campaign or whether those women using condoms for disease prevention were in the group with more frequent changes of sexual partner. Acute uncomplicated gonorrhoea is a useful indicator of risky sexual practices. In our clinic we have seen a fall in the number of cases and incidence of acute gonorrhoea in both sexes. In 1987 there was a 54% reduction in the number of cases of acute gonococcal urethritis among heterosexual men (from 430 to 197) and a 46% reduction in acute gonococcal cervicitis among women (from 413 to 224) over the preceding year. We remain optimistic that the national campaign has increased public awareness about the dangers of unprotected intercourse with any partner whose state of health is uncertain. It is unclear whether this fall is due to an increase in condom use, a reduction in the number of casual sexual encounters, or a more selective choice of casual sexual consort. Further studies are required to determine the full impact of the campaign on the sexual behaviour of both sexes.

Benign multinodular goitre and Horner's syndrome

Dr M P WILLIAMS (Royal Marsden Hospital, Sutton SM2 5PT) writes: I was distressed to see the figure in the article by Dr Stella Lowry and others (20 February, p 529) entitled "Computed tomograph of neck and upper thorax" when in fact it shows a single computed tomographic section through the upper mediastinum. I was doubly distressed by the labelling: the structure labelled "left carotid sheath" is clearly the left subclavian artery and the structure labelled "right carotid sheath" appears on this single section most likely to be either the right brachiocephalic vein or the superior vena cava. The right common carotid artery may be seen in the position indicated in the figure when it arises anomalously as a single vessel from the aortic arch and passes behind the trachea and oesophagus to reach the right of the upper mediastinum. If this was the case here then surely it would be worthy of comment.

Drs STELLA R LOWRY, R A SHINTON, G JAMIESON (Dudley Road Hospital, Birmingham B18 7QH), and A MANCHE (East Birmingham Hospital, Birmingham B9 5ST) write: The figure is a computed tomogram of the upper mediastinum and shows the distortion to structures in this area caused by the goitre. We regret that the labels are incorrect as the carotid sheaths are not seen at this level.

Controlling symptoms in advanced cancer

Dr RUTH OWEN (Ealing Hospital, General Wing, Southall, Middlesex UB1 3HW) writes: In their excellent review of the pharmacological control of symptoms in advanced cancer Drs T D Walsh and T S West (13 February, p 479) state that some patients whose vomiting is induced by opioids respond well to metoclopramide, ascribing the effect to the drug's action in assisting gastric motility. In fact the gastric emptying effect of metoclopramide is antagonised by opioids,[1] and its central antiemetic action is not as powerful as that of phenothiazines such as prochlorperazine and perphenazine.[2] Metoclopramide is effective in combating the nausea of cancer chemotherapy when opioids are not part of the regimen. If opioids are needed for cancer pain, however, the phenothiazines are the antiemetics of choice.

1 Nimmo WS, Wilson J, Prescott LF. Narcotic analgesics and delayed gastric emptying. *Lancet* 1975;i:890-3.
2 Gillies HC, Rogers HJ, Spector RG. *Textbook of clinical pharmacology*. 2nd ed. London: Hodder and Stoughton, 1986.

Hepatitis B vaccines

Mr T J ATTREE and Dr R K KNIGHT (Smith Kline and French Laboratories Ltd, Welwyn Garden City, Herts AL7 1EY) write: With reference to the answers given by Dr Elizabeth Fagan and Professor Roger Williams about hepatitis B vaccines (20 February, p 551), we should like to point out that, although our new genetically engineered hepatitis B vaccine (Engerix B) was marketed in Britain in September 1987 and is now available in many countries, it is not available in the United States.

Wheelchairs

Dr CHARLES M FLOOD (Fitzroy Nuffield Hospital, London W1H 8BB) writes: There is one omission from Dr John Young's excellent article (27 February, p 625). He does not mention the necessity for having some adjustment to the chair for the height of the attendant. If the handles at the back are too low the attendant suffers backache. If they are too high then it is impossible for the attendant to get his or her weight behind the chair to push it, particularly up hill. Furthermore, backward pointing handles, grasped by the hand, are not the most efficient way of pushing a heavily laden chair, so there should be some cross bar between the handles so that full weight can be put on the chair.