and to evaluating and, if necessary, modifying screening policy. The Department of Health has recently disbanded its committee on gynaecological cytology and the lead should therefore be taken by the National Health Service, which needs to give leadership and support to programme managers on all these topics, including screening policy. Is annual screening necessary for people who have had colposcopy? Or for people with wart virus infection? What proportion of people should be referred for colposcopy? Programme managers need a national lead on such issues; at local level there is always pressure to take the policy with least risk, whatever the benefit and cost. The faculty has proposed to the five main groups concerned in screening—women's organisations, the 18 major providers, professional associations, the health departments, and research workers—that a national coordinating network should be set up to weave the 213 screening programmes into one NHS cervical screening programme.

To those concerned in cervical screening criticism is a familiar theme as, for example, expressed in an editorial in the *Lancet*[2] which implied that it is individual incompetence which is impairing the effectiveness of the programme. This is not the case. What is missing is an adequate investment in management—nationally, regionally, and at district level. 1987 was the year the circular said what should be done; 1990 could be the year in which a system is effectively implemented if a small amount of resources were made available for better management.

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1 Smith A, Elkind A, Eardley A. Making cervical screening work. *Br Med J* 1989;**298**:1662-4. (24 June.)
2 Anonymous. Cancer of the cervix: death by incompetence. *Br Med J* 1989;ii:363-4.

SIR,—As someone who works in one of the screening laboratories detecting cancer of the cervix I take exception to the viewpoint taken by Professor A Smith and colleagues that the present system fails to detect all but a few potentially invasive lesions and subjects many women to unnecessary investigation and treatment.[1]

Over the years here we have seen invasive carcinomas only in women who have not had a smear at any time or who have had only occasional smears, usually at least eight to 10 years before presenting with invasive carcinoma. Our screening has not missed significant disease in those who are presenting for cervical smears. Indeed, the time wasted doing external and internal quality control has proved that the screening is detecting almost every abnormal smear. The unfortunate fact is that within about 10% of smears that we report as abnormal there is a considerable proportion showing features due to the wart virus.

Within that 10% of abnormal smears a small percentage progress, often very rapidly, to cervical intraepithelial neoplasia grades II and III, for which active and sometimes aggressive treatment is undertaken. At present cytology is unable to distinguish between the abnormal cells that are shed from the cervix (which will eventually heal itself) and those that are shed by epithelium that is about to progress to invasive carcinoma. As a result monitoring with either colposcopy or repeat cervical smears is needed to ensure that progressive disease is not developing. It is difficult to foresee any more economic system than the one presently in operation, as sufficient material must be available to allow secondary testing of abnormal smears for the potential of progressive and aggressive disease, should such a test ever become available.

Having been involved in the Cheshire call system from its original setting up and being continually involved in its operation, I do not think that there exists any better database than that presently in the computers of the family practitioner committee for obtaining names and addresses of women in the groups at risk. Until some form of national computer records become available to the cervical screening service the present problems of patients changing their address will continue, with appreciable numbers of women failing to have smears and being at risk of developing undetected cancer of the cervix.

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1 Smith A, Elkind A, Eardley A. Making cervical screening work. *Br Med J* 1989;**298**:1662-4. (24 June.)

Hypercalcaemia in malignancy

SIR,—Hypercalcaemia in malignancy is a fairly common problem encountered by cancer specialists and most have their own ideas on its correct management. I was, however, a little surprised at the suggestion in Dr D A Heath's editorial that not all patients should be treated.[1]

Even in terminally ill patients the symptoms of hypercalcaemia are often extremely distressing and correction of these symptoms will improve quality of life. One symptom of hypercalcaemia that is never referred to in textbooks or editorials, but which seems to be a common feature in clinical practice, is an apparent change in pain threshold, and, of course, most of these patients have widely disseminated bone metastases, which are often symptomatic; correction of the raised calcium concentration seems greatly to aid pain control, often reducing the amount of analgesic required. This provides another reason for considering treatment, even in those gravely ill.

I hope that Dr Heath's article helps to dispel the myth that steroids have a useful role in metastatic hypercalcaemia and to emphasise the essential role of rehydration. The priority of these two treatments commonly tends to be transposed.

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1 Heath DA. Hypercalcaemia in malignancy. *Br Med J* 1989;**298**:1468-9. (3 June.)

Twenty one years of legal abortion

SIR,—Mr R Balfour's diatribe against the Abortion Act[1] contains several unscientific and anecdotal observations that are not confirmed by published data. Although I am not qualified to comment on the effect of abortion on mental sequelae, the physical problems that he mentions do not seem to be true. In my own small series only 3% of abortion patients needed readmission for retained products and none were septic.[2] Also Daling *et al* showed that legal abortion as carried out in the United States produces no increased risk of future tubal infertility.[3] I have seen no published data in prospective studies to indicate that therapeutic abortion causes complications such as cervical incompetence provided the termination is done before 13 weeks. In 17 years of consultant gynaecological practice I have seen only one case of endometriosis in an abdominal scar after a hysterectomy I carried out in 1973 (31 in that year). Now that almost all late abortions are carried out with prostaglandins the problem of endometriosis should no longer exist. Finally, the latest report on confidential inquiries into maternal death for the first time records no cases of maternal death attributed to illegal abortion.[4] Surely this one single fact is enough to continue to make therapeutic abortion freely available on the NHS? Maybe Mr Balfour is too young to remember married women with several children leaving widowers and orphans due to criminal abortion before the humane 1967 act came into successful being; and this act has continued to work reasonably well for the past 21 years as reported by Munday *et al*.[5]

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5 Munday D, Francome C, Savage W. Twenty one years of legal abortion. *Br Med J* 1989;**298**:1231-4. (6 May.)

Osteopoietin rediscovered

SIR,—The news that a growth factor has been found that stimulates the development of bone cells was fascinating.[1] Surely the "osteopoietin" of Dr Karlheinz Schmidt and his team is also the bone morphogenetic protein of Marshall Urist. The German group is to be congratulated for its recent work on cholesteatoma but any praise for the discovery of this potentially invaluable substance must go to Urist and his colleagues at the UCLA Bone Research Laboratory in Los Angeles. He has spent most of his professional life working in this field, a fact noted in this journal when his textbook on bone physiology was reviewed several years ago.[2] His voluminous basic science output continues with recent reports of improved potency of bone morphogenetic protein when coupled with human fibrin[3] and its success in inducing repair of skull trephine defects in sheep.[4]

I heard Urist review his work when he came to Oxford recently, and it seemed clear that sooner or later this substance will become an invaluable tool for all practising orthopaedic surgeons. That this is now imminent is to the credit of Marshall Urist.

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Sexual behaviour of men

SIR,—Dr A Mills raises a number of methodological criticisms[1] of our report on sexual behaviour in young and middle aged men in England and Wales.[2] In particular, he believes that our findings regarding the proportion of men who consider themselves to be homosexual may be neither valid nor accurate.

We reported that 1·7% of interviewed men stated that they had had homosexual intercourse at least once. We fully accept that the proportion of men who "experience homosexual attraction" may be higher than this. We were careful to emphasise that our figures were specifically concerned with intercourse, as only this is related to the spread