consumer satisfaction surveys; building into their contracts provision for ensuring that patients do not have to wait excessively long in outpatient departments; devising criteria for measuring the quality of life on the ward (as well as criteria for assessing the quality of the medical care delivered); and using the complaints system as a new way of learning about their own organisation. In all these respects the separation of the purchaser and provider functions should make it much easier for the new health authorities to innovate without being overly defensive; they may not represent the community, but neither will they represent the self interest of the organisation in the traditional way.

All this would therefore suggest that the main responsibility of community health councils will be to monitor the health authority rather than the services being provided and that their new function will be to look at whether in fact managers are taking adequate account of consumer interests in drawing up contracts and in the way they assess adequacy, accessibility, and appropriateness. No community health council can possibly represent the sheer diversity of often conflicting consumer interests in any population: given resource constraints, satisfying one group of consumers may mean leaving another lot frustrated. Surely the crucial responsibility of community health councils is, therefore, to audit the management and to give voice if managers interpret the consumer interest in an excessively technocratic or paternalistic way. But this argument needs to be qualified in one respect. The membership of the councils is deliberately biased towards the representation of the most vulnerable and least articulate consumers of NHS services, such as the elderly, the mentally ill, and the handicapped⁸—those with the least ability to assert their own interests. With regard to these groups there may well be a strong case for members of community health councils to continue to monitor the quality

of the services rather than to concentrate on monitoring the quality of management. Successive reports from the Health Advisory Service have made it clear that there is still cause for anxiety and that close contacts may be necessary to show what is happening.⁹

In summary, then, the new managerialism of the NHS will also call for a new consumerism, including a more prominent, if rather different, role for community health councils. Though in the past much irritation was caused by community health councils interpreting their function as one of challenging NHS providers, their main function may well be to challenge NHS managers. This responsibility will require more specialist skills as the NHS management process itself becomes more professional, and that may mean that the councils will need access to skills to match those of the accountants, planners, and public health specialists in the new managerial system.

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Graves' ophthalmopathy

Close liaison between physician and ophthalmologist essential

Most patients with Graves' disease have clinically apparent eye signs when first seen, though these may precede the onset of hyperthyroidism or follow its successful treatment by many years. Like the hyperthyroidism the ophthalmopathy is immunologically mediated, and the extraocular muscles seem to be the main target. Even in patients without clinical evidence of ophthalmopathy damage to the eye muscles may be shown by computed tomography¹ or ultrasonography.² The extraocular muscles undergo lymphocytic infiltration and are swollen, often to many times their normal size, by oedema. This is due to the hydrophilic properties of glycosaminoglycans, which are released by proliferating fibroblasts.³ As there is little space in the orbit the increased muscle mass causes a rise in retrobulbar pressure, which may lead to exophthalmos, excessive lacrimation, exposure keratitis, corneal ulceration, and—more seriously—a compressive optic neuropathy with reduction in vision.⁴ Paradoxically, the greatest visual loss may occur in patients with minimal exophthalmos. The function of extraocular muscles is impaired, and diplopia is common.

The mechanism underlying the retrobulbar immune damage is not known: no antibody has been identified that is in any way similar to the thyroid stimulating hormone receptor antibody responsible for the hyperthyroidism. Nor is it known whether the ophthalmopathy and hyperthyroidism

of Graves' disease are two closely related but independent organ specific autoimmune disorders (such as primary atrophic hypothyroidism and pernicious anaemia) and, if so, what the antigenically unique retrobulbar tissue is or whether they have a common immunopathogenesis and, if so, what the shared antigenic determinant is.

Does treatment of the hyperthyroidism of Graves' disease influence the progress of the ophthalmopathy? Published reports are bedevilled by claims and counterclaims.^{5,6} Most patients with Graves' disease are treated with iodine-131, and there is anecdotal evidence that ophthalmopathy may worsen after this treatment, presumably in association with the release of thyroid antigen. It has been suggested, indeed, that the administration of radioactive iodine is an inappropriate treatment in patients with considerable eye lesions.⁵ Nevertheless, a recent report by Bartalena *et al* is reassuring: this showed that prednisolone started at the same time as the administration of ¹³¹I in a dose of roughly 30 mg daily for one month and gradually withdrawn over the next three months prevented either the onset of or deterioration in mild ophthalmopathy.⁷ For patients with moderate or severe eye disease the sensible treatment seems to be the administration of a high dose of carbimazole (40 mg daily) combined with thyroxine 150-200 µg daily. This regimen is based on two principles: firstly, the hope that the well established immuno-

suppressive action of carbimazole will affect not only the thyroid but also the retrobulbar immune response, and secondly, to ensure a normal or undetectable serum thyroid stimulating hormone concentration—in view of the clinical observation that any tendency to hypothyroidism may make the eye disease worse. If thyroid surgery is indicated there is a basis for total rather than subtotal thyroidectomy, as thyroid antigens and antibodies might reach the orbit through the lymphatic system and trigger a local inflammatory reaction.⁸

The treatment of Graves' ophthalmopathy is far from satisfactory, and signs of disease may persist indefinitely. In patients with severe disease and visual loss immediate treatment with high doses of corticosteroids—either oral prednisolone or intravenous methylprednisolone—may avert blindness.⁹ Plasma exchange, by removing harmful but unspecified immunoglobulins and immune complexes from the circulation, may be a useful adjunct.¹⁰ If, however, there is no improvement after 72-96 hours the compression of the optic nerve should be relieved by surgical removal of the floor and medial wall of the orbit.¹¹

The main therapeutic problems, however, are posed by patients with moderate ophthalmopathy. Most clinicians adopt an expectant policy in the hope that the condition will settle spontaneously or at least improve substantially during the next two to three years—and it does in most patients. In the interim the symptoms of pain and grittiness may be ameliorated with methylcellulose eye drops by day and a lubricating eye ointment at night; exposure keratitis may be relieved by lateral tarsorrhaphy or preferably by a procedure to lower the upper lid; and diplopia may be relieved by prisms and possibly by surgery to the extraocular muscles at a later date. Static or worsening ophthalmopathy is often considered to be an indication for treatment with steroids, which may produce some improvement but do not modify the natural course of the condition. Maintenance doses of 10-20 mg of prednisolone daily are usually required—with all their potential disadvantages of osteoporosis, hypertension, and diabetes mellitus in a population that is usually middle aged or elderly. It is in the group of patients with moderate ophthalmopathy,

therefore, that the neglected treatment of orbital irradiation should be seriously considered at an early stage,¹² as should surgical decompression, especially if diplopia—the main complication of surgery—is already present. Patients should be advised to stop smoking, as this habit has been associated with ophthalmopathy.^{13 14} The distress caused by the appearance of the eyes, particularly in patients considered to have mild ophthalmopathy, should not be underestimated; more attention should be given to cosmetic eyelid surgery to correct lid retraction and to remove the prolapsed orbital fat that is responsible for the unsightly periorbital puffiness.¹⁵

The single most important aspect of the management of patients with Graves' ophthalmopathy, however, is close liaison between the physician and the ophthalmologist.

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Cervical cytology

The terms used on the smear report form provide a workable system

The report on a cervical smear should convey a clear message to the clinician who took it. The future management and welfare of the patient depends not only on accurate interpretation of the smear by the cytologist but on the effective communication of the result. The terminology and classification used must also provide an accurate basis for wider reference.

In 1986 a working party of the British Society for Clinical Cytology reported on terminology in gynaecological cytopathology.¹ Its recommendations were endorsed by the report of the intercollegiate working party on cervical cytology screening,² and the national cervical smear request form (HMR 101/5(1989)) has been redesigned to take account of the recommended terminology.

Smears from women with cervical intraepithelial neoplasia or invasive carcinoma contain cells that show dyskaryosis ("abnormal nucleus"). Dyskaryosis is classified as mild, moderate, or severe according to its compatibility with cervical intraepithelial neoplasia grades I, II, or III (CIN

I, II, and III)—mild, moderate, or severe dysplasia and carcinoma in situ in the old histological terminology. A smear with severe dyskaryosis may contain certain features that are associated with invasive cancer, and the report draws attention to these; but a definite diagnosis of invasion can be made only by using a histological biopsy specimen.

Problems arise in practice when attempting to impose a rigid classification on an assessment that is a subjective interpretation of a continuous range of disease. Inevitably there must be examples that fall between the defined abnormalities. In cervical cytology it is the borderline between reactive change, usually described as inflammatory, and the mild dyskaryosis of CIN I that presents the most frequent challenge to the cytologist. A variable degree of inflammatory change is seen in all cervical smears, but the appearance of the epithelial cells in a few cases is so nearly dyskaryotic that cervical intraepithelial neoplasia cannot be excluded entirely. These equivocal smears are classified as borderline in the new report format.