As the microcomedo is a precursor of many acne lesions it is reasonable to introduce a topical retinoid (or retinoid-like drug, such as adapalene). Such drugs reverse formation of comedones. Retinoids should be used early on and continued throughout much of the treatment programme. In contrast to the United States, the topical retinoid tazarotene is not licensed for acne. A topical retinoid can be used in the evening and an antimicrobial agent in the morning. It is important to emphasise the benefit of benzoyl peroxide, which may reverse the increasing problems of resistance to *Propionibacterium acnes*. Benzoyl peroxide can be used in combination with oral and topical antibiotics or during "antibiotic holidays" (breaks from antibiotic use).

We agree that when an oral antibiotic is needed, oxytetracycline is the first choice. More expensive preparations are not proved to be more effective. As a second line drug, minocycline is worth trying. General practitioners should be aware of the possible side effects, especially drug induced lupus.[4] General practitioners in the United Kingdom prescribe minocycline in a dose of 100 mg a day but American dermatologists regularly prescribe 200 mg a day. Generic trimethoprim is both effective and inexpensive.

Patients should be warned to expect little improvement in the first month, but thereafter they should expect about 20% improvement a month. After successful control of the disease, maintenance treatment with topical agents is essential. Oral antibiotics should be reintroduced if the acne occurs.

Women with acne who need the contraceptive pill for gynaecological reasons are often prescribed cyproterone acetate and oestrogen (Dianette) and topical treatment. Oral isotretinoin is highly effective at treating acne, but in the United Kingdom it can be prescribed only in secondary care because of its teratogenicity and the risk of adverse psychiatric events. In the United States the prescribing of oral isotretinoin and contraceptive advice is very proscriptive. UK guidelines are expected soon. The idea of prescribing oral isotretinoin in the community is a matter of debate. If general practitioners with a special interest in dermatology were able to prescribe isotretinoin it may reduce the waiting time for secondary care. However, any small changes in the threshold for prescribing isotretinoin could have serious financial implications for the NHS.[5]

1 Associate Parliamentary Group on Skin. *Report on the enquiry into primary care dermatology care services*. London: APGS, 2002:1.
2 National Prescribing Centre. The treatment of acne vulgaris: an update. *MeReC Bulletin* 1999;10(8):29-32.
3 National Institute for Clinical Excellence. Referral Advice. *A guide to appropriate referral from general to specialist services*. London: NICE, 2001:7-8.
4 Gough A, Chapman S, Wagstaff K, Emery P, Elias E. Minocycline induced autoimmune hepatitis and systemic lupus erythematosus-like syndrome. *BMJ* 1996;312:169-72.
5 Williams HC. H*ealth care needs assessment: dermatology*. Oxford: Radcliffe Medical Press, 1997:34-6.

Corrections and clarifications

Randomised trial of endoscopy with testing for Helicobacter pylori compared with non-invasive H pylori testing alone in the management of dyspepsia
In this paper by K E L McColl and colleagues (27 April, pp 999-1002), we inadvertently published the wrong date for when we finally accepted the paper for publication. The correct acceptance date was 20 December 2001 [not 2 February 2002].

A time for global health
In this editorial by Richard Smith (13 July, pp 54-5), we managed to mangle a currency conversion. In the second sentence of the third paragraph, $119bn is £76bn (exchange rate at time of writing this correction), not £158bn, which is patently wrong, even with the recent shifting exchange rates. We should also have followed our policy, in place since 1 January 2002, of including a conversion to euros (which would be €121bn).