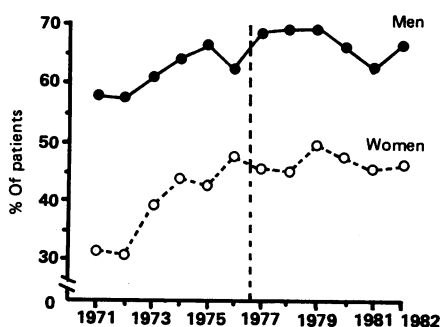


Dunfermline: parasuicide rates rose to a peak in 1976 and fell in 1977 and subsequent years. In Oxford there was also a decline in the rate among women but a rise in the rate among men from 1976 to 1977. Thus trends in 1976-7 among men were in the opposite direction to that predicted by the licensing law effect hypothesis: the parasuicide rate fell in Edinburgh and rose in Oxford.

I also examined trends in the use of alcohol at the time of parasuicide among patients admitted to the regional poisoning treatment centre at Edinburgh's Royal Infirmary in an attempt to replicate the changes noted at Milesmark Hospital. (Although about 10% of cases admitted to the centre are self injuries, this proportion does not differ significantly from year to year. The trends reported here almost certainly apply to the subgroup of self poisoners alone.) Following the method of presentation of Dr Northridge and colleagues I show the proportions of patients taking alcohol at the time of their parasuicide in two six year periods before (1971-6) and after (1977-82) the change in the law (table) and yearly trends (figure). Between 1971 and 1976 there was a

*Proportions of patients admitted to regional poisoning treatment centre, Edinburgh, taking alcohol at time of parasuicide before and after change in licensing laws*

	1971-6		1977-82	
	Total No of patients	No (%) taking alcohol	Total No of patients	No (%) taking alcohol
Men	2166	1342 (62)	2387	1611 (68)
Women	4121	1639 (40)	4004	1876 (47)



Percentage of patients taking alcohol at time of parasuicide 1971-82.

5% increase (95% confidence limits 2% to 8%) among men and a 7% increase (95% confidence limits 5% to 9%) among women. Although both these changes were significant, there was only a modest 6% increase between 1976 and 1977 among men, while there was actually a 2% decrease among women. As the figure shows, the upward trend in the use of alcohol started in 1972 and peaked in 1979. Again, trends in Edinburgh are dissimilar to those reported for Dunfermline. These discrepancies must raise doubts about the interpretation of the Dunfermline data offered by the authors.

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### Long live health promotion

SIR,—In his leading article on the recently announced management reorganisation of the Health Education Council (6 December, p 1457) Dr

Richard Smith raises a number of critical issues about effective health promotion. In particular, he makes the interesting suggestion that the new authority which is to be responsible for health promotion from 1 April 1987 might be accountable to a senior interdepartmental standing committee derived from the cabinet subcommittee responsible for the acquired immune deficiency syndrome. It is increasingly clear that policies in sectors outside health, such as agriculture, transport, and energy, have profound implications for people's health, and the interdepartmental ramifications of tobacco and alcohol are notorious, though still not tackled properly.

Consideration might also be given to an alternative method of creating accountability for public expenditure on health promotion that has more credibility than the traditional but largely bogus formula of "accountability through ministers to parliament." (With an inflated majority through disproportionate representation such accountability on most occasions really means cabinet control at best and prime ministerial control at worst.)

The Public Accounts Committee of the Commons provides a regular example of the diligent pursuit of financial accountability which is unarguably political as well as competent but characteristically non-partisan. For health promotion that is precisely the kind of approach needed but with accountability for health as well as money. It is an understatement to observe that parliament innovates slowly and with difficulty, even when there is a precedent, but might consideration not be given to an appropriate widening of the role of the Commons Social Services Committee?

However, while the effectiveness of health promotion in Britain clearly needs to improve, and that will require attention to involuntary unemployment and poverty, this is quite the wrong time to disorganise the Health Education Council. The health professions have too much experience of ill prepared and ill timed reorganisations to countenance yet another, and in the middle of the AIDS crisis. Mr Fowler should withdraw his proposal and when he has done his homework consult before he acts.

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### Human papillomavirus infection of the uterine cervix of women without cytological signs of neoplasia

SIR,—Dr Philip G Toon and colleagues (15 November, p 1261) provide further evidence that no absolute correlation exists between the degree of abnormality on a cervical smear and the eventual cervical histology. It is already known that patients with mild dyskaryosis may be harbouring any degree of cervical intraepithelial neoplasia (CIN) or microinvasive or invasive carcinoma,<sup>1,2</sup> and it appears that the same pattern is beginning to emerge for women showing non-specific inflammatory changes.

The authors' findings have been confirmed and extended by my own retrospective analysis of cervical biopsy records, which has shown that non-specific inflammatory changes on cervical smears may be associated with cervical adenocarcinoma in situ and microinvasive squamous carcinoma as well as CIN.

The cytology records of women undergoing cervical biopsy from April 1984 to April 1986 were reviewed (n=342). Colposcopy directed biopsy had been performed on 10 patients with recurrent inflammatory smears and no reported dyskaryosis. Review of the original cytology resulted in one case being reclassified as dyskaryotic and this was omitted from the series. No infective agent was

identified in any smear, and histological signs of human papillomavirus infection were absent. After biopsy six (mean age 36 years; range 27-49) of the nine patients were identified as having significant histological abnormalities: CIN 2 (1), CIN 3 (2), microinvasive squamous carcinoma (1), and adenocarcinoma in situ (2).

I agree with the conclusion that patients showing non-specific inflammatory changes should be paid as much attention as those displaying dyskaryosis. However, as each of our patients had undergone two to five repeat smears over eight to 16 months before referral to a gynaecologist, the suggestion by Dr Toon and others of frequent, regular repeated cervical smears as a bare minimum would seem inappropriate. On current evidence it would appear that these women should be referred for colposcopic examination and biopsy with the same degree of urgency as those displaying dyskaryosis.

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1 Cotton RE, Elwood JM, Jones GM. Results of delayed follow-up of abnormal cervical smears. *Br Med J* 1986;292:799-800.

2 Slater D, Duke E. Cervical smear policy. *Lancet* 1985;ii:1305.

SIR,—Dr Philip G Toon and others dismiss the role of bacterial infection in the aetiology of non-specific inflammatory cervical smears on the basis of very low isolation rates for all organisms in their patient sample.

As part of a larger study into the role of factors other than human papillomavirus in cervical premalignancy 51 women, initially referred to the colposcopy clinic at the Western Infirmary, Glasgow, with mildly abnormal findings on cervical cytology, were found to have histological evidence of non-specific cervicitis without evidence of cervical intraepithelial neoplasia or human papillomavirus infection. These, and 24 women with normal findings on cervical cytology, no history of vaginal discharge, and no history of previous cervical abnormality, underwent a full colposcopic examination.

Endocervical swabs for *Chlamydia trachomatis* and herpes simplex virus were obtained. High vaginal, urethral, and endocervical swabs were obtained for anaerobic and aerobic culture. Directed punch biopsy specimens of any colposcopically abnormal areas were taken, and when no colposcopic abnormality was visualised two random biopsy specimens were taken from the transformation zone. All women with mildly abnormal smears and no colposcopic or histological evidence of cervical intraepithelial neoplasia were reviewed six months later.

Our results, admittedly on a smaller sample than

### Organisms isolated in three groups of women

	Abnormal cytology, abnormal colposcopy (n=37)	Abnormal cytology, normal colposcopy (n=14)	Normal cytology, normal colposcopy (n=24)
Mean age (range) (years)	29.4 (17-48)	34.2 (24-54)	35.5 (24-56)
Mean parity (range)	1.2 (0-5)	2.0 (0-6)	2.7 (1-6)
No (%) with positive isolates	19 (51)	9 (64)	14 (58)
Isolates:			
Chlamydia	2	3	0
Trichomonas	2	2	1
Gardnerella	1	0	0
Group B streptococcus	4	2	3
Streptococci	1	1	2
Candida	1	1	4
Coliform organisms	4	2	2
Enterococci	6	1	4
Bacteroides	2	0	1