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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Immunisation policies

SIR,—Dr Charles Brook's leading article (2 April, p 1082) on immunisation policies requires an answer on several counts. I can find no mention in the reference quoted[1] of an increase in neonatal rubella in 1982. The statement attributed to Dr W C Marshall of an increased reporting of neonatal cases could be the result of his stimulus to paediatricians and others to report cases of congenital rubella syndrome to the Southern Registry when he took over from me in January 1982. The statement that: "No scientific defence is possible of the current British approach to rubella vaccination," is without foundation. The evidence was well prepared from detailed scientific studies and has been fully documented.[2] As far as I can see there is no reference in the article by Hinman *et al*[3] that the UK policy is lacking in scientific support.

I am not surprised by the poor vaccine acceptance rates for measles and pertussis in the Brent Health District, to which Dr Brook refers. Having tried to teach the values of preventive medicine for many years, I am aware of the apathy and lack of interest in measles vaccination within our profession. I share the view of Professor A G M Campbell[4] that measles is not such a trivial and innocuous disease that prevention is unnecessary. He suggests ways of improving the uptake of measles vaccine in this country, but I doubt whether we could reach a level of acceptance comparable to that of the United States without a change in attitude and some compulsion. And this is a big point—whether to use monovalent or combined vaccines and at what age immunisation should start. The two are interrelated.

Dr Brook is advocating a complete review of our immunisation policy; presumably against rubella and measles, but this is not clear. It is as well to distinguish between strategy and tactics. With rubella the strategy, whether in the UK, US, Sweden, or elsewhere, is clear—the control and ultimate elimination of congenital rubella infection and therefore of rubella defects. The tactics, however, to achieve this purpose can be different. At a recent conference in Baltimore we discussed current vaccination policies,[5] and there was general agreement that a policy that worked well in one country did not necessarily provide the best answer for another. Unless acceptance rates for measles vaccine can be improved in the UK a change to the US scheme, which is dependent on the use of combined measles-mumps-rubella vaccine and a degree of compulsion, could be disastrous for us. This does not mean that a review of priorities for receiving vaccine should not be undertaken. I agree with Hinman *et al*[3] that it should, and women of childbearing age are a most important priority group for both countries. The US approach is having an impact on the control, but congenital rubella has not yet disappeared. An outbreak of congenital rubella in Chicago,[6] admittedly in 1978, brought out some of the problems of vaccine delivery which are common to both our countries. None of the mothers in this episode had been vaccinated.

The US scheme is also based on the assumption that vaccine induced immunity will be lifelong.[3] We are not so certain, and this particular problem was a key factor in deciding on our policy in 1970. Surveillance of immunity following vaccination is essential, as workers in this country have recently shown.[7]

I wonder whether Dr Brook has made the correct diagnosis in directing his wrath at those who help make policy decisions rather than at those whose responsibility it is to implement them. Our main obstacles at present are apathy, ignorance, excuses, and above all failure in the delivery system. These can be overcome by an all out effort at intensifying our current campaign aimed at immunising 95% not 85% of girls aged 10-14 years and by a special effort at immunising susceptible women. Congenital rubella is a preventable disease. We have available good vaccines. Let us deliver them to those who need them without losing our sense of direction.

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1 Communicable Disease Report (CDR) 82/36 10 September 1982.
2 Proceedings of the International Conference on Rubella Immunization. *Amer J Dis Child* 1969;**110**: 1-410.
3 Hinman AR, Bart KJ, Orenstein WA, Preblund SR. Rational strategy for rubella vaccination. *Lancet* 1983;i:39-41.
4 Campbell AGM. Measles immunization. Why we have failed. *Arch Dis Child* 1983;**58**:3-5.
5 Dudgeon JA. Current views on international control of rubella. In: Gruneley E, ed. *Conquest of agents that endanger the brain.* Baltimore: Johns Hopkins Hospital (in press).
6 Lamprecht C, Schauf V, Warren D, Nelson K, Northrop R, Christiansen M. An outbreak of congenital rubella in Chicago. *JAMA* 1982;**247**: 1122-33.
7 O'Shea S, Best J, Banatvala JE, Marshall WC, Dudgeon JA. Rubella vaccination: persistence of antibodies for up to 16 years. *Br Med J* 1982;**282**: 253-5.

Underdiagnosis and undertreatment of asthma in childhood

SIR,—In order to lend further weight to the points made by Dr A N P Speight and others (16 April, p 1253) and to widen the relevance of their survey, we report the following findings from a community campaign against childhood asthma in 4-11 year olds in west Newcastle.