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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.

Trimming fat or cutting bone?

SIR,—It is good to see the *BMJ* (17 September, p 780) recognising, even if somewhat belatedly, that "clinicians may have to accept that they can no longer claim total freedom to order investigations and prescribe treatments as they think best" and that "doctors should be seen to be willing to cooperate in efforts to improve their cost effectiveness."

It would be even more welcome if these sentiments were accompanied by a willingness on the part of the profession to try to understand what cost effectiveness and other forms of economic analysis entail. Certainly in the correspondence courses in health economics which we run from this department, we find administrators, nurses, finance staff, etc—and indeed community medicine specialists—applying in goodly numbers. Yet, with a closing date for next year's courses of 31 October, we again find, as in previous years, that applications from hospital clinicians and general practitioners are very few. Is it that they do not want to know about economics? Or do they think (falsely in the vast majority of cases) that they already do know?

The Danish Medical Association is adopting a different tack from that of the BMA in its somewhat similar plight of facing cuts in health care spending. It is considering setting up courses in health economics to allow Danish doctors to understand the language of economics and thereby better equip the profession with the necessary skills for dealing with problems of scarce resources. Certainly it takes nearly as long to train as an economist as it does to train as a doctor. But for doctors to train in the basic way of thinking of economics—if they show willing, of course—can be achieved in a few months.

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Congenital toxoplasmosis

SIR,—It may be of interest to add some current data from Scotland (17 September, p 835) to the epidemiological analysis of congenital toxoplasmosis in England, Wales, and Northern Ireland 1975-80 (13 August, p 453).

The Scottish prospective survey mentioned by Dr Susan M Hall was carried out in the west of Scotland during the years 1975-8[1]; since then two further antenatal populations in Scotland have been examined, one in central Scotland based on Perth from 1979 to 1983, and the other in Inverness from 1980 to 1983. The central Scotland study was in abridged form and was concerned mainly with the possibilities of detecting infection in antenatal populations in a multidisciplinary laboratory using a simple haemagglutination screening test; the Inverness study was part of a combined survey of antenatal patients for rubella, cytomegalovirus, and toxoplasma infection,[2] using enzyme-linked immunosorbent assay tests for toxoplasma IgG and IgM[3] antibodies with confirmatory dye tests, and the investigation is still incomplete. The results are as follows.

Perth—Haemagglutination tests on an antenatal population of about 7000 in four years showed 24 women to have a dye test titre of $\geqslant$ 1/512. In five the presence of specific IgM was confirmed. These figures would indicate a range of maternal infection from one in 300 to one in 400 pregnancies. One neonatal death occurred in the group, thought to be due to toxoplasmosis, and one placenta yielded the parasite, although the baby in this pregnancy and all other babies in the group appeared normal at birth.

Inverness—A total of 4245 pregnancies have been followed up using booking blood and cord blood serum only. At first examination 17% of women were seropositive; only three seroconversions were detected, all at low level. Eleven women had dye test titres of $\geqslant$ 1/512 at some time during pregnancy, and specific IgM was detected in three of them. Specific IgM was also detected in two women where dye test titres were less than 1/512. Thus the serological evidence for current infection in pregnancy was maximally 16 and minimally probably three, somewhere between 1 in 250 and one in 1500. So far only one baby is definitely infected, and there has been one neonatal death in the group. All the other babies in these pregnancies appeared normal at birth. Toxoplasma was recovered from only one placenta out of four examined.

The number of maternal infections detected in Perth and Inverness is considerably lower than that found earlier in the west of Scotland, where the maternal infection calculated on the same basis ranged from one in 50 to one in 400. This may have been due to the inherent limitations of the later surveys, but it coincides also with a decrease, first noted in 1979, in the overall numbers of new cases of toxoplasmosis diagnosed yearly in Scotland. Whatever the maternal infection rate, a major difficulty lies in ascertaining infection in infants in the absence of clinical signs, and in our experience infection can seldom be shown where maternal seroconversion has been at a low level, even when sensitive IgM enzyme-linked immunosorbent assay tests are used. There do seem to be differences in the incidence and severity of congenital toxoplasmosis between Britain and mainland Europe; what gives rise to these differences is hard to pinpoint; perhaps the tendency