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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.

PHLS inquiry into current BCG vaccination policy

SIR,—In its code of practice for the control and prevention of tuberculosis (15 October, p 1118) the Joint Tuberculosis Committee of the British Thoracic Society recommended that BCG vaccination should continue to be offered routinely to schoolchildren aged 10-14. It was emphasised that the policy should be maintained everywhere, including regions that currently have a low prevalence of tuberculosis. In the light of this recommendation the results of a recent inquiry by the epidemiological research laboratory of the Central Public Health Laboratory into current BCG vaccination policies may be of interest.

Inquiry forms were sent to and returned by all 201 district health authorities in England and Wales. The inquiry concerned the current practice of BCG vaccination in schoolchildren and neonates as well as the policy for prevaccination tuberculin tests, the grade considered to indicate that vaccination is unnecessary, and the method of vaccination.

Five of the 201 districts contacted have stopped routine vaccination of schoolchildren; two in 1974 and one each in 1977, 1980, and 1983. In all five districts neonatal immigrants and contacts are vaccinated, and in one Heaf testing continues. Ten districts have their policy under review, while the remaining 186 districts continue routine vaccination.

Ninety eight districts gave vaccination to neonatal contacts and/or immigrants, and six to all neonates; one is about to change from vaccination of selected neonates to vaccination of all neonates; and two are about to start neonatal vaccination. A total of 88 districts have no routine vaccination of neonates, and in six the policy is under consideration.

Of the 196 districts currently giving routine vaccination to schoolchildren 184 do so in children aged 11 to 14 (most during the 13th year); eight in children aged 10-11; one in children aged 5-13; two in those aged 5 (one of which vaccinates immigrants only); and one in the newborn, school entrants, and those aged 13. One hundred and fifty two districts use syringe and needle for vaccination, 16 jet gun only, 26 both jet and syringe, and two multipuncture. Three districts have changed from jet to syringe, and two others are considering a change.

Almost all districts (187) use the Heaf test, five use the Tine test, and three use the Mantoux test, while two districts use no prevaccination test. Of the 187 districts using the Heaf test most (148) take grade 2 to indicate no vaccination, 12 take grade 1, and 26 grade 3.

The results show considerable variation in the current BCG vaccination policy in different districts in England and Wales. While in five districts routine vaccination of schoolchildren has ceased and in 88 there is no neonatal vaccination, in others the policy for neonates is being introduced or extended. In districts where routine vaccination of schoolchildren has stopped the current rate of notification of tuberculosis is considered too low for vaccination to be justified. It is argued that notifications in these districts have not risen since the end of vaccination, in one case as much as 10 years ago. However, if young people who are unvaccinated leave their homes to seek work and subsequently develop tuberculosis they will appear as notified cases in the areas to which they have moved rather than in those that they have left.

The geographical distribution of tuberculosis in England and Wales in 1978-9 showed wide variation, in some cases unexpected.[1] For instance, the local authority with the highest rate (excluding Greater London) was Rutland, a rural area with virtually no immigrant population. This was due to an outbreak of 24 cases in a primary school (before the age of vaccination) caused by a teacher whose sputum was positive. Several outbreaks of tuberculosis in the past five years have shown that tuberculosis is still present and not only among immigrants, alcoholics, and the old. The most recently reported outbreak was caused by a single focal case in a patient aged 31, who infected 41 patients aged from 4 to 37, in nine of whom sputum became positive.[2]

To allow the proportion of unvaccinated young people to increase while more than 6000 new cases of tuberculosis are notified annually must be to increase the risk of disease, which may well not be diagnosed until others have been infected. The population is highly mobile; Brent (annual notification rate 114·3/100 000) and Oxfordshire (11·7/100 000) are only 40 miles apart.

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[1] Medical Research Council. Geographical distribution of tuberculosis notification in national survey of England and Wales 1978-9. *Tubercule* 1982;**63**: 75-88.
[2] Hill JD, Stevenson DK. Tuberculosis in unvaccinated children, adolescents, and young adults: a city epidemic. *Br Med J* 1983;**286**:1471-3.

Rubella immunisation: whose baby?

SIR,—Dr Stephen E Blair (14 January, p 145) asks if it would not be more advisable to immunise all children at the age of 1 year against rubella, as suggested by Hinman *et al*,[1]