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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Helping the sick doctor

SIR,—The initiative described by Professor K Rawnsley (5 October, p 922) is welcome. Competence to practise is crucial to the function of the General Medical Council, but as far as sickness (and health) of the profession is concerned it merely touches the tip of the iceberg.

During my professional career I have been concerned particularly with sick consultants and, although they do not have the same inhibitions in seeking help as those in cases that concern the GMC, other factors operate to prevent their having access to an effective health or sickness service. The first and most important is that no such facility exists at district or regional level.

The occupational health service as it stands may be adequate for nurses and ancillary staff but it is certainly inappropriate for consultants. They also may feel awkward and embarrassed at the thought of approaching colleagues and may have equal difficulty in confiding in their own general practitioners. The result is the traditional "kerb-side" consultation, with an embarrassed and minimised account of the problem, which may attract a superficial reassurance, possibly based on a casual blood or x ray examination. I have subsequently seen colleagues who have sought help in this way only to find that they do in fact have a serious or fatal condition. The hierarchical position of the consultant in the National Health Service produces a negative discrimination as far as his own health is concerned that I have observed in no other profession.

I believe there is a need for a personalised health service for consultants and general practitioners at district or regional level, a facility to which a doctor could go with any sort of health or sickness problem and for advice on lifestyle, work patterns, etc, rather similar to but better than the average BUPA executive check. Critics may say why are consultants and principals in general practice different? Why should they have this luxury? It is not a luxury, it is a necessity; it is a facility to which they do not have access at the moment, and I am sure there are many general physicians approaching retirement who would provide the professional expertise at a minimal cost.

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Is the incidence of ectopic pregnancy rising?

SIR,—Messrs Michael Burke and Peter Dale wonder whether the incidence of ectopic pregnancy is rising (5 October, p 967). It is known that *Chlamydia trachomatis* is a major and increasingly common cause of pelvic inflammatory disease[1]; the resultant tubal damage may predispose to ectopic gestations. We have studied women with severe tubal damage who sought treatment of their infertility by in vitro fertilisation and embryo replacement. The study group comprised 114 women at Bourn Hall Clinic, Cambridge,[2] and 98 women attending the regional in vitro fertilisation unit at St Mary's Hospital, Manchester. The number of women with known tubal disease in Cambridge was 90/114 (79%) and in Manchester was 83/98 (85%). The modified microimmunofluorescence test was used to provide serological evidence of exposure to *C trachomatis*.[3] In those women with known tubal disease the exposure to this pathogen was, as expected,[4] much greater than in those with non-tubal causes for their infertility (57% *v* 13%). Thirty nine women gave a history of ectopic pregnancy and 27 (69%) of these had evidence of previous chlamydial disease (table). In eight cases the titres were compatible with active cervical infection.[5]

Many infertile women seeking in vitro fertilisation and embryo replacement have evidence of genital infection with *C trachomatis* and often they have received treatment which has been ineffective or inappropriate for the organism.[6] Their sexual partners may never have been investigated or treated, permitting the possibility of recurrent damage to the genital tract. In many women ectopic pregnancy may represent a late presentation of a previously unrecognised chlamydial infection. It would seem appropriate, therefore, that all women who have surgery for their first ectopic pregnancy should be investigated for *C trachomatis*. This should include serology to detect all cases of *C trachomatis* infection. Correct diagnosis and treatment at this stage for both partners may improve the function of the remaining fallopian tube or enhance the outcome of any conservative tubal surgery for ectopic pregnancy.[7]

As resources for in vitro fertilisation and embryo replacement are limited in the NHS it is important

Results of microimmunofluorescence chlamydia serology in patients with history of ectopic pregnancy

No of ectopic pregnancies	No of patients	No seropositive
1	26	17
2	12	9
3	1	1
Total	39	27