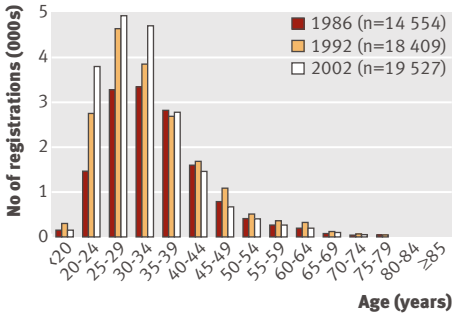
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

CERVICAL SCREENING

Women under 25 should be offered screening

There may be several reasons why cervical screening coverage in young women has fallen yet again, including problems with access to appointments with general practitioners, but the new policy not to screen women aged 20-24 can hardly have helped.[1] It was announced with the message that screening that age group caused more harm than good, which is unlikely to encourage them to accept their invitations from age 25. Prevalence of carcinoma in situ (CIN3) has increased in women aged 20-24 (figure), which is consistent with more women in recent birth cohorts starting sexual activity in their mid-teens.



Registrations of carcinoma in situ (CIN3), England (source: www.statistics.gov.uk)

The new policy will add more than 3000 women with untreated CIN3 to the larger numbers failing to accept their invitations later on. We accept that any degree of CIN may regress, invasive cervical cancer (ICC) is rare in women under 25, and screening does little to reduce its incidence in such young women. However, ICC can develop within a couple of years of missed high-grade cytology, failure to investigate cytological abnormalities, or incomplete treatment,[2] emphasising the importance of treating high-grade CIN when it is found.

Screening in the UK has been highly successful since it was centrally organised in 1988: incidence and mortality have fallen by more than 40% despite increased risk of disease.[3] This has been achieved by treating high-grade CIN, particularly CIN3, in young women. The peak prevalence of CIN3 is in women aged 25-29 amongst whom the fall in coverage has been greatest.

ICC is more difficult to prevent in young women because there are less screening opportunities to treat these lesions before they become invasive.[4] The peak incidence of ICC in the screening age groups is now in women aged 35-39. Most of these cancers are detected by screening at an early and treatable stage.[4]

Decisions about treatment of CIN should be based on a balance between risk of progression, likelihood of regression, and risk of treatment.[5] Women should be informed about the risk of high-grade CIN, its greater frequency in young women, the importance of surveillance of low grade abnormalities, and the fact that an epidemic of cervical cancer has been prevented by screening wo men when they were young.[2] General practitioners and clinics should not be prevented from screening women whom they believe to be at risk if those women themselves want to be screened.

Amanda Herbert consultant histopathologist and cytopathologist, Guy's and St Thomas' NHS Foundation Trust, London SE1 7EH amanda.herbert@kcl.ac.uk
John H F Smith consultant histopathologist and cytopathologist, Royal Hallamshire Hospital, Sheffield S10 2JF

Competing interests: None declared.

1. News. In brief. Women attend fewer smear tests. *BMJ* 2007;334:172. (27 January.)
2. Janerich DT, Hadjimichael O, Schwartz PE, Lowell DM, Meigs JW, Merino MJ, et al. The screening histories of women with invasive cancers, Connecticut. *Am J Public Health* 1995;85:791-4.
3. Peto J, Gilham C, Fletcher O, Matthews FE. The cervical cancer epidemic that screening has prevented in the UK. *Lancet* 2004;364:249-56.
4. Herbert A. Screening young women: how soon should we start? *HPV Forum* (in press).
5. Kyrgiou M, Koliopoulos G, Martin-Hirch P, Arbyn M, Prendiville W, Paraskevaidis W. Obstetric outcomes after conservative treatment for intraepithelial or early invasive cervical lesions: systematic review and meta-analysis. *Lancet* 2006;367:489-98.

MALIGNANT PLEURAL EFFUSION

Video assisted thoracoscopic surgery is still the standard

We were surprised that Rahman et al did not mention video assisted thoracoscopic surgery in investigating malignant pleural effusion.[1] For more than 15 years it has been the cornerstone of investigation and palliation of such disease in those fit for general anaesthesia.[1] Complex loculated effusions can be evacuated and the pleural cavity debrided appropriately.

The systematic examination of the mediastinum, pericardium, and diaphragm as well as the visceral pleura and underlying lung is easily and safely performed. Multiple targeted pleural biopsies can be performed, as well as biopsies of mediastinal nodes as required.

The expansion of the lung in response to positive pressure ventilation determines the appropriate method of palliation. If there is apposition of the visceral and parietal pleura talc pleurodesis is the method of choice, where this does not occur talc is detrimental and potentially leads to empyema. In most series, surgical talc insufflation provides superior palliation to talc slurry.

Lastly, as a thoracic surgeon operating on a large volume of patients with malignant mesothelioma, video assisted thoracoscopic surgery represents an excellent staging tool and determinant of the best surgical option for such patients.

Loic Lang-Lazdunski consultant thoracic surgeon loic.lang-lazdunski@gstt.nhs.uk, **John E Pilling** specialist registrar in thoracic surgery, Department of Thoracic Surgery, Guy's Hospital, London SE1 9RT

Competing interests: None declared.

1. Rahman NM, Davies RJO, Gleeson FV. Investigating suspected malignant pleural effusion. *BMJ* 2007;334:206-7. (27 January.)

Tuberculosis is differential diagnosis in developing world

In countries with a high prevalence of tuberculosis, malignancy is still the commonest cause of bloody pleural effusion, but the next most common causes are tuberculosis and trauma.[1 2] Accordingly, in the absence of associated stigmata of malignancy, even pleural effusion whose outward appearance is highly suggestive of malignancy should be considered to be potentially tuberculous, and appropriate tests should be instigated if initial investigations do not confirm malignancy. In this context, appropriate tests for tuberculosis include not only closed biopsy (with histology and culture),[1] but also measurement of interferon γ in the pleural fluid.[3]

Oscar M Jolobe retired geriatrician, Didsbury, Manchester M20 2RN oscarjolobe@yahoo.co.uk

Competing interests: None declared.

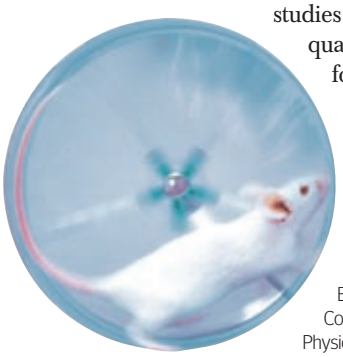
1. Rahman NM, Davies RJO, Gleeson FV. Investigating suspected malignant pleural effusion. *BMJ* 2007;334:206-7. (27 January.)
2. Onadeko BO. Haemorrhagic pleural effusion in Nigerians. *Trop Geogr Med* 1979;31:57-61.
3. Aoe K, Hiraki A, Murakami T, et al. Diagnostic significance of interferon-gamma in tuberculous pleural effusions. *Chest* 2003;123:740-4.

ANIMAL TESTING

A broader view of animal research

Perel et al examined only immediate preclinical testing of new drug therapies,[1] but animal research aids medical science in many more ways. Animal studies play a part in the initial development of candidate drugs, and the development and testing of medical devices and surgical procedures. Even more crucial, animal research informs clinical research by building the foundation of biological knowledge. Basic research that expands our understanding of how life systems function indicates to clinicians not only what direction to pursue but what directions are possible.

Although animal research informs clinical research, its circumstances and experimental goals differ from those of clinical research. Thus their protocols and experimental designs necessarily differ. Animal studies generally seek a mechanism of action for treatment, rather than treatment efficacy. They are usually conducted on defined, genetically homogenous subjects with near perfect compliance, as opposed to the large scale diversity of genetics and behaviour of a clinical population. Some clinically necessary procedures, such as double blinding, serve little purpose in an animal study, since rats are not susceptible to the placebo effect. Furthermore, accepted standards for animal welfare as well as many national and institutional protocols insist that sample sizes of animal studies be small. Despite these differences, the protocol used by Perel et al to determine that the animal studies were of "poor" quality was based, for the most part, on standards meant for large clinical trials.



Timothy I Musch professor chair, Animal Care and Experimentation Committee, American Physiological Society Department of Anatomy and Physiology, College of Veterinary Medicine, Kansas State University, Manhattan, KS 66506, USA
Robert G Carroll, Brody School of Medicine, East Carolina University, Armin Just Department of Cell and Molecular Physiology, University of North Carolina at Chapel Hill
Pascale H Lane, Department of Pediatrics, University of Nebraska Medical Center
William T Talman chair, FASEB Animal Issues Committee, Department of Veterans Affairs Medical Center, University of Iowa College of Medicine

Competing interests: None declared.

1. Perel P, Roberts I, Sena E, Wheble P, Briscoe C, Sandercock P, et al. Comparison of treatment effects between animal experiments and clinical trials: systematic review. *BMJ* 2007;334:197-200. (27 January.)

Studies in animals should be more like those in humans

The settings of animal studies are very different from those of therapeutic studies in human patients.[1] They need to be more similar.

In clinical studies, a human subjects committee must approve the methods of the study, determining that it is of sufficient power to produce a meaningful result and that the risk:benefit ratio is acceptable. There should be animal subject committees similarly to scrutinise drug trials in animals. The task of such committees would be to assess sample size, randomisation of treatments, blinding of observers, selection of animal subjects, statistical methods, and elimination of biases that may be introduced by the pharmaceutical company that sponsors the work.

Alexander S D Spiers retired professor of medicine Cookham Dean, Berkshire spiersuk@btinternet.com

Competing interests: None declared.

1. Hackam DG. Translating animal research into clinical benefit. *BMJ* 2007;334:163-4. (27 January.)

BORDER CROSSING

Alliance of regulators addresses professional mobility

Two articles reflect recent media interest in health tourism in the context of the European Commission consultation on health services in Europe.[1,2] What neither article addresses is the equally important issue of professional mobility that provides the other focus of the commission's consultation.

In 2005, over 7000 healthcare professionals from the European Economic Area registered with UK regulatory bodies for the first time so that they could work in this country. The United Kingdom has undoubtedly benefited from this high degree of professional mobility, with many dedicated individuals contributing positively to UK health care. But the EU rules that facilitate this level of mobility must also ensure proper protection for patients and the public.

The Alliance of UK Health Regulators on Europe (AURE) brings together the 10 health and social care regulators in the UK to work collaboratively on European issues affecting patient and client safety. While ensuring that professionals are able to benefit from their rights to free movement, regulators must also ensure that the few with impaired fitness to practise do not put patients at risk. European legislation must give regulators the tools to enable them to do this.

For crossborder healthcare to be safe and effective, greater information must be available for patients, professionals and regulators. In AURE's response to the European Commission's consultation (launched on 23 January), we called on the European Commission to propose a legal duty on regulators across the EU to exchange registration and disciplinary information and to act on it. This action, supporting the role of national regulators, would make a real contribution to enhancing patient safety in the EU.

Graeme Catto president, General Medical Council Alliance of UK Health Regulators on Europe scrack@gmc-uk.org
Hew Mathewson president, General Dental Council
Rosie Varley chairman, General Optical Council
Nigel Clarke chairman, General Osteopathic Council
Peter Dixon chairman, General Chiropractic Council
Anna Van Der Gaag president, Health Professions Council
Sandra Arthur president, Nursing and Midwifery Council
Hemant Patel president, Royal Pharmaceutical Society of Great Britain

Competing interests: None declared.

1. Richards T. Time to tune into Europe. *BMJ* 2007;334:185. (27 January.)
2. Legido-Quigley H, Glinos I, Baeten R, McKee M. Patient mobility in the European Union. *BMJ* 2007;334:188-90. (27 January.)

REPUTATIONS

Slow handclapping and the sound of silence

Much as I like the idea of slow handclapping speakers who do not declare their conflict(s) of interest,[1] this method of protest can really only be practised by the few that pay their own way to attend the meeting. Too many snouts are in the trough to expect anything other than shameful silence.

Paul K Morrish neurologist, Gloucester paulmorrish903@btinternet.com

Competing interests: None declared.

1. Godlee F. Reputations for sale? *BMJ* 2007;334: editor's choice. (27 January.)