National survey of notifications of tuberculosis in England and Wales in 1988

In the otherwise superb paper from the Medical Research Council Cardiothoracic Epidemiology Group (October 1992;47: 770-5), the authors imply in their first sentence that there was only a slight reduction in the rates of decline of disease in the 1960s at a time when immigration from the Asian subcontinent and East Africa was high. In fact two-page of notifications declined at an annual rate of 9.3% from 1954 until the mid-1960s, at which time the decline changed to 3% per year until 1980 when a decline of over 9% resumed. A threefold decline in notification rates could hardly be described as slight.

What is not alluded to in the paper but is of great concern is that since 1987 there has been a steady increase in tuberculosis notifications in England and Wales amounting to approximately 2% annual increase.

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AUTHORS' REPLY We are grateful to Dr Davies for his kind comments on our paper. Although he is correct in saying that the rate of decline in tuberculosis notifications in England and Wales in the 1970s was considerably lower than between 1954 and 1967, the rate of reduction was also relatively slow before 1953. In the context of the century as a whole, therefore, the change in the late 1960s was fairly slight.

We are aware of the increases in numbers of notifications over the past five years and, indeed, gave the figures in the discussion section of the paper. Although the increase has not been steady—for example, numbers for 1990 were 4.2% lower than those for 1989—between 1987 and 1991 the figures rose by an average of 1.7% per year. The reasons for this are not known, but the national survey of notifications of tuberculosis in England and Wales in 1993 should throw some light on them by determining in which groups of the population the increases have occurred.

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Does a positive Haem test reaction in Asian schoolchildren predict later breakdown of tuberculosis?

Comparing names at two points in time as was done in the study by Drs J B Cookson and A G I Cookson (October 1992;47: 776-7) is a notoriously inaccurate method of follow up. The authors did not know whether the 756 children with a strongly positive Haem test who were found not to have tuberculosis had moved out of the area or if the notifications of tuberculosis in England and Wales in 1993 should throw some light on them by determining in which groups of the population the increases have occurred.

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AUTHORS' REPLY We thank Dr Davies for his interest in our paper. Although we do not know how many of our children moved out of the area, we do present evidence that migration in this age group in Leicestershire as a whole is very small. Failure of notification is, of course, the difficulty of any study like this but we do have a good system of cross notification from microbiology and pathology reports.

The small number of notifications did not surprise us. In 1991, for example, of 213 notifications only three were in the 13-17 years age group and two of these had had a recent close contact rather than breakdown of earlier disease.

The figures on children of Asian origin born in the UK and BCG coverage of 80% were from a similar, although admittedly separate, cohort of children with grades III and IV Haem reactions who were tested as well. They do not refer to the general population of Asian children. Relapse of disease may occur late in life but with so few occurring early it seems unlikely that a large number will occur later. Dr Davies urges acceptance of the BTS guidelines but they only cover tuberculosis in the UK and not other causes such as new immigrants, not the population with which we are concerned. Dr Citron suggests continuing chemoprophylaxis in this group to those with no previous BCG vaccination.

We agree with Dr Davies that further work is necessary but we wanted to provide some answers where currently there are none. Mass chemoprophylaxis of hundreds of children each year does not seem to be right.

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Tuberculosis contact tracing: are the British Thoracic Society guidelines still appropriate?

On the basis of their study which found relatively few contacts of patients with tuberculosis to have the disease, and all those at the first screening, the article by Dr SF Hussein et al (November 1992;47: 984-5) calls into question the British Thoracic Society (BTS) guidelines on contact tracing. The authors have recently made the same point in another paper as has another centre in South Wales. Both sets of authors conclude that there should be a new nationwide study of contact tracing. Our own experience in Liverpool has been somewhat different. Within the last 12 months we have seen several close contacts of patients with tuberculosis, usually from the disease between three and six months after initial screening.

There are many data to suggest a genetic predisposition towards the disease. Historical data have shown, for example, that tuberculosis rates in north Pembroke were considerably higher than those in south Pembroke. North Pembroke is traditionally Welsh speaking whereas south Pembroke, occupied by the English since Norman times, is not. Genetic factors probably are playing a part in susceptibility to the disease within the relatively small confines of South Wales.

Before an unnecessary amount of time and money and effort is spent on a new contact tracing survey, perhaps we should look at the results by area of the 1978 survey carried out by the British Thoracic Association and on which the BTS guidelines are based, to determine whether there is a geographical and therefore possibly a genetic difference between areas. I feel there are more important areas of tuberculosis research which we should be investigating at present such as the reasons for the current increase in notifications in England and Wales.

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