

trend. The number of elderly people and Asians has increased considerably in the past decade, and therefore great care needs to be exercised before an increased incidence of tuberculosis in England is predicted. Evidence in Birmingham points to a steadily decreasing rate, and we doctors need to ensure that it stays that way.

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1 Davies PDO. Tuberculosis is increasing in England and Wales. *BMJ* 1993;307:63. (3 July.)

Europeans may be more at risk

EDITOR,—P D O Davies expresses concern about a tendency to play down the apparent increase in tuberculosis in England and Wales.¹ Although there are local differences in incidence and not all health regions report appreciable changes, notifications in Britain increased by 5% in 1992 compared with 1991.¹ Isolates of *Mycobacterium tuberculosis* in Dudley during the four years 1989-92 increased by 48% compared with the preceding four years, 1985-8 (totals being 102 and 69 respectively). Only 20% of patients with the disease in developed countries are younger than 50²; in Dudley, however, 32 (30%) of 107 Europeans with tuberculosis were younger than 50.

Dudley has a largely urban population of some 304 000, of whom 95.5% are white Europeans. The number of isolates of *M tuberculosis* increased by 108% in Europeans aged between 15 and 60 and by 100% in Asians of Indian subcontinent origin in the same age group. The total population of Dudley increased between the censuses of 1981 and 1991 by 8% from 281 707 to 304 615. This change was largely due to an increase in the number of Europeans—from 184 499 to 202 787 in those aged 15 to 65 years and from 37 631 to 89 205 in those over 65. The number of Asians increased from 3890 to 9017 in those aged 15 to 65 and from 103 to 621 in those over 65.

Numbers of cases of tuberculosis in Dudley according to age and ethnic origin

Age (years)	Asian (Indian subcontinent origin)		European	
	1985-8	1989-92	1985-8	1989-92
< 15		1	1	1
15-59	15	30	12	25
≥ 60	8	5	31	37
Unknown			2	3
Total	23	36	46	66

Although laboratory investigations increased by 61% over the eight years studied, the number of positive cultures as a proportion of the total number of requests, 1.7%, did not change substantially (range 0.9 to 3.1%). Thirty nine of 107 European patients were under 60 (table). Only two infections occurred in European children under 15. In the 37 cases of Europeans aged between 15 and 60 the mean age was 37.5 years for men and 34.4 years for women. No case was related to HIV infection or an outbreak with a common source.

A recent report of tuberculosis in south east England showed a minor peak occurring in people aged between 20 and 30 and a more diffuse rise in elderly people.⁴ Dudley's local figures may be too small to reflect important national trends, but they are disquieting and should reinforce determination to detect and control tuberculosis in the community.

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- 3 Kochi A. The global tuberculosis situation and the new control strategy of the World Health Organisation. *Tubercle* 1991;72:1-6.
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Attempted suicide

Are affective disorders missed?

EDITOR,—The Danish follow up study of patients admitted after attempted suicide looked at an important health problem.¹ In view of the recognised risk of suicide in depression the low prevalence of affective disorder and the high prevalence of the category "no mental illness" are puzzling. Could this be a result of the well known under-diagnosis of affective disorders, especially in young people?^{2,3} The editorial commenting on the study challenges the authors' views about the suitability of a high risk strategy for preventing suicide.⁴

It would be interesting to know whether an analysis comparing the patients who did and did not receive treatment (whether psychological, social, or with drugs) was or can be performed. If medical treatment reduced the suicide rate this would support its use as a preventive strategy. Studies like this one offer a rare opportunity to answer some basic questions about how a person at risk of taking his or her life should be dealt with.

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- 1 Nordentoft M, Breum L, Munck LK, Nordestgaard AG, Hundung A, Bjeldager PAL. High mortality by natural and unnatural causes: a 10 year follow up study of patients admitted to a poisoning treatment centre after suicide attempts. *BMJ* 1993;307:1637-40. (19 June.)
- 2 Hodgman C, McAnarney E. Adolescent depression and suicide: rising problems. *Hospital Practice* 1992;Apr 15:73-96.
- 3 Keller M, Lavori P, Beardslee W, Wunder J, Ryan R. Depression in children and adolescents: new data on "undertreatment" and a literature review on the efficacy of available treatments. *J Affect Dis* 1991;21:163-71.
- 4 Morgan G. Long term risks after attempted suicide. *BMJ* 1993;306:1626-7. (19 June.)

Authors' reply

EDITOR,—The diagnoses given in the study are those given in the record by the consulting psychiatrist after one or more consultations at the poisoning treatment centre. Some of the patients classified as not suffering from any mental illness may have had depressive illness that was not recognised at the consultation.

In univariate analysis of mortality from suicide the variable unwillingness to receive treatment raised the risk of dying of suicide (relative risk 1.99 (95% confidence interval 1.13 to 3.49)). In the multivariate analysis, however, this variable became non-significant. We considered the validity of information about willingness to receive treatment that was based on case records to be questionable, and we therefore omitted it from our final analysis. In the univariate analysis admission to a psychiatric department after discharge from the poisoning treatment centre was associated with a relative risk of later suicide of 1.40 (0.95 to 2.08). This variable was non-significant in both the univariate and the multivariate analysis.

We have permission to follow up the patients listed in the Danish psychiatric case register, which will give us more information about later suicide attempts, psychiatric treatment in the follow up period, and changes in diagnoses. Analyses of these data have not been completed.

Gethin Morgan's editorial challenged our view about the suitability of a high risk strategy. We agree that special attention should be paid to treating people who attempt suicide who fulfil criteria indicating that they are at high risk of later suicide. We pointed out, however, that people who attempt suicide but who do not fulfil such criteria are also at risk.

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Primary care and public health

Have a lot in common

EDITOR,—We welcome David R Hannay's call for primary care and public health medicine to work more closely together to provide effective health care.¹ Their roles are complementary: general practitioners are advocates for individual people and public health physicians are advocates for populations. This difference in emphasis can be a strength provided both branches of the profession understand and respect each other's perspective.

We agree that general practitioners have had little training in population medicine. But public health doctors increasingly have backgrounds in general practice—for example, about half of the current trainees in Wales have either been principals or undergone vocational training for general practice. The Faculty of Public Health Medicine has a primary care group, which has already held several successful conferences. Membership of this group is open to general practitioners.

There are many examples of joint ventures, particularly in the development of morbidity systems for general practice. An example is the Welsh general practice morbidity database project. This is funded by the Welsh Office and aims to develop a method of extracting information on total morbidity from selected computerised practices in Wales. These data will be pooled centrally and then analysed. The information obtained will be used by both general practitioners and epidemiologists. The methods are expected to be developed by early next year.

The project has two broad aims. Firstly, it will provide practices with both information that has been analysed and comparisons with other participating practices. Secondly, the pooled data will provide baseline information for the health gain targets set under the "strategic intent and direction" for Wales. The project is therefore an example of primary care and public health medicine working together towards their common responsibility for preventing disease and promoting health. Most family health services authorities have developed links with their departments of public health medicine or have appointed public health physicians to provide advice. With more mergers between health authorities and family health services authorities these links will become even closer.

We note with disquiet the recent consultation document prepared jointly by the BMA's committee for medical advisers to family health services authorities and the Association of Primary Care Medical Advisers on the role and future career development of medical advisers. The creation

of a separate career structure and training programme for people who are essentially public health physicians, albeit with a strong background in general practice, seems a retrograde step. Suninda Kaul, Hill Condit, Cerelan Rogers, Clwyd Health Authority, Mold, Ref. 1. Hannay DR. Primary care and public health. *BMJ* 1993; 307:516-7.