screened and yet they had a sharper fall in mortality rates (between 1967–70 and 1975–78) than the younger age group". In the paper referred to[1] we find the following:

(1) Age-specific mortality rates per year per 10^5 women for the age group 20–59 averaged 9·8, 16·6, 20·6, 17·9, 10·2, and 6·6, for the six 4-year periods 1955–58 to 1975–78, showing a 66% fall between 1963–70 and 1975–78. The corresponding fall for the age group 20–74 is 60%. Thus our error in giving figures for age 20–74 in our July 25 letter cannot have resulted in false inflation since the percentage fall in mortality rate was less for the age group 20–74 than for the 20–59 age band on which Skrabanek concentrates.

(2) In 1969 screening was extended to all women in Iceland aged 25–69. Fig 1 in the paper shows that among all women over 60, some 40% had been screened by the end of 1974 and some 70% by the end of 1977. Table I and fig 1 taken together indicate that among women aged 60–74, some 55% had been screened by the end of 1974 and over 85% by the end of 1977. So much for Skrabanek's remark that most women aged 60–74 were not screened.

(3) Table II shows that the fall in the average age-specific mortality rate between 1967–70 and 1975–78 was 63% for the women aged 20–59 and 60% for the women aged 60–74; if one takes the drop in rates between 1963–1970 and 1975–78, to cover more completely the period immediately before screening might be effective, the corresponding figures are 66% and 53%. Yet Skrabanek says the older age group had a sharper fall in mortality.

Skrabanek clearly hopes that *Lancet* readers will not examine the articles that he cites.

MRC Biostatistics Unit,
5 Shaftesbury Road,
Cambridge CB2 2BW

N. E. DAY
M. HAKAMA

1 Johannesson G, Geirsson G, Day N, Tulinius H Screening for cancer of the uterine cervix in Iceland, 1965–1978. *Acta Obstet Gynecol Scand* 1982; **61:** 199–203

AIDS ADVICE TO HAEMOPHILIACS

SIR,—Dr Evans (Sept 5, p 574) highlights a very important problem. Many haemophiliac boys in the UK under the age of 17 are HIV antibody positive and are approaching the years when nature has programmed them for sexual experimentation. They must be told of their positivity and counselled patiently, expertly, kindly, and repeatedly. Teenagers pay little attention to contraception. Many will also disregard advice about smoking, drinking, and drug taking. Will they accept advice that will inhibit the spontaneity of their sexual activity? Perhaps not, but because of the consequences of unrestricted sexual activity in this group we dare not give up. My experience leads me to believe that the quality and intensity of counselling before the adolescent is told of his seropositivity will influence the acceptance of subsequent advice. An education programme about HIV disease is likely to precipitate inquiries from young people about their own HIV status. If the positive aspects of the disease have been emphasised a truthful answer can then be given more easily and the child should not be devastated. From then on counselling must gradually emphasise responsibility towards sexual partners. The logistics of such a programme may be daunting but this matter is serious and those of us who care for haemophiliac children should be addressing it urgently.

Treloar Haemophilia Centre,
Holybourne, Alton, Hampshire

A. ARONSTAM

PROGNOSIS OF MENINGOCOCCAL SEPTICAEMIA

SIR,—I read with great interest the report of Dr Sinclair and colleagues (July 4, p 38) on the prognosis of meningococcal septicaemia. Why did they select those seven factors to score and how did they allocate 1, 2, or 3 points? They proposed to apply this scoring system to all patients, in shock or not. However, patients not in shock usually survive, and no scoring system is necessary to predict a good outcome. How many patients without hypotension and or a skin-rectum temperature difference of more than 30°C (which are signs of shock) died? Would the score established by the French Club of Paediatric Intensive Care for patients with shock[1] have allowed prediction of outcome in the patients studied by Sinclair et al? I agree that prognostic scoring systems are very important in the evaluation of new forms of treatment.

Infant Resuscitation Unit,
Hôpital Calmette,
59037 Lille, France

F. LECLERC

1. Leclerc F, et al. Prognostic factor of severe infectious purpura in children. *Intensive Care Med* 1985, **11:** 140–43.

SIR,—On Aug 10–25, 1987, we experienced a large epidemic of meningococcal meningitis in 700 patients, 70 of them children. We used the scoring system devised by Dr Sinclair and colleagues to rationalise intensive care; the number of the patients overstretched the services available. 10 patients presented with fulminant septicaemic and encephalitic meningococcaemia, of whom 8 died, confirming the high case fatality rate for these two manifestations.[1,2] All patients received "conventional medication". The outcome was clearly less favourable when conventional medication was given, in contrast to the claim by Dr Hampton's group (Aug 15, p 395). Our experience confirms the validity of Sinclair's scale in quickly predicting which children were likely to die despite intensive care. Immunological detection of meningococcal capsular antigen, to determine the severity, is not readily available in all centres.[3]

Combined plasmapheresis and leucapheresis or blood exchange[4] are the only options left open, for the time being, for the desperately ill patients who can readily be identified by use of Sinclair's scale.

King Fahd Hospital,
POB 7990 Jeddah,
Saudi Arabia

ELSAYED AHMED ABDALLA

1. Banks HS, Meningococcosis a protean disease. *Lancet* 1986; ii 635–40.
2. Banks HS. Meningococcosis a protean disease. *Lancet* 1984; ii: 677–81
3. Edwards EA. Immunologic investigation of meningococci disease I: Group-specific *Neisseria meningitidis* antigens present in the serum of patients with fulminant meningococcaemia. *J Immunol* 1971; **106:** 314–17.
4. Bjorvatan B, Bjertnaes L, Fadnes HO, et al. Meningococcal septicaemia treated with combined plasmapheresis and leucapheresis or with blood exchange. *Br Med J* 1984, **288:** 439–41.

SIR,—Dr Sinclair and colleagues pick out six bedside findings and one laboratory factor for evaluating prognosis in meningococcal septicaemia. Their selection agrees fairly well with our unpublished meta-analysis, a review of our own cases and published material. Sinclair's method of factor weighting was not given. Our material[1,2] showed that the most interesting factors were correlated so that weightings were not of decisive importance. For routine use, however, the composition of the score is very important. When choosing a standard score for clinical use, we think that a pure bedside clinical score is generally much more applicable in the important early stages before and on admission in hospital. Such a choice may help to improve understanding and communications between health-care staff.

Multivariate analysis of our first material[1] prompted us to choose factors to record on admission. Analysis of that material then led to our scoring system, with the following elements: systolic blood pressure (age adjusted) less than 100 mm Hg; cyanosis; ecchymosis (skin haemorrhages of at least 5 mm diameter); diarrhoea, before or on admission; cold extremities (significant skin/rectal temperature difference); no nuchal or back ridigity; rectal temperature of at least 40·0°C. We score the percentage of these features found present.

Sinclair et al stress the need for a good coma scale. We too found the degree of consciousness a feature worth elaborating on, especially for a late sequelae severity score. This score differs from scores aimed at predicting a fatal outcome,[3,4] and in animal experiments, clinical practice, and epidemiological research these two objectives must be differentiated.

Dr Hampton and her colleagues (Aug 15, p 395) seem to presume that the main aim of prognostication is to pick out those who will inevitably die. Such an approach, to avoid stressful and expensive, but useless, intensive care, is seldom a practical option for meningococcal disease management in western countries today. However, with a high cut-off and a score validated as almost ideal, this aim is theoretically attainable. Hampton et al, among others,