installed the prompt. There were three main reasons why the prompt was not installed: did not want prompt (n=4); technical difficulties (n=9); and no practical value because reception staff were weighing/measuring children (n=6). Practitioners with and without the prompt did not differ significantly in age, gender or socioeconomic status. The 25 GPs using the prompt weighed and measured significantly more children for LEAP (mean 74.7, standard deviation 44.2) than the 41 who did not (mean 53.5, standard deviation 37.3; p=0.04).

These findings suggest that a computerised prompt significantly enhanced recruitment into a major primary care trial for which a systematic, universal recruitment protocol was necessary. The results may also be relevant for the implementation of any population based screening program.

Lucy Rogers, Bibi Gerner, Melissa Wake
Murdoch Childrens Research Institute, Vic
Jane Gunn, University of Melbourne, Vic

Reference

1. Veitch C, Hollins J, Worley P, Mitchell G. General practice research. Problems and solutions in participant recruitment and retention. Aust Fam Physician 2001;30:399–406.

Malaria

Dear Editor

In 'Malaria in the Australian refugee population' (*AFP* August 2007), I noted with some concern a comment regarding testing '... if the RDT is positive, it should be followed up by a thick and thin film'. RDTs/immunochromatographic malarial tests (ICTs) have a high sensitivity in diagnosing *P. falciparum* and may be appropriate as a first line screening test in field areas where access to rapid, high quality microscopy may be a limiting factor. However, in the diagnosis of malaria in Australia, microscopy of thick and thin films for malaria should be performed in parallel with the ICT and not only if the ICT is positive. Current notification definitions for malaria only include microscopy and PCR as 'definitive' criteria for a diagnosis of malaria.[1] The authors do allude to this, albeit, slightly confusingly in the next line. The ICT does have a number of limitations, including lower sensitivity in diagnosing non-*P. falciparum* infections, inability to diagnose mixed infections, lack of parasite quantification, and occasional false positives in patients with elevated serum rheumatoid factor,[2] which exclude this test as a first line screening test in the absence of microscopy.

Duncan Carradice
Consultant Haematologist
Royal Melbourne Hospital, Vic

References

1. Public Health Laboratory Network. Case definition for diagnosis of malaria. Available at www.health.gov.au/internet/wcms/Publishing.nsf/Content/cda-phlncd-malaria.htm.
2. Iqbal J, Sher A, Rab A. Plasmodium falciparum histidine rich protein 2-based immunocapture diagnostic assay for malaria: cross-reactivity with rheumatoid factors. J Clin Microbiol 2000;38:1184–6.

Reply

Dear Editor

I agree with Dr Carradice's statement that in Australia the RDT and thick and thin films are done simultaneously, and with his comments about sensitivity and notification.

I work in a remote area of Nepal where an RDT is done as a first line test, and in refugees who have had only an RDT as screening before they fly to Australia. Neither of these situations relate directly to screening in Australia and I apologise for presenting this in a confusing manner.

I also work in a remote Aboriginal community where there are only limited medical facilities. The potential for malaria to be a problem in our remote north is very real and it may be that in the future, health workers could be screening for malaria with RDTs in these areas.

Jill Benson
Discipline of General Practice
University of Adelaide, SA

Prostate cancer

Dear Editor

The study by Madjar et al[1] makes interesting reading (*AFP* May 2007). Many of us would like to see a reduction in the morbidity and mortality caused by prostate cancer, and it is pleasing that women feel they have a role in promoting men's health. It is understandable that women 'used the examples of cervical and breast cancer to illustrate how public education campaigns have informed and empowered women in relation to their own health'.

However, a danger of extrapolating from women's experience is that some people may assume that the (generally accepted) benefits of screening mammography and Pap tests also apply to prostate cancer screening. The benefits and harms of screening for prostate cancer in asymptomatic men are still uncertain.[2] If solid evidence of benefit is to emerge, it will come from rigorous, large scale randomised controlled trials, which are still in progress.

While Madjar et al briefly acknowledge the ongoing debate about the role of screening, much of their article talks of 'early detection', and draws parallels between women's cancers and the issue of prostate cancer. Their article does not clearly discriminate between early detection by screening versus early detection of symptomatic disease. It is unfortunate that their discussion fails to clarify this distinction, and instead makes selective use of the literature to suggest 'emerging evidence' of benefit from PSA testing.

While many of the women in the study feared their partner experiencing harm due to prostate cancer, the article does not canvass women or men's thoughts about potential harms due to treatment of cancer. A previous qualitative study showed that some men who have had high PSA levels detected come to regret ever having had the test.[3] Also, while many men are in favour of attempts to detect cancer early, some may feel ambivalent about the consequences of early prostate cancer detection and treatment on their quality of life.[3]

Madjar et al state that 'men and their partner need clearer guidance from medical experts'. However, in informing men about the wisdom of prostate cancer screening, at present 'the only honest information is uncertainty'.[4] Thankfully, evidence based resources exist to help inform men and their partners of the complexities of this issue. An example of such a resource, which I find very useful in practice, was published in this journal.[5]

Brett Montgomery
Fremantle, WA

References

1. Madjar I, Denham J, Rashid P. Do women have a role in early detection of prostate cancer? Lessons from a qualitative study. Aust Fam Physician 2007;36:375–7.
2. Ilic D, O'Connor D, Green S, Wilt T. Screening for prostate cancer. Cochrane Database of Systematic Reviews 2006, Issue 3. Art. No.: CD004720.
3. Chapple A, Ziebland S, Sheppard S, Miller R, Herxheimer A, McPherson A. Why men with prostate cancer want wider access to prostate specific antigen testing: qualitative study. BMJ 2002;325:737.
4. Law M. The vagaries of prostate cancer screening. J Med Screen 2004;11:163–4.
5. Gatteliari M, Ward JE. PSA: pros and cons. Aust Fam Physician 2003;32:429–30.