hybridisation to *RHCcEe* or to other genes. In our description of the use of PCR for prenatal determination[1] we used two pairs of primers in a multiplex reaction. The first pair amplified a region of exon 7 common to *RHD* and *RHCcEe* whereas the second pair amplified a region of exon 10 with one common primer and one unique primer. Although this technique is reliable when pure RhD-positive DNA is used as the template we have found that at dilutions of RhD-positive DNA in RhD-negative DNA of greater than 1 in 10 the technique becomes unreliable and will frequently fail to detect the presence of RhD-specific DNA. Similarly we have found that PCR primers that are common to sequences on both X and Y chromosomes, but which generate different product sizes from each, are less sensitive than truly Y-specific primers in detection of DNA from males diluted in DNA from females. We believe that this finding is attributable to consumption of primers annealing to the excess *RHCcEe*-specific or X-specific template present in the reaction.

Adinolfi and co-workers provide the sequences of their *RHCcEe*-specific primers (which are not specific but have 90% and 100% homology with *RHD*) but omit the sequences of their RHD-specific primers. We suspect that at least one of these has homology to *RHCE* or to other genes, which may account for the low sensitivity of their technique. Lo et al[2] have described similarly disappointing results when amplifying fetal RhD-positive DNA from maternal blood. In their heminested system two of the three primers used were common to both *RHD* and *RHCcEe* genes. The use of truly *RHD*-specific primers together with a nested PCR approach might greatly improve the rate of detection and reduce the risk of missing an RhD-positive fetus should the technique be applied in clinical practice.

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1 Bennett PR, Le Van Kim C, Colin Y, et al. Prenatal determination of fetal RhD type by DNA amplification. *N Engl J Med* 1993; **329:** 607–10.

2 Lo Y-MD, Bowell PJ, Sellinger M, et al. Prenatal determination of fetal RhD status by analysis of peripheral blood of rhesus negative mothers. *Lancet* 1993; **341:** 1147–48.

Sex of editor in medical journals

SIR—Although women comprise 30% of all physicians licensed in the United States, men continue to dominate the field of academic medicine.[1,2] Those women who do specialise in academic medicine tend to be less involved in research and to publish fewer articles than their male counterparts.[3] We questioned whether this trend would also be evident at the editorial level.

For each of the 100 most influential journals in the domain of clinical medicine, as determined by the annual frequency of citation (impact factor),[4] we recorded the sex of the editor-in-chief as printed in the first issue of 1994. Where any uncertainty existed about the sex of the editor (unisex name or initials only) or the chain of command, the journal was contacted for clarification. Where more than 1 primary editor was cited, all names were recorded and subsequently prorated.

The 100 journals in the clinical medicine domain[4] with an impact factor above 2·54 were included. Among these, 92 men held primary editorial positions compared with 4 women. The most influential journal to have a female editor-in-chief is *AIDS*, but her position is shared with 3 men. 4 journals did not have a distinct primary editor (eg, *WHO Technical Report Series*), or did not respond to our request for clarification.

Fewer than 7% of senior management positions in the 500 largest multinational companies based in the US are occupied by women (Database, US News & World Report 1994; 11/7; 12). Our findings indicate a similar disparity in the domain of clinical medicine. Does this shortage of female medical editors-in-chief result from the still low numbers of women in medical research, or is it due to a lack of female role models? Worse yet, might a pre-existing sex bias[5] be the limiting factor? Could the perceived value of a journal be altered by the sex of its chief editor?

Since most medical journals have a peer review system, the editor-in-chief is clearly not the lone reviewer of articles. However, he (or she) will often have the prestige of the "final word". It takes many years of research and writing to reach the position of chief editor, and the lower numbers of women may be to some extent a reflection of the cohort from which they can be selected. With the proportion of female physicians increasing, women should be encouraged to take more active roles in research and writing, and eventually to assume editorial positions. Only thus can we ensure that the contribution of men and of women will be considered equally in all fields of medicine.

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1 Bickel J. Women physicians: change agents or second class citizens? *Hum Med* 1990; **6:** 101–05.

2 Carr PL, Friedman RH, Moskowitz MA, Kazis LE. Comparing the status of women and men in academic medicine. *Ann Intern Med* 1993; **119:** 908–13.

3 Smedstad K, Cohen M. Growing number of women physicians not reflected in academic medicine. *Can Med Assoc J* 1991; **144:** 1313–15.

4 Garfield E. SCI journal citation reports: a bibliometric analysis of science journals in the ISI database. Philadelphia: Institute of Scientific Information Inc, 1993.

5 Gilbert JR, Williams ES, Lundberg GD. Is there gender bias in JAMA's peer review process? *JAMA* 1994; **272:** 139–42.

CORRECTIONS

A controlled study of hepatitis C transmission by organ transplantation—In this article by B J G Pereira and colleagues (Feb 25, p 484), line 11 of the last paragraph should read "Due to the high probability of acquiring liver disease and the uncertain long-term outcome, we believe that the use of kidneys from anti-HCV positive donors is undesirable".

Double-blind comparison of lamotrigine and carbamazepine in newly diagnosed epilepsy—An error at our typesetters meant that figure 3 of this article by M J Brodie and colleagues (Feb 25, p 476) appeared twice, as figure 2 and as figure 3. The correct figure 2 appears below.

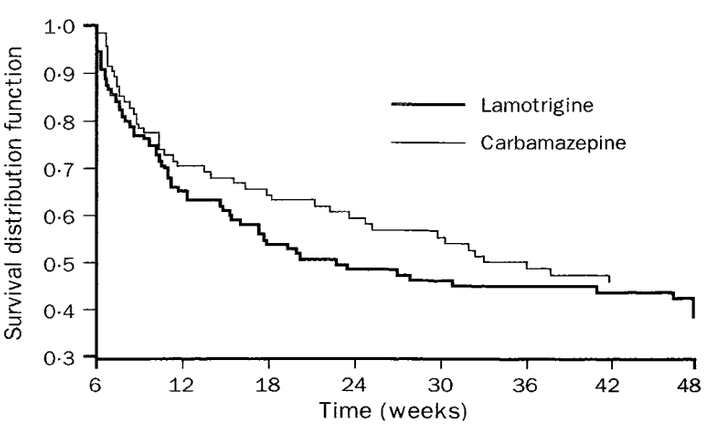

Figure 2: **Kaplan-Meier distribution curve for time to first seizure after 6 weeks' treatment**