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Clinical picture of early primary HIV infection

Infection with the human immunodeficiency virus (HIV) appears to be particularly contagious during the first days after onset. General awareness of the clinical symptoms and signs at that stage is therefore important if spread of the AIDS epidemic is to be contained. On p 1363 Gaines *et al* describe the clinical picture of primary infection developing in 20 homosexual men after incubation periods (defined in 10 men) ranging between 11 and 28 days (median 14). All patients presented with a glandular-fever-like illness with fever, sore throat, lymphadenopathy, and rash as the predominant complaints. A distinguishing feature in 12 patients was shallow, painful ulcers in the mouth or on the genitals or anus or as manifested by oesophageal symptoms. Gaines *et al* speculate that these ulcers may have been the site of entry of the virus. Primary HIV infection may be subclinical in many cases and a firm diagnosis requires serological investigation. Nevertheless, knowledge about the typical clinical picture in patients who present with symptoms will aid early diagnosis of the disease.

Efficient surgery

The continual emphasis in the past few years in cutting hospital costs has been on cutting beds, with the idea of increasing throughput. Yet, as everybody who actually practises medicine knows, ill patients don't follow this cosy theoretical model. The trouble is that data are sparse. Professor John Wyllie and his surgical colleagues at the Whittington Hospital set up a computerised daily audit of a single firm over three years (p 1368). As might be expected, admissions fluctuated widely, both in numbers on individual days and in duration of stay. Their 38 beds were adequate only 68% of the time, but a flexible use of beds elsewhere combined with early discharge overcame the difficulties. Nevertheless, emergency cases made up 42% of the total and rose by 19% over the three years. Early discharge and transfer of chronically ill elderly patients offer the only potential for further economy, but increased throughput will of course add to the overall costs. Truly, as others have commented, the NHS must be unique in that it actively discourages or prevents workers from doing as much as they would like or are able to.

Asthma and oesophageal reflux

Though the importance of "morning dipping" in nocturnal asthma, in which the peak expiratory flow falls during the night, has been recognised for some time, what causes this is still unknown. One factor suggested is gastro-oesophageal reflux, whereby the gastric acid stimulates vagal nerve endings in the oesophagus causing reflex bronchoconstriction. Nagel and her colleagues (p 1371) have investigated this possibility by ambulatory monitoring of the oesophageal pH over 24 hours. No significant difference in oesophageal reflux was found between the "dippers" and "non-dippers," and in those with reflux a randomised double blind crossover trial of reducing gastric activity with ranitidine had no effects on either respiratory symptoms or function. Hence the search must go on for other possible causes of morning dipping in asthma.

Recombinant tissue plasminogen activator and acute myocardial infarction

Recombinant tissue plasminogen activator is a new clot specific thrombolytic agent that re-establishes patency of coronary arteries in a higher percentage of patients with acute myocardial infarction than does intravenous streptokinase. The clinical benefit of coronary thrombolysis with the plasminogen activator has now been studied in a large controlled double blind trial. Van de Werf and Arnold, for the European Cooperative Study Group (p 1374), investigated the effect of 100 mg of the activator or placebo with low dose aspirin and heparin in 721 patients with acute myocardial infarction of less than five hours' duration. For the first time benefits on the size of infarction, left ventricular function, and cardiovascular morbidity and mortality has been shown in a single study. Treatment with the activator was, however, associated with an increased risk of bleeding, suggesting the need for careful selection of patients for this type of treatment.

Hazards of fetal blood sampling in patients with Rh isoimmunisation

When a fetus is severely affected by Rh haemolytic disease one or more intravascular blood transfusions may be needed. Direct access to the fetal circulation also gives the doctor reliable information about the severity of the fetus's anaemia.

The drawbacks of intravascular transfusion include its mortality (at least 1%) and the risk of fetomaternal haemorrhage enhancing the mother's immunological response and so making the disease worse. On p 1379 Nicolini *et al* report a study of fetomaternal haemorrhage after 68 consecutive fetal intravascular transfusions. Fetomaternal haemorrhage occurred in 27 cases, and the mean estimated volume was 2·4 ml. The authors concluded that fetal blood sampling and intrauterine fetal transfusions should be performed sparingly and timed carefully just before fetal anaemia becomes severe.