# BRITISH MEDICAL JOURNAL



SATURDAY 16 MARCH 1985

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*Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.*

*Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.*

***Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.***

## AIDS and the health professions

SIR,—Dr Anthony J Pinching, our colleague at St Mary's, and his fellow experts in the acquired immune deficiency syndrome (AIDS) (2 March, p 709) believe that the guidelines drawn up by the Advisory Committee on Dangerous Pathogens (ACDP) are too stringent. We are unable to comment on this but we do note that similar recommendations are not implemented in operating theatres where hepatitis B type precautions currently prevail. We have operated on several patients with AIDS or with persistent lymphadenopathy. Major procedures have been performed, including abdominoperineal resection of the rectum and wide local excision of anal carcinoma. Our anaesthetists, junior doctors, nursing staff, and operating attendants are naturally concerned, not only because little thought seems to have been given to their safety, but by the double standards they see being applied. It is somewhat disconcerting to be immersed in a bloody and difficult operation on a carrier of HTLV-III virus, taking a so far unquantified risk, only to be told that a perfectly reasonable request for a frozen section to confirm tumour clearance is being refused because of ACDP guidelines. We have noted similar problems in other laboratories and we are, therefore, driven to the inevitable conclusion that Dr Pinching and cowriters are correct when they state that suboptimal care may ensue.

However, we would also like to respond to the request to open up for public debate the whole question of AIDS and to comment on other points raised by Dr Pinching and his colleagues. As far as safety is concerned, while the present scientific evidence would seem to suggest that the risks are small,[1] it is too early to judge. It may be that the "infectivity" of the HTLV-III virus is less than that of hepatitis B but the analogy is worrying for operating theatre staff, in whom there has been evidence of spread of the latter. The application of an ACDP type of ruling to theatres would make their running virtually impossible, particularly if a list of cases—that is, node biopsies—is to be performed. We are, then, as surgeons responsible for our whole team and their safety, on the horns of a dilemma. Not to operate would be unthinkable, but exposure to risk is definite, albeit small. In this context we would like to know whether the DHSS has considered the situation of the surgeon or anaesthetist who becomes seropositive for HTLV-III virus, as has happened to health workers in the USA and begun to happen in the UK, after "stick" injuries. Would such a medical practitioner be allowed to continue in practice? Would he or she be indemnified? These questions require an immediate and unequivocal answer from the authorities.

As to other matters in the letter from Dr Pinching and colleagues, the fact that a small number of centres—mainly London teaching hospitals—have so far borne the main brunt of this epidemic is clearly unreasonable. Our institution is a finely balanced but overloaded teaching hospital, a referral centre for multiple specialties and also serving a local population. In this single hospital, owing to its large sexually transmitted disease clinic and its expertise, about one third of all AIDS cases seen in the UK have been treated and, as a consequence, the hospital is becoming overwhelmed. The implications for the future are clear and the DHSS and regions must act at once. Patients must either be distributed throughout several hospitals (and no hospital can be allowed to refuse such patients) or specific, properly equipped units must be opened. The latter course may well be rejected on financial and social grounds but it is clear that some financial provisions for AIDS victims will have to be made whichever course is followed: current estimates in the USA suggest that the cost there so far is in the region of half a billion dollars. The UK problem is bound to be smaller than that of the USA, but whatever the final cost it cannot be borne by a