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CORRESPONDENCE

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.

Demographic changes and resources for the elderly

SIR,—Dr Keith Andrews is to be congratulated on his leading article (6 April, p 1023) in which he issues a warning, if any is needed, to government, the DHSS, and health authorities about the approaching crisis in the health care of the very elderly. However, figures based on the population over 65 are less than ideal because few patients in geriatric wards are less than 75, and most are in their 80s. Dr Andrews criticises the DHSS for suggesting that some regions should decrease their target to 8·5 beds per 1000 population aged 65 and over from 10 per 1000. But the absolute number of beds is less important than where they are, how they are staffed, and how they are used.

In my opinion 8·5 beds per 1000 are probably adequate provided that: (*a*) most of them, at least two thirds, are in general hospitals, and all beds have direct and unquestioned access to the district's full range of diagnostic facilities and rehabilitation services; (*b*) there are enough nurses, physiotherapists, and occupational therapists. The importance of this cannot be overemphasised; but what is enough? Regional norms are often ludicrously inadequate, and those suggested by the British Geriatric Society should be aimed at; (*c*) a high turnover policy is practised. Much has been written about this subject, but the crux seems to be a discharge policy which is best described as aggressive; (*d*) there should be either an age related admissions policy or, where this is not practicable, some other formal integration with general medicine. The Newcastle system, now adopted in Southend, links a geriatrician to a medical team. He does a fortnightly medical "take" as part of that team (all ages, into medical beds) and provides a consultative service to the other physicians on the team. It seems, in Newcastle and Southend at least, to work very satisfactorily.

While Dr Andrews's conclusion that more funding is required is undeniable, authorities must be aware that the mere provision of beds without realistic levels of nursing and rehabilitation staff will be counterproductive, as these are the very conditions which encourage a custodial mentality and actually create long stay patients.

This dilemma is typified by a situation we have in Southend at present. We have the lowest nursing staff levels in the country. A new ward complex is about to be built which will provide 96 additional geriatric beds. However, with no prospect of an increased establishment of nurses, these beds will be an embarrassment rather than an asset.

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AIDS: the African connection

SIR,—The acquired immune deficiency syndrome (AIDS) has been described in homosexual and bisexual men, intravenous drug abusers, haemophiliacs, and people in or from Haiti and central Africa. To date only one indigenous female case has been reported in the UK,[1] and that patient had multiple sexual partners. It has been suggested that this disease had its origins in central Africa[2 3] (23 March, p 932). We report the case of a woman with AIDS in whom the only risk factor appears to be sexual contact with her ex-husband, who was born in Ghana and lived in Zambia.

A 49 year old white Englishwoman presented in July 1984 with a two month history of fever, dry cough, malaise, and weight loss. She had suffered from late onset asthma for 10 years but had never taken either oral or inhaled steroids. On admission she was cachectic, febrile, and centrally cyanosed. There was extensive labial and buccal herpes simplex, widespread oral candidiasis, and enlargement of both axillary and inguinal lymph nodes. The chest radiograph showed extensive bilateral pulmonary infiltrates, and transbronchial lung biopsy showed *Pneumocystis carinii* pneumonia. Haemoglobin was 11·2 g/dl, white cell count $8·2 \times 10^9$/l, with 9% lymphocytes (total lymphocyte count $0·74 \times 10^9$/l), and erythrocyte sedimentation rate 85 mm in first hour. The Mantoux test was negative (100 TU) despite previous BCG vaccination. Results of the Venereal Diseases Research Laboratory and *Treponema pallidum* haemagglutination tests were negative, as was the test for hepatitis B surface antigen. Further lymphocyte studies (after some weeks) confirmed lymphopenia ($1·2 \times 10^9$/l) and showed a T helper (Leu 3a) count of $0·23 \times 10^9$/l and a T suppressor (Leu 2a) count of $0·53 \times 10^9$/l, with a Th:Ts ratio of 0·43. This is the characteristic immunological profile of AIDS.[4] Antibodies to HTLV-III were detected in a membrane fluorescence assay by Dr D J Jeffries and Dr E L Berrie, indicating that the patient had indeed been infected with HTLV-III. The occurrence of *Pneumocystis carinii* pneumonia in a person not known to be immunosuppressed is sufficient for the surveillance definition of AIDS; the immunological profile and the HTLV-III antibody result confirm that this patient is indeed part of the epidemic of AIDS due to that retrovirus.

The patient had been married to a Ghanaian businessman for 18 years, but had been divorced from him for four years before admission, last sexual intercourse having taken place between them in December 1979. Anal intercourse had not taken place at any time. She had never had any other sexual contacts and had no history of intravenous drug abuse or blood transfusion. She had lived in