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LEADING ARTICLES

From New to old England: the progress of Lyme disease	ANN PARKE	525
Continued medical education must not be an optional extra	T P C SCHOFIELD	526
Late abortion	PETER BROMWICH	527
Gastric cancer, diet, and nitrate exposure	DAVID FORMAN	528
Juvenile intestinal polyps—are they always benign?	C J ROLLES	529
Funding the universities	D A SHAW	529

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Moderate sodium restriction with angiotensin converting enzyme inhibitor in essential hypertension: a double blind study	GRAHAM A MacGREGOR, NIRMALA D MARKANDU, DONALD R J SINGER, FRANCESCO P CAPPUCCIO, ANGELA C SHORE, GIUSEPPE A SAGNELLA	531
Are we drinking our neurones away?	CLIVE HARPER, JILLIAN KRIL, JOHN DALY	534
Hepatitis B, tropical ulcers, and immunisation strategy in Kiribati	C J TIBBS	537
Micturition and the mind: psychological factors in the aetiology and treatment of urinary symptoms in women	A J MACAULAY, R S STERN, D M HOLMES, S L STANTON	540
Association of placenta praevia and sex ratio at birth	JAMES L MILLS, BARRY I GRAUBARD, MARK A KLEBANOFF	544
Tolerance to glyceryl trinitrate patches: prevention by intermittent dosing	CAMPBELL COWAN, JOHN BOURKE, DOUGLAS S REID, DESMOND G JULIAN	544
Immunoscintigraphy of metastases with radiolabelled human antibodies	F AL-AZZAWI, J SMITH, W H STIMSON	545
Rapid progression of a growth hormone producing tumour during dopamine agonist treatment	KATARINA HEIDVALL, ANNA-LENA HULTING	546
Hepatitis B: risk to expatriates in South East Asia	DONALD G DAWSON, GARY H SPIVEY, JAMES J KORELITZ, REYNOLD T SCHMIDT	547
Inadequacy of oleic acid in erythrocytes as a marker of malignancies	O SØREIDE, A M BAKKEN, T LYGRE, M FARSTAD	548
Three further cases of Lyme disease	D E BATEMAN, J E WHITE, G ELRINGTON, N F LAWTON, M F MUHLEMANN, R J GREENWOOD	548
Effect of carbonic anhydrase inhibitors on glomerular filtration rate in diabetic nephropathy	P SKØTT, E HOMMEL, S ARNOLD-LARSEN, H-H PARVING	549
Role and responsibilities of general practitioner organisers of continuing medical education	R M BERRINGTON, MICHAEL VARNAM	550

MEDICAL PRACTICE

Syringe driver in terminal care	SIMON B DOVER	553
Plasticised polyvinylchloride as a temporary dressing for burns	G WILSON, G FRENCH	556
Prescribing in Pregnancy: Treatment of diabetes in pregnancy	N J A VAUGHAN	558
Portraits from Memory: 8—Lieutenant Colonel Frederick Murgatroyd RAMC (d 1951)	SIR JAMES HOWIE	561
Three cases of illness during a drug trial in healthy volunteers	E J FAZACKERLEY, N P C RANDALL, B J PLEUVRY	562
Coroner overruled: time for reform?	CLARE DYER	564
Any Questions?		555, 563
Medicine and the Media—Contributions from TONY SMITH, JANE DAWSON, ALISON GREEN		565
Medicine and Books		567
Personal View	MALCOLM FRAZER	570

CORRESPONDENCE—List of Contents	571
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NEWS AND NOTES

Views	579
Medical News	580
BMA Notices	582
Scientifically Speaking	583

OBITUARY	584
----------	-----

SUPPLEMENT

The Week	586
Champion of good health mugged by ministers?	
JOHN WARDEN	587
From the GMSC: Two schemes rejected because of "no extra money"	588
Government's extra £25m to cut waiting lists	590

CORRESPONDENCE

AIDS and intravenous drug use J R Robertson, MRCP, and Carol Skidmore, MA; P J W Wood, MRCPsych 571	Prejudice against doctors and students from ethnic minorities B Thalayasingam, MRCP; I M Jessiman, MRCP; P Richards, FRCP, and I C McManus, MB; D H Vaughan, FFCM; M S Ali, FRCP 575	Doppler studies in the growth retarded fetus D G Sims, MRCP 577
Who may give blood? R J Crawford, MRCPATH, and others 572	Potentially dangerous ampoule confusion W F Hutchinson, MB 576	Telling the patient P G T Ford, MRCP 577
AIDS and the life years lost: one district's challenge A J H Stevens, MSc, and others 572	Cost of anaesthetic drugs and clinical budgeting J M Cundy, FFARCS; J R Lethbridge, FFARCS, and J Secker-Walker, FFARCS 576	WHO not amused J E Asvall, MD 577
HIV antibody testing C E D Taylor, FRCPATH 573	Adverse reaction monitoring using cohort identification J P Griffin, FRCPATH 576	Points The potential and benefits of advanced prehospital care (W Rutherford; C J Wright); The increase in molluscum contagiosum (C B S Schofield); Adenosine: an importance beyond ATP (G C S Smith) 578
Dally, O'Donnell, and the GMC D Bolt, FRCS; D H Marjot, FRCPsych; P Monahan, FRCS 573	Adverse drug reactions checklist A H W van Assendelft, MD 576	Drug Points Syrup of ipecacuanha (I M Anderson and C Ware); Alfalcidol and hypercalcaemia (B T Marsh); Angio-oedema and urticaria associated with enalapril (W H W Inman and N S B Rawson); Nephrotoxic drug interaction between metolazone and cyclosporin (P Christensen and M Leski) 578
Should we be screening for cervical cancer or breast cancer? P M Hendy-Ibbs, MB; T M C Lindsay, MFCM 574	The debasing of medicine in the Soviet Union Philippa M Ludlam, MRCP 577	
Effects of breast conservation on psychological morbidity associated with diagnosis and treatment of early breast cancer Gill A McClare, BA 574		

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 intravenous drug use

SIR,—Two distinct patterns of spread of human immunodeficiency virus (HIV) infection among drug injectors sharing needles have been shown: the epidemic type observed in Edinburgh, New York, and Milan¹⁻³ and the more gradual but continuous dissemination seen in San Francisco (A Moss, personal communication), London, and other European centres.⁴ As Dr A R Moss discussed in his leading article (14 February, p 390), the provision of clean needles and syringes has been suggested as a means of preventing the former disasters from occurring elsewhere and controlling the insidious type of spread.

The table shows an epidemic of heroin use in Edinburgh in 1982-4, which appears to have passed its peak. It also shows that those who started taking heroin in 1982 and 1983 seemed to have a greater risk of having the HIV antibody than those starting in later years ($p < 0.005$) and indicates that the spread of HIV also reached a peak at that time. If needle sharing was present in those starting to take heroin in the other years and continuing to take it during the years after introduction of the AIDS virus (1983) then some other factor or factors must have been operating for those starting to take heroin in 1982 and 1983.

No evidence has been found to support the hypothesis that those starting in these years formed an exclusive group, and others found to be negative for HIV antibody have at times shared equipment with these individuals. We think that a minor epidemic of heroin use resulted in extreme and damaging behaviour, giving rise to ideal conditions for trans-

mission of virus. These conditions have now passed, and those starting to take heroin in years other than 1982 cannot have been using drugs in a damaging enough way to allow transmission. The many anecdotal accounts of needle sharing between those with antibodies and those without in the absence of apparent transmission requires further investigation and may indicate non-infectious seropositive individuals or resistant partners.

Changes in behaviour and the ebb and flow of these particular epidemics seem to be unrelated to any obvious medical or educational provision. Thus the reduction in the numbers starting to use heroin in 1984 predated the government's educational campaign. Our findings may be the earliest indication of the self limiting nature of this particular heroin epidemic. Such minor epidemics have occurred in Europe in the 1980s and tend to decrease in velocity over time,⁵ being followed by an endemic pattern of heroin use. National statistics are notoriously slow in showing change and serve better to indicate trends.^{6,7} One would expect therefore that Home Office statistics might show an increase again when the 1985 figures become available but may well decrease in 1986 or 1987.

The plan for the next decade in managing both drug abuse and HIV infection in this group must take these findings into account, especially when analysing the effectiveness of such interventions as the provision of sterile equipment. Local baseline data are required on the status of drug taking and the level of infection of drug users with HIV before

and after the introduction of new preventive measures. If these are not available then there may well be no scientific data to support or refute the value of this sort of intervention.

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- 1 Robertson JR, Bucknall ABV, Welsby PD, *et al*. Epidemic of AIDS-related virus (HTLV-III/LAV) infection among intravenous drug abusers. *Br Med J* 1986;292:527-9.
- 2 Marmor M, Des Jarlais DC, Friedman SR, *et al*. The epidemic of acquired immunodeficiency syndrome (AIDS) and suggestions for its control in drug abusers. *J Subst Abuse Treat* 1984;1:237-42.
- 3 Lazzarin A, Galli M, Geroldi D, *et al*. Epidemic of LAV/HTLVIII in drug addicts in Milan: serological survey and clinical follow up. *Infection* 1985;5:215-8.
- 4 Webb G, Wells B, Morgan JR, *et al*. Epidemic of AIDS related virus infection among intravenous drug abusers. *Br Med J* 1986;292:1202.
- 5 Kaplan J. *The hardest drug: heroin and public policy*. Chicago: Chicago Press, 1983.
- 6 Home Office. *Statistical bulletin*. London: Home Office, 1984.
- 7 Stimson GV. Making sense of official statistics. *Br J Addiction* 1984;79:373-5.

SIR,—Dr A R Moss (14 February, p 389) seems to have missed some important points. Firstly, he seems to have assumed that the mode of spread to the spouses or partners of addicts infected with human immunodeficiency virus (HIV) is sexual, whereas clinical experience suggests that the spouses of intravenous drug addicts often take drugs themselves. Epidemiologists may fall into the trap of assuming that shared needles and syringes are not of particular relevance to the risk of infection in this group.

Secondly, the comparison of the city of Amsterdam, which has 7000-8000 recognised drug addicts,

Number of new heroin addicts each year and number starting in each year who developed HIV antibody

	1975	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86
No of new heroin users:	1	2	4	2	1	13	21	26	27	11	12	3
No with HIV:	0	1	1	1	1	6	13	20	20	4	2	0