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SUPPLEMENT

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CORRESPONDENCE

● ***All letters must be typed with double spacing and signed by all authors.***

Nursing grievances

SIR,—Dr Tony Delamothe's articles (6 February, p 406) contained comments which I hear often from all grades of nursing staff. Our morale is desperately low and working conditions are deteriorating with frightening rapidity.

I have worked continuously in the National Health Service since 1978 and have been employed in three London teaching hospitals. During this period I have seen a gradual deterioration in recruitment. At the age of 18 I would not have believed that I could feel such cynicism and demoralisation as I do now about a job I loved so much. How must the students of today feel?

The desperation we feel was shown in the recent strike. It was about pay and working conditions. Most nurses would rate working conditions as a greater cause of job dissatisfaction. We are professionals, not "angels," and we would like to have an acceptable standard of living. A small proportion of the workforce is prepared to take industrial action. On the day of action I felt that nurses were given little support by their medical colleagues. I thank Dr Delamothe for being our advocate.

J K SANDERSON

34 Tufton Gardens,
East Molesey KT8 9TE

SIR,—Dr Tony Delamothe asks "Where do the nurses go from here?" (13 February, p 449). Sadly, an increasing number of them are going elsewhere. I was introduced to an enrolled nurse who had come to us for a few days through an agency. Her anticipation and obvious experience helped me to complete a complicated arterial case very quickly. She had resigned from the National Health Service and was doing agency work while waiting to start her new job as a counter clerk with the Post Office. This will give her a considerably better income than she can earn as an experienced scrub nurse.

Surgeons are under constant pressure from the Department of Health to reduce waiting lists. We are given occasional extra sums of money to help with this. It must be realised that waiting lists depend on the number of operations performed in a day and this depends on the speed with which each operation can be safely performed. It is becoming increasingly difficult to find people with the ability and skill to act as a competent scrub nurse. To pay those with these skills less than a counter clerk seems to be counter productive.

DAVID NEGUS

Lewisham Hospital,
London SE13 6LH

HIV infection: the challenge to general practitioners

SIR,—At the end of his summary of how general practitioners see the present epidemic of infection with the human immunodeficiency virus (HIV) and their role in it (20 February, p 516) Dr Paul Hodgkin raises the question of false positive results in tests for antibody to HIV. He is right to focus on the one practical way to diagnose HIV infection unequivocally, but he misrepresents the present situation.

Firstly, his figure for HIV prevalence of 0·002% is far too low: it implies only 1000 infections in the United Kingdom, whereas by the end of 1987, 1227 cases of AIDS were known and over 6000 people had been reported to be HIV antibody positive. A more likely, though unproved, level of prevalence is 0·1%.

Secondly, Dr Hodgkin recommends that general practitioners should regard positive results as false until confirmed by specialised tests. Positive reports are sent to general practitioners only when the initial result has already been confirmed.

The system set up by the Public Health Laboratory Service in 1985, when testing on a national scale began, specifies that all initially positive samples will be retested and then referred to one of seven confirmatory laboratories, where other tests are done. The key point is that the extra tests differ in methodology, so that while all detect true positives they are not usually susceptible to the same false positive effect. The same principle has been applied successfully for years to serological testing for syphilis.

Most HIV antibody tests now commercially available are highly specific, reflecting the extraordinary efforts which have been put into their development. If each test is, as Dr Hodgkin suggests, 99·5% specific, a single test will lead to about 1 false positive in 200 samples. Two methodologically different tests each giving 1 in 200 falsely positive reactions would be expected to find the same sample falsely positive on 1 in 40 000 occasions and three tests on fewer than 1 in a million occasions. Applying this approach to testing a 50 000 sample of the UK population with an HIV prevalence of 0·1% would yield about 50 true positives and no false positives, figures different from those derived by Dr Hodgkin.

A A GLYNN

Public Health Laboratory Service
AIDS Centre,

P P MORTIMER

Virus Reference Laboratory,
Central Public Health Laboratory,
London NW9 5HT

Antigen detection in primary HIV infection

SIR,—Dr M van Sydow and coworkers reported that antigen p24 of the human immunodeficiency virus (HIV) is generally detectable during acute infection (23 January, p 238). We measured neopterin concentrations in subjects with established HIV infection and support the suggestion that HIV continues to be replicated in almost all infected individuals.

Neopterin is a sensitive marker for the induction of a cellular immune response.[1] It is produced from macrophages after stimulation with γ interferon. In common acute viral infections neopterin concentrations peak during antigenaemia and remain high as long as virus is produced. The presence of viral structures evokes a cell mediated immune response. Neopterin concentrations return to normal when antigen synthesis stops.

In people infected with HIV neopterin concentrations are high during acute infection and decline moderately thereafter.[2] Asymptomatic carriers of HIV antibody have increased neopterin concentrations in serum or urine when compared