Letter from . . . Amsterdam

No waiting

ROBIN HULL

Parking in overcrowded Amsterdam is a nightmare and often leads to vandalism of vehicles. My car has been forced open six times in 15 months. Recently, searching for a place to park when calling at the mission clinic (which provides primary care for the social misfits of the red light district), I found myself in the Zeedijk. This narrow alley is the seamiest street in this seamy city; indeed, some guidebooks specifically advise tourists not to enter it because of "undesirable conditions" caused by the drug addicts. But, as I arrived, there was that rare phenomenon, an empty parking place. Someone else spotted it too, but, arriving first, I positioned my car to reverse in. The rival drew up so close behind me that I could not move. Hence an altercation ensued that attracted a crowd of curious and bizarre onlookers. One of these staged a dramatic fall from his bicycle, blaming this on my driving of a stationary car. A colourful tirade, mostly concerning genital function, further interested the crowd, who started to pack and glower ominously. A friendly Dutchman hissed through the open car window, "Get out of here before there's trouble." I relinquished my parking place, only to be pursued by the irate cyclist bombarding the car with missiles.

An uncomfortable, irritating incident like this leaves one ruffled and indignant. Petulantly I felt that I should like to explain to those angry youths in the crowd that my reason for being there stemmed from a wish to help. Momentarily, when the hand that feeds is bitten, one feels like chucking up one's ideals as misplaced. But then I reflected: these people are human beings bent on a path to destruction, where but for the grace of God I might go myself. Certainly, were I on that same path, I would view the relative affluence of a doctor in a comfortable car with envy and possibly anger.

Death from AIDS

So we view others less fortunate, blaming them as poorly motivated abusers of alcohol or drugs, or as sexual misfits and so deserving of the ills that afflict them. Then we stand at the bedside of young men dying of the acquired immune deficiency syndrome (AIDS) and have to readjust.

In the past month I have seen eight such men and one is dead. They all have a certain quality about them that makes me think of hyperthyroidism. But that overvisible white of eye is not Graves' disease but fear of the grave. These are young men terrified of their disease and by the rejection of society. They have one other common factor: though young, they look old and when seen a second time a fortnight later seem to have aged years. But there the similarity ends for their clinical appearances are so divergent. One developed oral Kaposi's sarcoma over a year ago. He is a fit, bronzed athlete just returned from a swimming holiday in the Mediterranean. Another wastes away with papery skin stretched so tightly over his face that

individual foramina in the underlying bone can be seen. He has intractable diarrhoea caused by cryptosporidium and a positive blood culture for shigella. A strange aspect of his wasting is the disappearance of his buttocks. The emaciation is like that seen in the pictures of Belsen victims, subtly different from the cachexia of malignancy.

Another patient presented with thrombophlebitis and thrombocytopenia. Others complain of florid skin infections, herpes, or impetigo or widespread seborrhoeic dermatitis. Last week two patients staggered into the policlinic hardly able to breathe with pneumonia due to *Pneumocystis carinii*. Both improved with co-trimoxazole, but that did nothing for the hairy leucoplakia on their tongues or the rich palatal coating of "schimmel," as the Dutch call candida. One man stepped off the plane at Schiphol not knowing who or where he was. He soon arrived at the Free University teaching hospital, which lies under the flight path to Amsterdam's huge airport. This man, who was disoriented to the extent of urinating in the hospital corridors, bore a letter warning that he was seropositive—and as he had gross haematuria the nursing staff were far from happy. Aspiration of a large node in his neck disclosed tubercle bacilli, results of serological tests for syphilis were strongly positive, and his cerebrospinal fluid was clear. The differential diagnosis between neurosyphilis, tuberculous meningitis, or AIDS encephalitis was established in favour of the last only by a brain scan.

The great mimic

Of the eight men, one came from the Middle East and one from South Africa; the rest were Yugoslav, German, Austrian, or American, and only two were Dutch. Seven were known homosexuals and the eighth, a Moslem, denied this because Mohammed forbade such practice. Two had untreated syphilis and all had had multiple episodes of other sexually transmitted disease. But despite some common points of history the feature of this disease is its inconsistency. The eight patients showed oral, pulmonary, haematological, skin, lymph node, gastrointestinal, and neurological symptoms and signs. The one clear fact seems to be that AIDS may present in any form. Perhaps the best rule is that if you find yourself saying "that's odd" about any presentation then you may be looking at a patient with AIDS.

After difficulty in parking my car I arrived very late at the mission to discuss the research they are undertaking into drug related medical problems and sexually transmitted diseases. They showed me their records. Among some 2000 cards there were 32 green markers indicating the known seropositive cases. A figure of 1.6% may not seem many, but the known cases represent the iceberg's tip—God knows how many more are in the pipeline. Yet little is done: at the Free University only one physician concerns himself with AIDS and, as I write, he leaves for two weeks' holiday with no senior doctor to deputise for him. It seems that everywhere ignorance and prejudice form a convenient sand in which we bury our heads. AIDS concerns all doctors—particularly general practitioners—but are we adequately prepared?

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