they are scanty the auramine stain undoubtedly provides the most sensitive method of finding them.

As a paediatrician it is curious that the author omits any mention of the increased incidence in children^{9,10} or of its importance in the Third World,^{11,12} where the infection carries a high mortality, or of the positive benefits of breast feeding.¹¹

While he correctly draws attention to the need for hospitals looking after children and immunocompromised patients to regard the search for cryptosporidium as routine, the steady increase both in the use of immunosuppressive therapy and in the number of cases of acquired immune deficiency syndrome brings most hospitals into the fold. Examination for *Cryptosporidium* does not carry a massive cost: as a demand led service it could be said that more attention paid by clinicians to avoiding unnecessary tests would help to neutralise any financial constraints.¹³ We were the first to draw attention to the fact that this simple test could avoid unnecessary invasive clinical investigations.⁴ Since we began to look for cryptosporidium in this rural area three years ago its incidence here has remained at about 2%: during this period it has been a pleasure to encourage others to maintain vigilance through fallow periods when it was lying low. It has never failed to oblige our colleagues in the long run.

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Palliative care—specialty or generality?

SIR,—Dr Graham Thorpe's Personal View on the evolution of hospice medicine (9 August, p 388) raises many points. Certainly the rapid growth of hospices has improved the care of the dying in small areas but it is now widely recognised that with the United Kingdom's varied geography and demography this is not the answer to a general improvement in care.

I believe there is a serious danger in the insidious development of a new specialty of palliative medicine, which may in fact reduce the quality of care for the majority by making ordinary hospital or family doctors feel inadequate in dealing with the problems of their own patients. I saw this most

clearly in the allied subspecialty of "pain relief," where anaesthetists were summoned to surgical wards to consult on the prescription of morphine to control patients' pain because the surgical staff felt that this was now a complex subject requiring specialist knowledge.

The National Society for Cancer Relief has recognised this problem, and, as Dr Thorpe has pointed out, has funded various imaginative university projects. The one in the department of medical education in the University of Dundee is aimed at producing a distance learning package for hospital and family doctors to teach the simple and straightforward principles of palliative care, which I hope will remove the mystique and reassure doctors that if they are willing they can provide the quality of care achieved in hospices for the great majority of their own patients.

The development of traditional training programmes with a "career ladder," and before long no doubt a specialist examination, surely is misconceived. Medical staffing and training for existing hospices must continue to be individualised according to the talents and training of the doctors available and interested.

The attributes required, however, remain in my experience those personal qualities of sensitivity, availability, and a willingness to provide continuity of care rather than those that can be provided by a sophisticated training scheme.

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AIDS, cotton wool spots, and cytomegalovirus retinitis

SIR,—We read with great interest the article by Professor Peter G E Kennedy and coworkers on the presence of cytomegalovirus but not human lymphotropic virus type III (HTLV-III) in retinal lesions in patients with the acquired immune deficiency syndrome (AIDS) (19 July, p 162).

From the text of their article it is evident that large amounts of cytomegalovirus RNA were found in the retina of two patients with a clinical diagnosis of cytomegalovirus retinitis for over four months. It is satisfying that there is such a good correlation between the simple technique of ophthalmoscopy and a sophisticated research procedure such as in situ hybridisation techniques with DNA probes.

In a third patient with bilateral cotton wool spots they found small amounts of cytomegalovirus RNA in a few cells. This does not contradict our opinion,¹ shared by others,² that cotton wool spots may act as an entrance port for a cytomegalovirus infection of the eye but that they are primarily the result of microvascular damage induced by immune complex deposition. We believe, however, that the title of their paper is slightly confusing as it states that cytomegalovirus but not HTLV-III is detected in what are loosely called "retinal lesions." In fact, their data prove that cytomegalovirus is indeed responsible for clinical cytomegalovirus retinitis and that HTLV-III is absent in this and a number of other retinal manifestations in patients with AIDS. The spectrum of retinal manifestations in AIDS retinopathy³ is, however, much broader than the retinal lesions encountered in the five patients described by these authors, and hence their study does not say anything about the possible causal role of HTLV-III in other retinal lesions.

We described a perivasculitis of the peripheral retinal vessels in children⁴ and adults¹ with AIDS or the AIDS related complex and we suspected that HTLV-III might be responsible for these lesions.

We performed a paracentesis in two HTLV-III seropositive patients with active perivasculitis of the retinal vessels and isolated infectious HTLV-III from aqueous humour in both patients.⁵ A third patient had intense perivasculitis of the retinal vessels in one eye. Viral cultures were done on a peripheral blood sample, on spinal fluid, and on aqueous humour. HTLV-III was recovered from aqueous humour after nine days, from cerebrospinal fluid after 20 days, but from peripheral blood after one month's culture, strongly implying that the active inflammation of the peripheral retinal vessels was related to the presence of HTLV-III. We believe that these findings give an affirmative answer to the question raised by Professor Kennedy and his coworkers whether HTLV-III is present at an earlier stage of the ophthalmic disease.

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Hazards of bronchoscopy

SIR,—Dr Ian W B Grant's leading article (2 August, p 286) rightly draws attention to the potential hazards of fiberoptic bronchoscopy. We wish to add the following comments from our own experience of around 5000 examinations over eight years.

The incidence of moderate haemorrhage may be considerably reduced by the application of adrenaline to the area to be biopsied. It is also advisable to take special care in taking biopsy specimens when one or other main bronchus is occluded and when asphyxiation due to occlusion of the remaining major bronchus is possible. If these few patients are excluded it is possible to control quite substantial haemorrhage by continued aspiration to keep at least one lung well ventilated. The calibre of the aspiration channel is not in our experience a limiting factor; the obscuration of vision is a nuisance but with practice the tip of the bronchoscope can usually be kept clear, and if this is not possible the instrument may be removed and reinserted rapidly. Nevertheless, we would agree that the risks of haemorrhage must be greater if the facility or skill necessary for rigid bronchoscopy, and occasionally thoracotomy, are not available for occasional use.

With regard to transbronchial biopsy for diffuse lung diseases, we regard facilities for fluoroscopy as desirable rather than mandatory. If a biopsy is taken some way short of the limit of travel of the forceps tip, a technique easily acquired with a little practice, pneumothorax cannot occur.

With regard to fiberoptic bronchoscopy in