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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 the health professions

SIR,—Dr Anthony J Pinching, our colleague at St Mary's, and his fellow experts in the acquired immune deficiency syndrome (AIDS) (2 March, p 709) believe that the guidelines drawn up by the Advisory Committee on Dangerous Pathogens (ACDP) are too stringent. We are unable to comment on this but we do note that similar recommendations are not implemented in operating theatres where hepatitis B type precautions currently prevail. We have operated on several patients with AIDS or with persistent lymphadenopathy. Major procedures have been performed, including abdominoperineal resection of the rectum and wide local excision of anal carcinoma. Our anaesthetists, junior doctors, nursing staff, and operating attendants are naturally concerned, not only because little thought seems to have been given to their safety, but by the double standards they see being applied. It is somewhat disconcerting to be immersed in a bloody and difficult operation on a carrier of HTLV-III virus, taking a so far unquantified risk, only to be told that a perfectly reasonable request for a frozen section to confirm tumour clearance is being refused because of ACDP guidelines. We have noted similar problems in other laboratories and we are, therefore, driven to the inevitable conclusion that Dr Pinching and cowriters are

correct when they state that suboptimal care may ensue.

However, we would also like to respond to the request to open up for public debate the whole question of AIDS and to comment on other points raised by Dr Pinching and his colleagues. As far as safety is concerned, while the present scientific evidence would seem to suggest that the risks are small,¹ it is too early to judge. It may be that the "infectivity" of the HTLV-III virus is less than that of hepatitis B but the analogy is worrying for operating theatre staff, in whom there has been evidence of spread of the latter. The application of an ACDP type of ruling to theatres would make their running virtually impossible, particularly if a list of cases—that is, node biopsies—is to be performed. We are, then, as surgeons responsible for our whole team and their safety, on the horns of a dilemma. Not to operate would be unthinkable, but exposure to risk is definite, albeit small. In this context we would like to know whether the DHSS has considered the situation of the surgeon or anaesthetist who becomes seropositive for HTLV-III virus, as has happened to health workers in the USA and begun to happen in the UK, after "stick" injuries. Would such a medical practitioner be allowed to continue in practice? Would he or she be indemnified? These

questions require an immediate and unequivocal answer from the authorities.

As to other matters in the letter from Dr Pinching and colleagues, the fact that a small number of centres—mainly London teaching hospitals—have so far borne the main brunt of this epidemic is clearly unreasonable. Our institution is a finely balanced but overloaded teaching hospital, a referral centre for multiple specialties and also serving a local population. In this single hospital, owing to its large sexually transmitted disease clinic and its expertise, about one third of all AIDS cases seen in the UK have been treated and, as a consequence, the hospital is becoming overwhelmed. The implications for the future are clear and the DHSS and regions must act at once. Patients must either be distributed throughout several hospitals (and no hospital can be allowed to refuse such patients) or specific, properly equipped units must be opened. The latter course may well be rejected on financial and social grounds but it is clear that some financial provisions for AIDS victims will have to be made whichever course is followed: current estimates in the USA suggest that the cost there so far is in the region of half a billion dollars. The UK problem is bound to be smaller than that of the USA, but whatever the final cost it cannot be borne by a

few districts with inadequate resources. The problem goes beyond the AIDS victims to the much larger group of associated syndromes and the possible virus carriers. Screening, often surgical gland biopsy, treatment, and counselling will all consume resources. As surgeons, we can say clearly that we do not have the physical plant or manpower to deal with the predicted number of node biopsies, and the effect on other acute services within our hospital, ranging from access to limited isolation beds and intensive care units as well as various endoscopy and other services, would be such that other routine and specialist work would have to be curtailed.

It is important that, as clinicians, we should never be in a position where we have to refuse to treat patients (as has been suggested on a recent TV programme) not only because this would be totally unethical but also because the response of the homosexual community to even a suspicion of this would be that they would hide their carrier state, refuse to come forward for screening, and put the medical profession and others at even greater risk. Cases are now said to occur in which virus carriers awaiting routine surgery are hiding their problem for fear of cancellation. We have to accept also that our risks will be probably greater in the unrecognised (deliberate or otherwise) patient who is a virus carrier.

These are but a few of the problems that require urgent attention. It is not acceptable that any one institution becomes stigmatised as an AIDS centre, and it is imperative that these patients are adequately treated in many centres and with proper safety controls.

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1 Hirsch MS, Wormser GP, Schooley RT, *et al*. Risk of nosocomial infection with human T cell lymphotropic virus III. *N Engl J Med* 1985;312:1-4.

SIR,—We are concerned about the interim guidelines on AIDS of the Advisory Committee on Dangerous Pathogens (ACDP), especially as they affect clinical pathology services to patients. These guidelines have been responsible for considerable waste of time by laboratory and infection control staff throughout the country. Already there have been unjustifiable delays in carrying out essential pathology tests requested on patients with suspected AIDS, as staff in some hospitals have felt that they could not satisfy the safety requirements stated in the guidelines. The recommendation that all manual procedures on blood or other body fluids from certain patients should be carried out only in designated containment III laboratories, under a class I safety cabinet, is based on fear of aerosol spread but is scientifically unsound, largely impractical, and costly to implement. As your leading article (23 February, p 583) and Dr Anthony J Pinching and others (2 March, p 709) point out, there is no epidemiological evidence to support the possibility of aerosol transmission of HTLV-III infection or of AIDS. The evidence so far clearly indicates that the risk of a health care worker acquiring HTLV-III infection in hospital is remote and much less than with hepatitis B. The main risk appears to be from inoculation injury with the blood of a patient with HTLV-III infection, and in this situation the risk of acquiring

HTLV-III infection is very low. Carrying out of manual procedures in the confined space of a safety cabinet may possibly increase the risk of inoculation injury and certainly does nothing to decrease the chances of its occurrence. Emphasis should be placed on the need to reduce the incidence of inoculation injuries with the blood of all hospital patients, as occasionally HTLV-III infection is not suspected clinically.

There may now be particular confusion about the group of patients who need extra precautions to help prevent transmission of AIDS: the DHSS issued HC(85)2 in January 1985, which included patients with known or suspected AIDS, persistent generalised lymphadenopathy, and also known cases positive for HTLV-III antibody. The corrigendum to HC(85)2 issued in February 1985 stated that the guidelines were intended for the former patients but omitted to mention known HTLV-III antibody positive cases. This corrigendum may help to make the guidelines more practical, by reducing the numbers of "extra risk" patients, but it is scientifically nonsensical. HTLV-III virus may often be isolated from "healthy carriers" or mildly unwell homosexuals or others who are known to have HTLV-III antibodies—and these patients may be more infectious than some patients with diagnosed AIDS. Until the results of repeated HTLV-III antibody tests become more readily available it is probably best to assume initially that all homosexual or bisexual men, haemophiliacs, intravenous drug abusers, and central African patients have potentially HTLV-III infectious blood. Hepatitis B type precautions are indicated while caring for these patients when they are bleeding or have open wounds and for the collecting and handling of specimens, since the evidence available overwhelmingly points to similar routes of transmission for both the HTLV-III and hepatitis B viruses. A recent report on AIDS from the USA¹ reaffirmed that such hepatitis B precautions were adequate and continued to recommend the precautions published in 1982.² We feel that the American precautions for preventing the transmission of AIDS to health care workers should be implemented in Britain rather than the interim guidelines of the ACDP. An AIDS working party of the Hospital Infection Society, chaired by Professor D C E Speller, is currently preparing scientifically based guidelines on the prevention of hospital acquired AIDS, which it hopes will prove practical and relatively inexpensive to implement in Britain.

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- 1 Anonymous. Update: prospective evaluation of health-care workers exposed via the parenteral or mucous-membrane route to blood or body fluids from patients with acquired immunodeficiency syndrome—United States. *MMWR* 1985;34:101.
- 2 Centers for Disease Control. Acquired Immune Deficiency Syndrome (AIDS): precautions for clinical and laboratory staffs. *MMWR* 1985;31:577-80.

SIR,—I was dismayed to read in your leading article (23 February, p 584) that "AIDS is transmitted by close contact (usually sexual)." I find this hard to equate with the known epidemiology of AIDS and my own experience of investigating and managing this syndrome and its associated conditions.

In 1981 I examined and performed diagnostic tests on a patient with undiagnosed AIDS. I took rectal swabs via a proctoscope and performed post-pharyngeal swabs with the ensuing inevitable gagging and explosive coughing. My only protection was rubber gloves. Since then 17 confirmed and 10 presumed cases of AIDS, not all in local residents, have passed through the clinic, and multiple blood and tissue samples have been taken by routine procedures by all members of the medical and nursing staff. Recently the stringent guidelines laid down by the DHSS (HC(85)1) have prompted modification of the clinic procedures. In addition 85 patients with persistent generalised lymphadenopathy syndrome and 250 with AIDS related conditions, most of whom have circulating antibodies to the HTLV-III virus, the presumed cause of the syndrome, have been attending throughout this time as outpatients, using a common waiting room with other patients. Of the latter about 2000 homosexuals attended the clinic in 1984, and from studies using the sensitive reproducible competitive radioimmunoassay on sera collected in 1983 and 1984 we know that 20% to 30% of the homosexuals are positive for antibodies to the HTLV-III virus.¹ Therefore as part of a research project all health care workers in this clinic who have had "close contact" (not sexual) with the aforementioned homosexual patients have been screened voluntarily for the HTLV-III antibody, all with negative results.

In 1983 I postulated that the acquisition of the infective organism of AIDS was via traumatised and therefore bleeding anorectal tissue after passive (receptor) sexual acts, forming a portal of entry for the organism from active (donor) partners, whom we now know have infected lymphocytes with the HTLV-III virus in the semen. Since then I have learnt nothing from my own clinical experience to change my views.

I think that the transmission of the retrovirus HTLV-III is far less likely than, for example, that of the treponeme in early infectious syphilis—an undoubted venereal disease with highly infectious superficial skin and mucosal lesions—or the hepatitis B virus. Among the indigenous homosexual population of this clinic there was one confirmed case of AIDS in 1981 and eight in 1984. During that time the incidence of early syphilis was: 71 cases in 1981, 53 in 1982, 99 in 1983, and 99 in 1984. Assuming that the retrovirus was introduced into the local homosexual population in about 1979 with an incubation period of two to three years and given the high local morbidity for homosexually acquired disease, with syphilis a slow incubating venereal disease taken as a model, one would expect to have seen more cases of AIDS if it were as easily transmitted as the other venereal diseases.

To counteract the present misconceptions