- 10 Cuneo RC, Salomon F, Wiles CM, Hesp R, Sönksen PH. Growth hormone treatment in growth hormone deficient adults. I. Effects on muscle mass and strength. *J Appl Physiol* (in press).
- 11 Rudman D, Feller AG, Nagraj HS, et al. Effects of human growth hormone in men over 60 years old. *N Engl J Med* 1990;323:1-6.
- 12 Thuesen I, Christiansen JS, Sørensen KE, Jørgensen JOL, Ørskov H, Henningsen P. Increased myocardial contractility following growth hormone administration in normal man. *Dan Med Bull* 1988;35:193-6.

We cannot afford an AIDS epidemic

SIR,—The distressing picture of inadequate response to AIDS in sub-Saharan African countries painted by both Dr Steven Dodwell¹ and Dr Alison Fiander² is familiar. In our work in many of the world's poorest countries we have seen a similar mixture of apparent official indifference and obstruction of the efforts of individuals and development agencies to confront specific health and social issues. We must beware the conclusion that governments do not care or even that they do not understand. Often the inaction stems from not knowing where to start and not knowing from what to divert resources in order to intercept the new crisis.

The HIV epidemic is no different from any of the other diseases of poverty. Its origins lie in poor living conditions, education, nutrition, and access to health care and treatment mixed with the extremes of inequality found in developing countries. The remedies to the epidemic must be seen to lie in the development and strengthening of government health and social welfare sectors. Anything less will be like mending one hole in the bucket as it continues to rust away everywhere else.

No, we cannot afford the AIDS epidemic, not least because that cost may include any advances we have made in infant mortality or control of tuberculosis. We should be clear, though, that AIDS is just a symptom. What we really cannot afford is the cost of not doing anything about poverty.

MIKE BAILEY

Policy Development Unit,
Save the Children Fund,
London SE5 8RD

- 1 Dodwell S. We cannot afford an AIDS epidemic. *BMJ* 1990;301:1283. (1 December.)
- 2 Fiander A. We cannot afford an AIDS epidemic. *BMJ* 1991;302:238. (26 January.)

Changing disease patterns in AIDS

SIR,—We recently described a doubling in median survival among patients in whom AIDS was diagnosed in 1987 compared with survival in those in whom it was diagnosed earlier.¹ We have now analysed survival trends for patients diagnosed as having AIDS in 1988 and the first nine months of 1989. The criteria for patient inclusion and the methods used were the same as in our original study.¹

The median survival of patients diagnosed as having AIDS did not significantly increase between 1987 (20 months) and 1988 (23 months) (log rank $\chi^2=0.2$, $p=0.65$). Interestingly, the survival times for 90% and 75% of patients improved substantially during 1988 and 1989: the 90% survival increased from less than one month in 1986 to two months in 1987, eight months in 1988, and 13 months in 1989. The corresponding figures for the 75% survival for 1986-9 were four, nine, 16, and greater than 16 months. Similarly, one year survival, which was 65% for 1987, increased

One year survival in patients with AIDS by year of diagnosis, 1986-9

during 1988 and 1989 to 82% and 92% respectively (figure; log rank $\chi^2=3.9$, $p<0.05$).

We attribute this increase in short term survival primarily to a decrease in early deaths from *Pneumocystis carinii* pneumonia. For instance, deaths in the first month after AIDS was diagnosed fell from 18% (12/67) in 1986 to 10% (8/79) in 1987, 5% (3/61) in 1988, and 0% (0/41) in 1989. All but three of these patients (three dying in 1986 and one in 1987) died from *P. carinii* pneumonia.

Further improvements in outcome among patients with AIDS are likely to emerge only when substantial progress is made in managing those infections relatively refractory to treatment (for example, infections with *Mycobacterium avium intracellulare*, cryptosporidium, and cytomegalovirus) and tumours (Kaposi's sarcoma and lymphoma) or if using new antiretroviral drugs or combinations confers additional benefits.

BARRY S PETERS
DIANE COLEMAN
EDUARD J BECK
JEANNIE F TODD
JANICE MAIN
JOHN R W HARRIS
ANTHONY J PINCHING

St Mary's Hospital Medical School,
London W2 1PG

ANDREW HILL

Imperial College of Science, Technology, and
Medicine,
London SW7 2BB

- 1 Peters BS, Beck EJ, Coleman DG, et al. Changing disease patterns in patients with AIDS in a referral centre in the United Kingdom: the changing face of AIDS. *BMJ* 1991;302:203-7. (26 January.)

Tuberculosis and HIV infection

SIR,—Dr Kevin M De Cock and colleagues found a high prevalence of HIV infection in patients with tuberculosis in Abidjan on the Ivory Coast—40.2% of patients positive for either HIV-I or HIV-II, the vast majority for HIV-I.¹ It is surprising, therefore, that in a similar but much smaller survey I conducted in southern Africa in January 1990 the prevalence of HIV-I infection in patients with tuberculosis was as low as 1.4%.

In this two centre study, based in an urban hospital in Manzini, Swaziland, and a bush hospital in rural Zululand, patients with confirmed pulmonary tuberculosis were tested for seropositivity to HIV-I. Patients were diagnosed as having pulmonary tuberculosis on clinical, radiological, and microbiological criteria. Dried blood spots from all patients were collected on Guthrie cards and tested for the presence of anti-HIV-I using the assay described by Peckham and Tedder.²

The seropositivity rates were 7.2% (five of a sample of 69) in Manzini, Swaziland, and 1.4% (one of a sample of 71) in rural Zululand. Tubercu-

culin skin test reactivity varied between 15 mm and 21 mm in reactive patients (mean 17.4 mm). Only one patient had no response to tuberculin. The tuberculin sensitivity results tally with Dr De Cock and colleagues' findings. This raises the question of why, in these presumably advanced cases of HIV infection, the T cell response is not so impaired as to lose tuberculin sensitivity altogether.

There are a number of possible reasons why the HIV seropositivity rates vary so greatly between the Ivory Coast and southern Africa. Firstly, HIV-I reached endemic proportions in west Africa some years ago, and it may be only a matter of time before it reaches the South with the same impact. A comprehensive review of HIV infection in South Africa by Sher in 1988 concluded, "HIV infection and AIDS in South Africa have so far followed a pattern seen in Western countries. 1988 witnessed a predicted and alarming increase in the number of AIDS cases and HIV positive people in the black community. If this trend continues, we can expect an 'African type' HIV pattern in South Africa in the near future."³

Secondly, preventive measures may have been more effective in southern Africa than in west Africa, which was largely unprepared for the epidemic. This is, however, most unlikely. In Swaziland the only evidence I saw of a preventive campaign was a single tattered poster in English urging men to have "fewer sexual partners." The italicised plural in this phrase meant that the poster was doubly hampered: firstly, by the inappropriate message and, secondly, because the poster was in English and thus inaccessible to most of the population. In Zululand no preventive campaign was in evidence.

Unless effective preventive measures are taken soon, the expected massive increase in HIV infection in southern Africa will occur, with the same appalling effects that have already been documented in west Africa. The low prevalence of HIV-I in Zululand and Swaziland indicates an opportunity to nip the epidemic in the bud.

DAVID INWALD

Birmingham Accident Hospital,
Birmingham B15 1NA

- 1 De Cock KM, Gnaore E, Adjorbo G, et al. Risk of tuberculosis in patients with HIV-I and HIV-II infections in Abidjan, Ivory Coast. *BMJ* 1991;302:496-9.
- 2 Peckham CS, Tedder RS, Briggs M, et al. Prevalence of maternal HIV infection based on unlinked anonymous testing of newborn babies. *Lancet* 1990;335:516-9.
- 3 Sher R. HIV infection in South Africa 1982-1988: a review. *S Afr Med J* 1989;76:314-8.

Desensitisation

SIR,—When the recommendations of the Committee on Safety of Medicines were published in 1986¹ our department was asked to take on all the immunotherapy in Calderdale district. We responded by setting up double blind controlled trials for biologically standardised extracts of house dust mite and grass pollen in single allergen allergic rhinitis. The control (saline spiked with histamine) and method (including observation for two hours) were broadly similar to those of Dr V A Varney and colleagues.² Although our trial is still immature, we would support two of their observations.

Firstly, the two hour observation period precludes treatment for many potential beneficiaries—four out of the 16 patients in the trial so far have discontinued their fortnightly injections and seven have declined to take part in the trial solely because of the inconvenience. Secondly, with the 203 injections given so far there have been two reactions requiring adrenaline, and both of these were in the arm treated with house dust mite. They occurred less than 30 minutes after the injection and were rapidly reversed.

We therefore concur that the "two hour" rule

seems illogical and makes immunotherapy impractical.

C RAMANATHAN
GRAHAM J C SMELT

Royal Halifax Infirmary,
Halifax HX1 2YP

- 1 Committee on Safety of Medicines. *Statement on desensitisation*. *BMJ* 1986;293:948.
- 2 Varney VA, Gaga M, Frew AJ, Aber FR, Kay AB, Durham SR. Usefulness of immunotherapy in patients with severe summer hay fever uncontrolled by antiallergic drugs. *BMJ* 1991;302:265-9. (2 February.)

Freeman Hospital

SIR,—Despite the optimism of Mr Jeremy Laurance,¹ if what is happening at the Freeman Hospital is what the NHS "reforms" are really about then the first signs are not good. One of Newcastle's two dermatology wards is at the Freeman Hospital, but dermatology is not included in its trust prospectus because all dermatology services are to be centralised at the Royal Victoria Infirmary when ward space becomes available in two or three years. Yet on 1 April this year dermatology will be discontinued by the new Freeman Trust—to be replaced, it is believed, by a private surgery ward for overseas visitors.

Dermatology is a subregional specialty in Newcastle, and the loss of over 40% of its beds will affect the whole of Northumberland. Surely the Freeman can and should be compelled to maintain this essential regional service until adequate facilities are found elsewhere. If this ejection of dermatology by the new Freeman Trust Hospital is permitted we can only conclude that it is a victim not so much of the stimulating "scent of opportunity... in the air" as of the sharp whiff of commerce.

J S COMAISH
P M FARR
SAM SHUSTER

University Department of Dermatology,
Newcastle upon Tyne NE1 4LP

- 1 Laurance J. Freeman hospital: countdown to self government. *BMJ* 1991;302:580-2. (9 March.)

Child health computing

SIR,—The correspondence following our editorial on child health computing¹ has raised a number of important issues.

Drs Malcolm Aylett and Allan Colver are incorrect in suggesting that the national child health system is unable to provide rapid feedback of immunisation performance to practitioners.² Vaccine coverage data for individual general practitioners, health visitors, and child health clinics are available as a standard request from the statistics package of the system.³ Not all districts that use the system routinely feed back this information; failure to do so, however, is due not to a deficiency in the system but to failure to use an available resource.

Drs Aylett and Colver also advocate adopting the family health services authority's list as the basis for a community register. Other correspondents (Dr Sally Jefferies and colleagues⁴), however, draw attention to the inaccuracies that exist on both this list and child health computer lists. These discrepancies, which are due mainly to the lack of information flow between professionals,⁵ can be eliminated only by collaboration between the two systems working towards a common register, thereby increasing the number of opportunities for updating information on the register. It has to be remembered that up to 15% of children in inner city districts are not registered with a general practitioner, and the health authority

register thus remains necessary. The development of electronic links between the child health and family health services authorities' systems is now being piloted in Stockport (ICL version) and Avon (MUMPS version). This is only the first step, and future developments for the system will include direct linkage to general practitioners' micro-computers.

Dr D J Hewitt criticises the national system for being centralised and unresponsive to local needs.⁷ Many health authorities do not, however, have the resources to develop their own system. The interactive ICL version of the child health system, which will be available from July, allows considerably increased local flexibility while retaining the financial advantage of sharing the heavy development costs among user districts. Compliance with data protection and confidentiality requirements are already proved, and staff can operate the system without additional training when they move between health authorities. For every health authority to develop its own system would lead to chaos and unnecessary expense.

EUAN ROSS

Department of Community Paediatrics,
King's College School of Medicine,
London SE5 7RN

NORMAN BEGG

Child Health Management System Executive,
PHLS Communicable Disease Surveillance Centre,
London NW9 5EQ

- 1 Ross E, Begg N. Child health computing. *BMJ* 1991;302:5-6. (5 January.)
- 2 Aylett M, Colver A. Child health computing. *BMJ* 1991;302:409. (16 February.)
- 3 Child Health Computing Committee. *The child health system—a statistical guide*. Cardiff: Welsh Health Common Services Authority, 1987.
- 4 Begg NT, White JM. A survey of pre-school vaccination programmes in England and Wales. *Community Med* 1988;10:344-50.
- 5 Jefferies S, Victor C, Oerton J, McShane S, Beardow R. Child health computing. *BMJ* 1991;302:410. (16 February.)
- 6 Morris RW, Lakhani AD, Morgan M, Dale C, Vaile MSB. The role of information flow between health professionals and the child health computer system in the uptake of measles immunisation. *Community Med* 1988;10:40-7.
- 7 Hewitt DJ. Child health computing. *BMJ* 1991;302:409-10. (16 February.)

Trials of homoeopathy

SIR,—The scoring system employed by Dr Jos Kleijnen and colleagues does not adequately reflect the credibility of publications.¹ No account is taken of peer review; indeed, it is biased against peer reviewed publications. A study by some of us that was published in the *BMJ* achieved a relatively low score—because it had not been possible to include full details of patient characteristics, randomisation, etc, in a 600 word *BMJ* short report.² A fuller version of the paper published in a less competitive and less rigorously reviewed journal would have scored higher. But would it really have been better?

Excessive weighting was given to trial size. The main reason cited was "worry about incomparability at baseline." This can be entirely obviated by cross over, yet the authors discriminated against cross over studies.

We wonder if Dr Kleijnen and colleagues have considered the methodological and logical problems raised by their call for checks on blinding. Presumably this would take the form of a question: "Do you think your medication is active or a placebo or don't you know?" If investigators can influence assessments, they can also influence patients to answer "don't know" to this question, which would be taken as indicating adequate blinding.

We believe that the questions surrounding homoeopathy will be resolved by the classical method: repetition of trials, with methodological improvement, at disinterested centres of excel-

lence. This is the strategy that we are pursuing in several clinical trials at our two centres.

PETER FISHER
E C HUSKISSON
D L SCOTT
PAUL TURNER

Departments of Rheumatology and Clinical Pharmacology,
St Bartholomew's Hospital,
London EC1M 6BQ

T E WHITMARSH

Princess Margaret Migraine Clinic,
Charing Cross Hospital,
London W6 8RF

- 1 Kleijnen J, Knipschild P, ter Riet G. Clinical trials of homoeopathy. *BMJ* 1991;302:316-23. (9 February.)
- 2 Fisher P, Greenwood A, Huskisson EC, Turner P, Belon P. Effect of homoeopathic treatment on fibrositis (primary fibromyalgia). *BMJ* 1989;299:365-6.

SIR,—A recent review of randomised trials of homoeopathy led the authors to the conclusion that: "in [our] opinion, the results do not provide acceptable evidence that homoeopathic treatments are effective."¹ To establish whether there is evidence of the efficacy of homoeopathy is not an easy task, and the methodology proposed by Dr Jos Kleijnen and colleagues is an important step forward.² However, some of their assertions seem debatable.

Firstly, is it true that "much evidence is available"? Perhaps, if the whole of homoeopathy is considered as a single medicine; surely not, if one counts the impressive number of ingredients, so that for some preparations positive results seem to be extremely scarce, whereas for the remaining preparations used in homoeopathy there are no results at all. Therefore the likelihood of a bias in reporting positive results is indeed tremendously high, probably higher than for other treatments.

Secondly, the indications given in table II were mostly for diseases the evolution of which is recognised to present huge fluctuations, making it difficult to assess the specific effect of a medical treatment. Thirdly, it seems (from the same table) that when homoeopathy had a more pronounced effect than placebo this was often on subjective symptoms (those assessed with a visual analogue scale), for which a psychological induction is likely: this must be emphasised because the authors have doubts about the blindness of most trials.

Finally, one can wonder whether the reported results, even when statistically significant, were medically important: is it very important to raise the percentage of recovery in influenza from 10.3% to 17.1%, or to wait for 4.0 days until first faeces rather than 4.9 (especially in view of the efficacy of laxatives when needed)?

I perfectly agree with Dr Kleijnen and colleagues that there is no reason to believe that the influence of bad methodology is much less in conventional medicine than in homoeopathy. But evidence that the assessment of allopathic treatments may be poor should be an incitement to become more demanding with our academic procedures, and by no means an encouragement to be less critical with alternative medicines.

MARC GIRARD

75013 Paris,
France

- 1 Hill C, Doyon F. Review of randomized trials in homeopathy. *Rev Epidemiol Sante Publique* 1990;38:139-47.
- 2 Kleijnen J, Knipschild P, ter Riet G. Clinical trials of homoeopathy. *BMJ* 1991;302:316-23. (9 February.)

Spontaneous pneumothorax

SIR,—Dr Douglas Seaton and colleagues present an interesting approach to the problem of managing patients with spontaneous pneumothoraces