Soutar and Ginsberg cite the 18% cross reactivity noted for Org 10172 in the series of Chong *et al*,⁵ but they have not appreciated that this study used a panel of stored serum samples, which represents a totally different situation. Any positive reactions found under these circumstances or by pretesting serum from a patient with heparin induced thrombocytopenia would preclude that patient from receiving the cross reacting drug, thus minimising the chances of a clinical disaster. It is these patients who show cross reactions, and those for whom doubt exists because a test was not done, who can alternatively be treated with anacrod or perhaps prostacyclin or hirudin analogues. Long term use of these drugs—for example, for renal dialysis or haemofiltration and in pregnancy—is usually, however, not possible.

In a continuing study of 350 named patients with heparin induced thrombocytopenia, of whom about three quarters had a thromboembolic complication or required urgent anticoagulation for a vascular operation or invasive procedure, over 93% were successfully treated with Org 10172. Five patients developed a cross reaction on testing, with thrombocytopenia persisting or recurring after one to six days' treatment. Only one of these patients suffered a non-fatal thrombotic clinical event. Two other patients developed thrombotic events soon after starting Org 10172, but testing for cross reactivity was not possible and the causal relation with the drug is unclear.

At present there is no absolutely safe replacement treatment for patients who develop heparin induced thrombocytopenia. All possible alternatives have one or more drawbacks. But even without prior testing for cross reactivity, which is always recommended but often not possible in the time available, Org 10172 is at least as safe and effective as anacrod and can be used in a wider variety of clinical situations.

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Anabolic steroids in sport

EDITOR,—John Gunn asks for scientific evidence of the benefits of anabolic steroids for people participating in competitive sport.¹ Haupt and Rovere reviewed published studies examining the effects of anabolic steroids.² They concluded that they showed no improvement in aerobic performance and were inconsistent with regard to the effects on strength; strength did increase if there was intensive training before and throughout periods when anabolic steroids were used. Landry and Primos drew similar conclusions in a more recent review.³

The most carefully conducted research was probably undertaken at the Sports Institute in Leipzig under state plan 14.25. The BBC *Horizon* documentary "A Question of Sport," transmitted on 8 June 1992, stated that some data avoided destruction around the time the Berlin Wall came down (a transcript is available from PO Box 7, London W3 6XJ). To our knowledge the surviving evidence has not been published. In our opinion

the political sensitivity of the issue, and the reputations of the athletes concerned, should not preclude publication.

All published studies examining use of steroids have been seriously flawed. Given the worldwide epidemic of use of anabolic steroids among athletes at all levels of competition, Perry *et al* have argued that controlled, double blind studies of the efficacy and dangers of high dose anabolic steroids are now ethically justified.⁴ The doses used by bodybuilders and others in Britain probably greatly exceed those needed for optimum benefit (if there is any benefit). Showing this might result in a reduction in doses and the risk of side effects. As belief in the efficacy of anabolic steroids has been reinforced by the fact that a user won an Olympic gold medal, only clear evidence of ineffectiveness is likely to deter current and future users.

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HIV and insurance

Catch 22

EDITOR,—The question of HIV testing and insurance gives rise to Catch 22. A spokesman for Commercial Union is quoted as saying, "The vast majority of people who are willing to go and have a test would do so because they feel that they had put themselves at risk in some way."¹

I applied for an income protection scheme recommended through BMA services and was told that I would have an HIV test. I said that although I was perfectly happy to have a test I must decline on the grounds that I would never again be able to answer that question asked by all insurance companies—"Have you ever had an HIV test?"—in the negative. I therefore do not have this form of insurance.

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- 1 Insurers inconsistent over HIV. *BMJ* 1993;306:1495-8. (5 June.)

Just say no

EDITOR,—I believe that the situation concerning HIV and insurers in Britain is actually far worse than is portrayed in a recent news article.¹ As a member of a low risk group who applied for life insurance recently and who honestly answered "no" to the standard screening question—"Have you ever had an HIV test?"—I was amazed that my wife and I were both automatically expected to take an HIV antibody test as a condition of possible cover. An obligatory test for all those asking for cover above a certain value was not mentioned on the application form.

The form I was expected to sign agreeing to the test contained a few paragraphs of information concerning HIV illness, which apparently took the place of any counselling. I was also expected to provide the name of a doctor to whom the insurers should write if HIV antibodies were found in the sample. Further investigation by my broker elicited the fact that illness related to HIV infection was in any case excluded from the cover offered.

This situation seems to me to be outrageous as people applying for cover are expected, without

warning or counselling, to undergo an investigation that is both potentially catastrophic to them and superfluous to the insurers. I now plan to obtain insurance from another firm, which does not demand a test for the amount of cover I require.

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- 1 Insurers inconsistent over HIV. *BMJ* 1993;306:1495-8. (5 June.)

Insurers don't penalise if test result is negative

EDITOR,—The news article entitled "Insurers inconsistent over HIV" unfairly criticises the British insurance industry.¹ The British industry is certainly consistent on its stance on AIDS and HIV, in no small measure because of the chief medical officers of life insurance companies.

The Association of British Insurers has stated unequivocally that a person will not be declined cover or charged more solely on the basis of a negative result of an HIV test, any more than he or she would be on the basis of a negative result of any other medical test such as intravenous pyelography, electrocardiography, or a blood glucose test for diabetes. Every doctor knows that a negative result does not guarantee that a disease or the potential for a disease to occur has been precluded; it is the underlying reason for any test, be it routine or clinical, that has to be assessed, and the same applies to HIV tests.

If an applicant who has had a negative HIV test result is charged an extra premium or is declined for life assurance cover, it will always be because of the presence of risk factors—be they risks of disease, lifestyle, or occupation—and not because of the negative result. If there are no other conditions than the negative HIV test result, that is the end of the matter.

Although the recent report by Day, which is the latest in a series of predictions, states that earlier projections regarding the increase in cases of AIDS and HIV infection have not been borne out,² this does not remove the difficulties for life insurance companies, which are writing business for the long term, where the future for HIV infection is still largely unknown. Insurers have a duty to look to the long term interest of policyholders. This duty extends to the assessment of the risk to ensure that, while it is equitable to all, it takes account of the fact that an insurer cannot alter the terms of a life insurance contract, which may run for 10, 15, or 20 years or more once it has been issued. Even with this careful selection, less than 1% of people are declined life insurance cover and only about 4% pay an additional rate of premium because of an increased health risk.

More and more people are having an HIV test for a wide range of reasons. In cooperation with the Department of Health, the Association of British Insurers advised its members that when there is a negative result of a routine HIV test—for example, during antenatal screening—the person can spell out clearly the circumstances surrounding the test. If it was a routine test and the result was negative no further information will be sought.

The article attempts to compare life insurance practices with regard to HIV in several countries, but medical practice varies considerably throughout the world. Insurance differs similarly, not only in the types of business sold but also because of the legal framework of the countries and the differing medical practices, which are reflected in insurance practice. Comparisons between countries can be made only after consideration of all the facts, otherwise the true picture is not given.

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