Smith and Taylor as the intravenous route may be useful in certain circumstances. Until conclusive advantages have been shown for the intravenous route in allergic emergencies, however, we recommend adherence to the guidelines in the *British National Formulary* and preferential use of the intramuscular route.^{2,4}

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HIV antibodies in babies

EDITOR,—Pietro Portincasa and colleagues describe what seems to be a very sensitive radioimmune western blot method for detecting IgA and IgM antibodies to HIV in the serum of HIV infected neonates born to seropositive mothers.¹ They conclude that it will discriminate early between babies who are and are not infected with HIV. There may, however, be reasons other than established HIV infection for the presence of IgA and IgM antibodies to HIV in the neonatal circulation, and they would detract from the value of tests for these antibodies at birth as indicators of transmission of HIV from mother to infant.

One possible explanation for the detection of IgA and IgM antibodies to HIV in neonates is that maternal IgM and IgA molecules cross the placenta and are detected by the sensitive assays of HIV antibodies now available, such as that used by Portincasa and colleagues. We use antibody capture assays for HIV specific IgG, IgA, and IgM. We detect IgG with HIV 1+2 GACELISA (Well-cozyme) and IgA and IgM by substituting anti- α and anti- μ for anti- γ in the solid phase of the same kit. With these assays we have often detected HIV antibodies of all three immunoglobulin classes in infected people. For example, we recently examined the blood of 37 parturient seropositive mothers: all 37 had detectable HIV specific IgG and IgA, and 35 had specific IgM. We also tested blood from their newborn babies. Those babies born to mothers with IgA reactivity (optical density:cut off reactivity) ≥ 8 and IgM reactivity ≥ 7 had detectable IgA and IgM (optical density:cut off reactivity ≥ 1), whereas in those babies whose mothers had weaker IgA or IgM reactivity neither specific IgA nor IgM was detectable.

Though not all of these results may be specific, the most likely interpretation of the findings is that, contrary to dogma based on insensitive assays, specific IgA and IgM do cross the placenta. When concentrations of these antibodies in the mother are sufficiently high and a sensitive assay is used the antibodies are detectable in the infant. The mothers with the highest IgA and IgM HIV antibody concentrations may be those who have the most intense viraemia. If so, the virus would be most likely to be transmitted to the infant when specific IgA and IgM reactivities are high in the mother and detectable in the infant; but the essential point is that the IgA and IgM antibodies detected in the infant may have been passively acquired, not actively produced, and cannot therefore be due to infection in the infant even though they may be suggestive of it. If, as has been hypothesised, transmission of HIV takes place "at the end of pregnancy or at delivery," the infected neonate is unlikely to have an active antibody response at birth.

Evidence from longitudinal study of babies born

Detection of IgA, IgM, and IgG antibodies to HIV in infants aged ≤ 3 months and > 3 months who were born to seropositive mothers and whose eventual HIV infection status was known

	≤ 3 Months	> 3 Months
<i>Infected</i>		
	(n=12)	(n=24)
IgA	4	20
IgM	5	14
IgG	12	24
<i>Not infected</i>		
	(n=37)	(n=12)
IgA	12	
IgM	14	
IgG	37	7*

*Aged 5-11 months; the five infants who were negative for IgG antibody were aged 9-17 months.

to seropositive mothers supports the view that IgA and IgM HIV antibodies detected very early in life are derived from the mother and do not necessarily indicate infection. We have investigated babies infected with HIV (positive for HIV DNA on polymerase chain reaction, antibody persistently found in second year of life, or clinical signs) and babies not infected (table). We found IgA and IgM antibodies almost as commonly in those of 3 months and younger who did not later show evidence of infection as in those who did. In the older babies, however, we detected IgA and IgM antibodies only in those who were subsequently shown to be infected. This agrees with other recent reports.^{4,5}

Though detection of IgA antibody to HIV after 3 months of age strongly suggests active infection, we doubt whether the presence of IgA or IgM antibodies earlier in life is a reliable marker of infection or their absence a sign of freedom from infection.

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Treatment of Hodgkin's lymphoma

EDITOR,—In writing on treatment and delayed morbidity in Hodgkin's lymphoma Patrice Carde states that "Patients unsuitable for transplantation include those in whom complete remission has never been achieved, those who have had previous extensive irradiation, or, in some centres, those in second complete remission."¹ Our view, based on

experience of treating 155 patients with Hodgkin's disease at this centre and the data reported to the European Bone Marrow Transplant Group's register of autologous bone marrow transplantation in lymphoma, is that the first two parts of this statement are incorrect.

The concept that patients refractory to induction therapy (but not those who have a very good partial response) have a prognosis so poor as not to justify the use of autologous bone marrow transplantation comes from a multicentre study of non-Hodgkin's lymphoma,² and our experience confirms this view.³ This principle, however, cannot be applied to the selection of patients for high dose therapy and autologous bone marrow transplantation in Hodgkin's disease. Our evidence for this is that in the patients treated at this centre with chemotherapy with carmustine, etoposide, cytarabine, and melphalan and autologous bone marrow transplantation the progression free survival at five years of patients who had never achieved remission was 40% compared with 50% for the whole group.⁴ In 1000 patients reported to the European Bone Marrow Transplant Group the progression free survival for patients with Hodgkin's disease who had never achieved remission was 29% at five years compared with 34% for the whole group (European Bone Marrow Transplant Group, 1992).

With regard to the exclusion of patients who have had extensive previous irradiation, again our experience is that this is rarely a problem when a conditioning regimen of high dose chemotherapy without total body irradiation is used before transplantation. In patients in whom the bone marrow reserve has been depleted by extensive irradiation of areas of active haemopoiesis stem cells obtained from peripheral blood may be used in place of bone marrow.⁵

We believe that high dose therapy and autologous bone marrow transplantation should be considered in Hodgkin's disease: (1) when patients fail to achieve remission with induction therapy with either a MOPP regimen (mustine, vincristine, procarbazine, and prednisolone) or a regimen of MOPP alternating with ABVD (doxorubicin, bleomycin, vinblastine, and dacarbazine) or a regimen similar to either of these; (2) when patients relapse within six months of initial treatment; and (3) when patients relapse after treatment with two or more modalities.

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Problem drug use in general practice

EDITOR,—John Cohen and colleagues report the experience of one general practice in central London with a large population of patients mis-using drugs long term.¹ I have similar experience,

although I have not had the time or skill to audit the quality of my care. My personal list is 2100 patients, and I look after about 100 patients who have misused drugs long term (about 60 of these receive regular prescriptions for various replacement drugs).

Practices with large numbers of patients who are long term drug users who are handled with skill, understanding, and firm discipline are a medical phenomenon. I believe that their experience should be canvassed nationally: they could contribute considerable knowledge to the debate on how primary care can take on the care of those who are chemically dependent.

Quality primary care for long term drug misusers is costly in surgery time and draining in personal energy but can be very worthwhile. I believe that questions concerning the financial resources for this work have not been adequately addressed. I strongly support the idea of establishing a forum for practices with 50 or more patients with serious problems of chemical dependence to exchange views and set up workable protocols to assess quality of care and for personal support. I would like to hear from anyone interested in exploring this further.

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1 Cohen J, Schamroth A, Nazareth I, Johnson M, Graham S, Thomson D. Problem drug use in a central London general practice. *BMJ* 1992;304:1158-60. (2 May.)

Performance related pay for radiologists

EDITOR,—Jonathan Boyce and Tim Morris are incorrect in their belief that the performance of either a radiologist or a department of radiology can be assessed by throughput.¹ Currently, good practice in radiology is concerned with reducing radiation dosage and eliminating unnecessary radiography. Any discussion of performance related pay in radiology must surely take this into account, especially if the application of good practice means a reduction in departmental workload and income. To relate a radiologist's remuneration to his or her workload would be a retrograde and dangerous step.

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1 Boyce J, Morris T. Performance related pay for hospital doctors. *BMJ* 1992;305:131-2. (18 July.)

Unawareness of dystonia

EDITOR,—After the publication of a review of the dystonias¹ the Dystonia Society carried out a pilot scheme in the north west, sending a concise information sheet on dystonia to all 2154 general practitioners (with four million patients) in the area. The bottom part of the information sheet had a tear off portion whereby recipients could ask for a free copy of Marsden and Quinn's article and to buy or borrow a video on dystonia. Twenty two recipients asked for a copy of the article and seven asked to borrow the video, which suggests that unawareness of dystonia is a thing of the past.

The best estimate of the prevalence of dystonia is 391 cases per million; this suggests that there should be an average of 1.73 patients with dystonia per practice, or 1564 in the north west. Of the hospitals with dystonia clinics in the area, two of the most active are at Walton Hospital in Liverpool (one clinic a week) and the Royal Preston Hospital

(one clinic every two weeks). Both see about six new patients each month, which suggests that the prevalence estimate is fairly accurate.

Requests for information and inquiries to the society from patients and the public's interest in talks organised by, and specialist leaflets available from, the society suggest that many patients are still suffering and awaiting treatment from neurologists in special clinics who have knowledge about dystonia. Thus it is unfortunate that our pilot scheme engendered such a low response from general practitioners. The Dystonia Society would like to be able to devote all its attention to supporting patients and raising funds for its research rather than being centres for disseminating information to patients. It would be much better if general practitioners could supply such information.

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1 Marsden CD, Quinn NP. The dystonias. *BMJ* 1992;304:139-44.

Asian doctors and the MRCGP examination

EDITOR,—It is no surprise to me that Richard Wakeford and colleagues did not find any systematic discrimination against doctors of Indian subcontinent ethnic origin ("Asian doctors") to explain their poor performance in the MRCGP examination.¹ The authors give some plausible explanations for the poor performance of Asian doctors: poor training or training that is not congruent with general practice in the United Kingdom, and the barrier of the English language.

As an Asian doctor myself, I believe that these explanations have a minor role. The common problem is the system of education and the principle of learning by rote, which is so much a part of teaching in the Indian subcontinent. Far greater importance is laid on collecting facts than on how to assemble knowledge and use it constructively. It requires a great deal of effort, time, conscious realisation, and guidance to absorb new methods of learning and put them into practice.

Secondly, the profound effects of the social, psychological, and cultural changes related to immigration should not be ignored. Asian doctors have to face the rigours of this transition together with the tremendous stress experienced while preparing for the postgraduate medical examination.

I hope that in any future investigation of poor performance case by case (as Wakeford and colleagues suggest) the above mentioned factors are seriously considered. It would be helpful if the royal colleges provided counselling and ran short induction courses and training workshops on examination techniques. These, I think, would greatly improve the performance of Asian doctors.

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1 Wakeford R, Farooqi A, Rashid A, Southgate L. Does the MRCGP examination discriminate against Asian doctors? *BMJ* 1992;305:92-4. (11 July.)

EDITOR,—Richard Wakeford and colleagues highlight the problem of about a fifth of general practitioners in the United Kingdom—those from ethnic minorities, mainly Asian—and the failure of the Royal College of General Practitioners to redress their plight from the beginning.¹ The college has mentioned wherever possible that the chance of passing the MRCGP examination is poor if you are an overseas doctor, but it has not

attempted to introduce graded educational programmes to help these doctors succeed in the examination: many would welcome a programmed distance learning course.

Training practices where overseas doctors often train should be inspected more frequently and the content of their training programme scrutinised. Even now in West Yorkshire overseas doctors and British born Asian graduates of British universities are trained in poor quality training practices, where they are no more than an additional pair of hands. Few good inner city practices run by overseas doctors are considered for training purposes, though the facilities and management protocols are far superior to those of many training practices.

As an undergraduate tutor in general practice and an overseas doctor, I do not think that Asian doctors fail on account of their clinical knowledge. They fail because of the multiple choice questionnaire and the language and, most of all, because they have to assimilate and "think British" along the lines of most of the examiners, who are middle to upper middle class with totally different socio-cultural values from those of the patients of most Asian doctors in inner cities. Wakeford and colleagues' paper may help a little to remedy this or at least make some people think and not alienate one fifth of the profession.

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Life as a junior hospital doctor's spouse

EDITOR,—Lorna Montgomerie urges junior doctors' wives to inject their lives with good cheer and a positive approach topped up with a dose of laughter.¹ Taking her advice, I have formulated an alternative 10 point survival plan.

(1) "Get to know your spouse well before you get married"—it will help you recognise him when he does actually come home.

(2) "Treat time together as precious"—particularly those tender moments when he falls asleep in your arms 10 minutes after arriving home and you've got four days' talking to do.

(3) "Don't ever keep meals waiting"—even better, don't even bother to learn to cook.

(4) Congratulate yourself on having chosen a superhuman husband who can survive on two hours' sleep a night. He must really be something special, mustn't he?

(5) Laugh your socks off when you catch a government spokesperson on Radio 4 assuring the nation that no doctor works more than 72 hours a week.

(6) Have great fun sabotaging your husband's plans to spend his precious free weekend working on research papers.

(7) Delight in being able to eat your "TV Christmas Lunch For One" in peace and quiet.

(8) Happily plan for the future when you can be together more: who knows, trips to the moon might be available on senior citizens' passes by then.

(9) Enjoy being able to decorate your (many) houses to your own taste—he'll never be there to enjoy them anyway.

(10) Be immensely grateful that your husband made it to the birth of your child.

Positive enough? I'm trying.

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