misleading and could only suggest to the reader that the source of the press leak was a member of one or other of our departments, which are regularly responsible for the care of the vast majority of HIV infected individuals in Birmingham. This is simply not true.

Confidentiality is a fundamental tenet of the service we provide for HIV infected individuals and under no circumstances would we divulge a patient's name to the media—certainly not to provide “a focus around which to challenge... mounting complacency about AIDS,” as suggested by Fitzpatrick. The article further implies that we have a “tendency to regard HIV infection as more a moral condition than a disease” and that we judge people with HIV and AIDS “according to the degree of their individual responsibility for their condition.” This does not reflect the attitude of the doctors and other staff dedicated to caring for such people in Birmingham.

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1 Fitzpatrick M. AIDS and ethics in Birmingham: a betrayal of trust. *BMJ* 1992;305:259-60.

AUTHOR'S REPLY.—I am happy to accept that Dr Wood and his colleagues in the regional HIV/AIDS unit and the department of genitourinary medicine were not responsible for the breach of confidentiality that I described in my article. However, somebody with access to detailed clinical information concerning people with HIV/AIDS in Birmingham clearly did leak such information to the press and that remains a matter of concern.

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Litigation over illness associated with tryptophan is possible

EDITOR.—The illness associated with tryptophan known as the eosinophilia-myalgia syndrome was newsworthy two years ago. Five Scottish patients were reported on in the correspondence columns of the *BMJ*^{1,2} and the *Lancet*.^{3,4} In the United States around 1500 cases were notified to the Centers for Disease Control, but there may have been 5000-10 000 cases.⁵

Two years on relatively few patients, possibly only 10%, are free of symptoms.⁶ The commonest persisting symptoms are myalgia, fatigue, paraesthesia, muscle cramps, and scleroderma-like skin changes.⁷ A problem for patients with such symptoms is that there is no objective indicator; there is no recurrence of eosinophilia or important increase in the erythrocyte sedimentation rate. Doctors should be alert to the risk of dismissing such symptoms as non-organic. Reports have suggested that the symptoms may slowly improve with time.⁷ Steroids frequently provide symptomatic relief, but there is no convincing evidence of an effect on the duration of the disease.⁷

The legal case is still being argued in the American courts. The cause has not yet been defined, but there is some evidence of an association with some batches of tryptophan made by the Japanese firm Showa Denko. The material was

prepared microbiologically,⁸ and several changes were made in the manufacturing process, including a change in the organism. There may be more than one contaminant.⁹

In the United States numerous support groups for patients with the eosinophilia-myalgia syndrome are well organised into a national network. According to a recent newspaper report in the United States, there are about 1400 plaintiffs with cases against Showa Denko.¹⁰ British sufferers who are generally less litigious, are probably unaware that they could join such action, and the opportunity to do so will soon be time barred. The American patient support groups are willing to guide British sufferers.

If any further information is required I am prepared to respond to any doctor writing to this address on issues affecting individual patients.

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HIV infection and certification of death

EDITOR.—John Aldous and colleagues' paper discussing the impact of HIV infection on mortality in young men in a London health authority highlights many of the problems regarding death certification, HIV infection, AIDS, and confidentiality.¹ The authors found that HIV infection was the leading cause of death in 15-44 year old men and emphasise the importance of accuracy in death certification. The fact that HIV infection is the underlying cause of death, however, is not as important as ascertaining the HIV infection status of those who have died.

The actual cause of death may have no immediate or obvious link with HIV infection, but the knowledge that the person was infected could be highly relevant, for example, in cases of suicide. It may also be wrong to assume that HIV infection was the underlying cause of death in people known to be infected but certified as having died of other causes. The most that may be assumed is that HIV infection might have been a contributory cause of death in those who are found to be infected after death.

While the information on death certificates remains non-confidential inaccuracy in certification will occur. The principle must be to maximise the accuracy of the initial certification. Apart from the current facility to offer further information on cause of death, methods should be established for checking the accuracy of death certification and linking with surveillance systems for HIV infection and AIDS. I suggest two possible methods of linkage.

Firstly, people known to be infected with HIV

or to have AIDS could be flagged at the NHS Central Registry as part of the notification system. This would need a level of identifying patients which is available only in some cases. When the flagged patients died the accuracy of their death certificates could be investigated. Secondly, record linkage of surveillance systems for HIV infection and AIDS with death certification data as held at the General Register Office in Scotland is possible. Such record linkages could be performed periodically, and matching cases with the same soundex code and date of birth could be identified and analysed. The advantage of this method would be that an anonymised identification system such as the soundex code could be used and confidentiality preserved.

The second method is also a check on the accuracy of the anonymised data typically held in national and local surveillance systems for HIV infection and AIDS. It could form part of a regular check to validate data held in these surveillance systems.

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1 Aldous J, Hickman M, Ellam A, Gazzard B, Hargreaves S. Impact of HIV infection on mortality in young men in a London health authority. *BMJ* 1992;305:219-21. (25 July.)

EDITOR.—John Aldous and colleagues, in their study of male residents of Riverside, concluded that HIV infection was the leading cause of death in those aged 15-44 and the third commonest cause of death in those aged 15-64 years.¹ The operational criteria for HIV or AIDS related death in this study is misleading as the diagnosis of HIV infection or AIDS does not necessarily imply a cause of death. On this basis, it is unclear what proportion of deaths was due to common bacterial pathogens or non-HIV related causes in those infected with the virus. McCormick, to whom Aldous and colleagues referred quite extensively, was careful in claiming a cause-effect relation and stated only that the observed increase in mortality is “unattributed to but probably associated with HIV infection.”²

Mientjes *et al* reported a high and rising incidence of bacterial pneumonia among HIV infected intravenous drug users in Amsterdam without a consequential rise in non-AIDS mortality.³ By contrast, an earlier study in New York showed that deaths caused by bacterial pathogens have risen greatly during the AIDS epidemic.⁴ The greater mortality among HIV infected intravenous drug users in New York than in Amsterdam would seem to reflect differences in these two cities in the early detection of bacterial pneumonia among intravenous drug users and accessibility to inpatient and outpatient medical services, both of which are important factors in preventing deaths due to common bacterial pathogens.

Aldous and colleagues did not consider the health consequences of homelessness in their study or the social and psychological deprivations which invariably follow the diagnosis of HIV. Social isolation, a sense of hopelessness and alienation, suicide or accidental drug overdose, and failure of early detection and treatment of bacterial pneumonia in people infected with HIV deserve specific comment in the analysis of data and interpretation of research findings.

Bacterial pneumonia, endocarditis, thromboembolism, and deliberate or accidental self poisoning were major causes of death among intravenous drug users before the advent of HIV and remain largely so. Among single men aged 15-54, HIV arguably has contributed in some degree to increased mortality in the decade 1981-91; that this picture will persist through to the next decade is unlikely, particularly in view of AIDS related self organisation and behaviour change among homosexual groups. We remain vigilant about