anitis. Even this route of administration is not entirely free of complications.

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- 1 Harnes JR. The foreskin saga. *JAMA* 1971;217:1241-2.
- 2 Warren JP, Smith PD, Dalton JD, Edwards GR, Foden M, Preston R, et al. Circumcision of children. *BMJ* 1996;312:377. (10 February.)
- 3 Cuckow PM, Rix G, Mouriquand PDE. Preputial plasty: a good alternative to circumcision. *J Pediatr Surg* 1994;29:561-3.

Chlamydial infection is asymptomatic in England as well as Tanzania

EDITOR,—H Grosskurth and colleagues conclude that infection with *Chlamydia trachomatis* is commonly asymptomatic among rural Tanzanian men.¹ In our experience, it is commonly asymptomatic among urban men in Lancashire, England.

During April 1994 to April 1995, 84 male patients were seen in whom *C trachomatis* infection was diagnosed on culture. Of these, only 43 complained of urethral discharge or dysuria, or both. Forty one had no symptoms of urethritis. It is our policy to trace all sexual contacts of patients infected with *C trachomatis*. Eighteen of the 84 patients were contacts, but only one was symptomatic. The remaining 66, who were not known contacts, were diagnosed by routine screening.

C trachomatis is a common cause of sexually transmitted diseases world wide and if not treated can lead to severe complications, especially in women.² Since 1988 it has been our policy to screen all men and women attending our department for *C trachomatis* infection. Some authors have argued against universal screening of men attending sexually transmitted diseases clinics,³ but, given our experience and that the true cost of any undiagnosed genital chlamydial infection to the community will be high, we will continue our current policy. We believe that the "syndromic approach" to the management of sexually transmitted diseases will not adequately address the impact of asymptomatic diseases and may lead to major gaps in programmes to control sexually transmitted diseases.

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- 1 Grosskurth H, Mayaud P, Mosha F, Todd J, Senkoro K, Newell J, et al. Asymptomatic gonorrhoea and chlamydial infection in rural Tanzanian men. *BMJ* 1996;312:277-80. (3 February.)
- 2 Taylor Robinson D. Genital chlamydial infections: clinical aspects, diagnosis, treatment and prevention. In: Harris JRW, Forster SM, eds. *Recent advances in sexually transmitted diseases and AIDS*. Edinburgh: Churchill Livingstone, 1991:219-62.
- 3 Van Duynhoven YTHP, van de Laar MJW, Fennema JSA, van Doornum GJJ, van den Hoek JAR. Development and evaluation of screening strategies for Chlamydia trachomatis infections in an STD clinic. *Genitourin Med* 1995;71:375-81.

Cause of AIDS

See p 1236

EDITOR,—It is not my intention to enter into the "genius or maverick?" debate¹; however, it is pertinent to reiterate the fact that until the postulates laid down in 1890 by Robert Koch are fully satisfied, an element of doubt concerning the aetiology of AIDS must remain.

Several historical examples serve to illustrate the dangers inherent in drawing (unjustified) conclusions of this nature. One concern is the

confusion surrounding the cause of African sleeping sickness (the "Negro lethargy") in 1902.² Patrick Manson (1844-1922) was of the opinion that the disease was caused by *Filaria (Mansonella) perstans* because he encountered three patients at the London and Charing Cross Hospitals in the 1890s suffering from the disease, who were infected with this haematogenous nematode. As a result of a great deal of research, Aldo Castellani (1877-1971), a member of the first "sleeping sickness" expedition, concluded (initially) that the disease resulted from a streptococcal infection—because he had visualised this organism in all of the patients investigated at Entebbe.³

To establish beyond doubt that an organism is the sole, incontrovertible, and inseparable cause of an infection, as stated by Koch, three criteria must be established: constant presence of the organism in every case of the disease; preparation of a pure culture, which must be maintained for repeated generations; and reproduction of the disease (in animals) by means of a pure culture several generations removed from the organism(s) initially isolated.³ It is pointless to decry Peter Duesberg without "cast iron" evidence.^{4,5} History has a curious tendency of recapitulation.

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- 1 Sabin CA, Pasi KJ, Phillips AN, Lilley P, Boffill M, Lee CA. Comparison of immunodeficiency and AIDS defining conditions in HIV negative and HIV positive men with haemophilia A [with commentary by P Duesberg]. *BMJ* 1996;312:207-12. (27 January.)
- 2 Cook GC. Correspondence from Dr George Carmichael Low to Dr Patrick Manson during the first Ugandan sleeping sickness expedition. *Journal of Medical Biography* 1993;1:215-29.
- 3 Singer C, Underwood EA. *A short history of medicine*. 2nd ed. Oxford: Clarendon Press, 1962: 379-80.
- 4 Duesberg P. Infectious AIDS: stretching the germ theory beyond its limits. *Int Arch Allergy Immunol* 1994;103:118-27.
- 5 Duesberg P, Bialy H. HIV results in the frame. HIV an illusion. *Nature* 1995;375:197.

Egyptian doctors held as prisoners of conscience

EDITOR,—I would like to draw attention to the outrageous fate of seven doctors in Egypt who were sentenced, on 23 November 1995 by the Supreme Military Court in Cairo, to between three and five years hard labour. These men were all members of the Muslim Brothers, an organisation which does not advocate violence; it publicly condemns violence.

The doctors concerned are Dr Issam al-Iryan, deputy secretary general of the Egyptian Medical Syndicate; Dr Ibrahim al-Zafarani, secretary general of the Alexandria branch of the Egyptian Medical Syndicate; Dr Mahmoud Izzat, lecturer at Zagazig University Faculty of Medicine; Dr Abd al-Munim Abu al-Futuh, deputy secretary general of the Arab Medical Association; Dr Anwar Shahata, treasurer of the Egyptian Medical Syndicate; Dr Mohey al-Din al-Zayat, dermatologist at Ain Shams University Hospital; and Dr Mohammad Saad, treasurer of the al-Giza branch of the Egyptian Medical Syndicate.

Amnesty International considers the detainees to be prisoners of conscience and is calling for their immediate and unconditional release. It believes the arrests may have been politically motivated.

The defence lawyers in the trials withdrew after only a few sessions, stating that these cases were political and that the defendants had not committed any recognised crimes. The lawyers had at this stage already petitioned the Supreme Constitutional Court about President Mubarak's decision to try civilians in military courts. Immediately after the lawyers' withdrawal, and before a ruling had been made on this petition, the court

appointed new defence lawyers, all of whom were former military judges or military staff. The defendants refused to cooperate with them and insisted that they would cooperate only with the original lawyers. Judgments were passed shortly after this. There is no right of appeal to the verdict or sentence of a military court to a higher court.

Some of the defendants had publicly stated before their arrest that they intended to stand as independent parliamentary candidates for the parliamentary elections on 29 November 1995.

These were part of mass trials of civilians before military courts and are violating some of the most fundamental requirements of international law, including Egypt's solemn treaty commitments under the International Covenant on Civil and Political Rights and the African Charter on Human and Peoples' Rights: the right to be tried before a competent, independent, and impartial court; the right to have adequate time to prepare a defence; the right to be defended by a lawyer of one's choice; and the right to appeal to a higher court.

It is ironic that on 25 November 1995, an amnesty was announced by President Hafez al-Assad of Syria of some 1100 political prisoners, including a number of doctors, who were detained without charge or trial over 15 years ago. One can only hope that efforts by our compassionate profession on behalf of our Egyptian colleagues, to secure justice and release, will not prove as tardy or ineffective as those exercised on behalf of the hundred or so health professionals arrested in Syria in 1980.¹

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- 1 BMA Working Party. *Medicine betrayed*. London: BMA, 1992:153-5.

Electronic mail can be protected from computer viruses

EDITOR,—J J Clarke stated that antivirus software struggles to detect viruses in electronic mail.¹ Computer viruses that can be transmitted by text documents are a recent problem. They were first noted when Microsoft accidentally distributed such a virus on CD ROM to software companies at the time of launch of their new operating system, Windows 95. This "prank macro" virus was not in itself malicious but because word processing documents can have any file extension it signified a need for antivirus programs to scan all files and not just those that indicated actual programs (such as .exe). Microsoft have now distributed a free program that will scan a floppy disk for infected files and flag macro viruses. These virus signatures have now been added to most antivirus software data files and so, providing all incoming files are screened, Millman and colleagues are correct when they state that the Internet does not pose an important threat to computer virus infection.²

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- 1 Clarke JJ. Electronic mail may infect computers with viruses. *BMJ* 1996;312:254. (27 January.)
- 2 Millman A, Lee N, Brooke A. Computers in general practice. II. *BMJ* 1995;311:864.

Correction

Ethnic differences in outcome of serum screening for Down's syndrome

An editorial error occurred in the last letter in this cluster, by Kevin Spencer (20 April, p 1041). The final sentence quotes an amniocentesis rate of 50%; this should be 5%.