tosis, actinic keratoses, and non-melanoma skin cancers, which are all objective indicators of excess exposure to the sun.³

Studies of migrants to Australia clearly implicate exposure to the sun in early childhood as a major risk factor for the development of melanoma.⁴ British studies have identified large numbers of benign melanocytic naevi as the main independent risk factor for melanoma.⁵ These observations have led to studies aimed at determining the main risk factors for developing naevi, one of which is exposure to the sun in early childhood.

Thus the case for excess exposure to ultraviolet radiation as a major risk factor for cutaneous malignant melanoma is established. More work is needed to define the relevant wavelengths of the spectrum and the exact quantity of ultraviolet radiation experienced by individuals of different phenotypes that lead to individual high risk. The pathogenesis of sunburn is also unclear, yet no one doubts the causal role of exposure to the sun.² Aetiological studies of melanoma over the long term should not be confused with current studies aimed at improving the nomenclature of early invasive malignant melanoma.

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Author's reply

EDITOR,—I am saddened but not entirely surprised by the comments from Rona M MacKie and colleagues, which if nothing else provide an example of what I referred to in my final paragraph when I said that "the antithesis of science is not art but politics"¹—in this case the politics of the prevention of skin cancer. I would, however, like to correct them on several points and disagree with them on others.

Firstly, I did not argue, as they suggest, against exposure to the sun being a factor in the aetiology of melanoma; quite the contrary. What is at issue is whether the secular trends in the incidence of melanoma are solely attributable to changes in exposure to sunshine. If they have objective evidence of these changes in individual exposure linked to rates then they should publish it rather than accept the usual chat of the glossy magazines and talk of package holidays, and so on. Their quasi-religious certitude on this issue contrasts with the more scholarly precision of a recent report from the National Radiological Protection Board (of which I note MacKie is a member).²

Secondly, I did not dispute that, after normalisation for surface area, melanoma is commonest on certain sites that are exposed to the sun. What I said was that most melanomas occur on sites that are only intermittently exposed and that the

body site distribution of melanoma differs from that of squamous malignancy, in which the relation with exposure to the sun is more straightforward. Rather than bask complacently we would do better to worry about the biology underlying these differences. The authors' comments about nomenclature miss the point entirely. Once the material is in formalin, nature's own bioassay has been denied. You can have consensus over policy and nomenclature until you are blue in the face: you need experiments, and until some experiments are done the predicament that those of us in clinics find ourselves in will continue.

Finally, do the authors really believe that the causal pathway between sunshine and melanoma is as sufficient or as rich as that between ultraviolet radiation and sunburn? Of course, if you do not distinguish visible from ultraviolet radiation, etc, you would have to argue that not only would we have to block out the ultraviolet but we would also have to continue to stay in the dark.

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Figures have risen by over 150% over 10 years

EDITOR,—For the past 20 years I have kept accurate records of every malignancy that occurs in the practice in which I work (an urban practice with an average of 14 000 patients). Analysis of the figures for the past 10 years shows a 150% increase in the number of skin cancers, in particular basal cell carcinomas and melanomas (table 1). The survey covers the period from January 1986 until December 1995 and is complete.

Table 1—Numbers of cases of various skin cancers in one general practice, 1986-95

	1986-7	1988-9	1990-1	1992-3	1994-5
Basal cell carcinoma	31	29	30	46	71
Melanoma	2	2	2	5	7
Intraepithelial carcinoma	11	8	4	11	18
Squamous cell carcinoma	8	0	5	2	8

My data come direct from the general practice population as opposed to statistics on hospital outpatients. The increase shown here is alarming.

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HIV antibody test should be a routine investigation for undiagnosed pneumonia

EDITOR,—The General Medical Council's booklet *Duties of a Doctor* set out the basic essentials of good medical practice for three topics—confidentiality, advertising, and HIV infection and AIDS.¹⁻³ Having a separate booklet about HIV infection perpetuates the myth that this is different from all other conditions.

A 37 year old man was referred with a three week history of cough, fever, and weight loss. A chest x ray film was normal one week into the illness. He had basal crepitations and bilateral shadowing in the lower zone, thought to be consistent with

resolving pneumonia. One week later, because the chest x ray film had not improved and no specific diagnosis was evident from the results of routine blood tests, sputum examination, or serological tests, bronchoscopy was arranged for four days' time. He was questioned twice about "risk factors," and none was elicited. He became ill three days after this consultation, discouraged his wife and friends from seeking medical help, and died within 24 hours. Necropsy showed *Pneumocystis carinii* pneumonia complicated by *Staphylococcus aureus* infection.

I contend that the clinicians should have felt able to order an HIV antibody test as part of routine investigations for undiagnosed pneumonia without feeling restricted by the General Medical Council's guidelines. While questioning failed to elicit risk factors, this must be a most insensitive way of trying to exclude exposure to HIV. In this case, knowledge that the patient was positive for HIV would have influenced his management and almost certainly altered his prognosis. It is as acceptable to counsel a patient after an HIV test as it is to tell someone that he or she has legionellosis, leukaemia, or syphilis. Performing any test to exclude a suspected diagnosis without mentioning all the possible differential diagnoses cannot breach the trust between patients and doctors. The level of discussion about investigations depends on the patient's understanding.

The guidance on confidential and sensitive treatment of all patients should be sufficient to deal with HIV infection and AIDS. The General Medical Council's booklet highlights only one specific distinction from other conditions: "the serious social and financial consequences which may ensue for the patient from the mere fact of having been tested for this condition." These consequences are unimportant compared with the value of excluding AIDS in a sick patient for whom specific treatment may be life saving. A doctor is not obliged to list in detail all the diseases that a patient does not have and therefore should not be required to tell a patient that he or she had an HIV antibody test.

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- 2 Court C. GMC launches new "blue book." *BMJ* 1995;311:972. (14 October.)
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Torture should not be trivialised

EDITOR,—What a depressing example of blinkered self pity Alison Martin's short article on the subject of "A patient who changed my practice" is.¹ No one would defend for a moment excessive hours worked in inhumane conditions to the detriment of both doctor and patient, but to compare a hard weekend on call with deliberate, politically motivated torture shows a breathtaking lack of perspective. In the first, the doctor is doing worthwhile work, which he or she has chosen, for agreed remuneration. If the conditions become intolerable the doctor is at liberty to resign, as Martin did. To equate this with incarceration and interrogation with hostile and dangerous men, with the threat of violence to oneself or one's family ever present, demeans and trivialises the experience of the victim.

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