Only from such full debate will both the medical profession and society be better educated.

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1 Dawson J. Vascular surgery in smokers. *BMJ* 1994;308:978.
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... when resources are limited

EDITOR,—Julie Dawson suggests that smokers should be asked whether they should have arterial surgery because "it is their life."¹ She asks how much longer society, which funds a national health service that is supposed to be there for all, is prepared to let doctors decide who gets treatment.

It may be the smoker's life, but it is society's resources. Doctors make decisions about treatment—in discussion if they are reasonable—because they know more about (the imperfect knowledge of) disease than most other people. If resources are limited (which they are: health is not there for all) decisions have to be made unless rationing is decided by lot or on a first come, first served basis.

Julie Hotchkiss distorts a serious discussion by asking whether differential survival by gender would justify expensive interventions being offered only to women.² This is not a valid comparison: smoking is addictive but is a lifestyle factor, which, unlike gender, entails an element of choice.

There is a view that we are all—smokers, heroin misusers, thieves—only victims of circumstance. It is a sustainable philosophical view but unrealisable practically. If we want the right to society's resources we have a duty to respect them and must be prepared sometimes to have resources refused if we ignore those duties.

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(9 April.)

Immunodeficiency without HIV

Clinical presentations vary

EDITOR,—A McNulty and colleagues reported on seven HIV negative patients with CD4 T lymphocytopenia and clinical diseases due to defective cell mediated immunity.¹ These cases were found during a national survey in Australia in which 96 practitioners were contacted. We present information on five HIV negative patients (four adults and one child) seen in our department between 1991 and 1993 (table) who meet the criteria set by McNulty and colleagues; two of them also satisfy the Centers for Disease Control's criteria for

CD4 T lymphocytopenia as defined by McNulty and colleagues. All patients had been referred to our department of immunology for evaluation of suspected immunodeficiency.

In contrast to the Australian group, our patients presented with a diverse range of clinical problems, from planar warts and vasculitis to recurrent infections. CD4 lymphocytopenia and defective cell mediated immunity may occur in medical conditions such as sarcoidosis, as in case 4. Acquired defects in cell mediated immunity may be associated with abnormalities of other parts of the immune system as in case 1; the patient was initially diagnosed as having panhypogammaglobulinaemia and was receiving replacement intravenous immunoglobulin treatment. The patient in case 2, who had the least clinical evidence of immunodeficiency, had the most profound CD4 lymphocytopenia. Interestingly, in the past she had failed to respond to BCG and hepatitis B immunisation.

Unlike McNulty and colleagues, we believe that defective cell mediated immunity without evidence of HIV infection may be uncommon but is not rare. Suspected immunodeficiency of any form should be investigated in conjunction with a department of immunology.

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1 McNulty A, Kaldor JM, McDonald AM, Baumgart K, Cooper DA. Acquired immunodeficiency without evidence of HIV infection: national retrospective survey. *BMJ* 1994;308:825-6.
(26 March.)

Consider HIV negative immunodeficiency in cryptococcosis

EDITOR,—A McNulty and colleagues suggest that a relation exists between CD4 T lymphocytopenia and cryptococcosis.¹ We report a case that gives credence to this view.

In 1993 a 48 year old man was referred to a dermatologist with an excoriated plaque on his right wrist. The lesion had arisen at the site of a peck by a pigeon. Biopsy showed cutaneous cryptococcosis. The patient kept pigeons, and earlier blood tests as part of investigations for an exacerbation of his chronic obstructive airways disease had yielded positive results for avian (pigeon) precipitants. In addition, a lymph node biopsy for inguinal lymphadenopathy in 1988 had shown a granulomatous disease, believed to be sarcoidosis. Tests for tuberculosis at that time had yielded negative results.

Further investigations in 1992 after weight loss and pneumococcal pneumonia identified florid oesophageal candidiasis and an absolute CD4 T lymphocyte count of $0.101 \times 10^9/l$ (much below $<300 \times 10^6$ required as a criterion for idiopathic CD4 T lymphocytopenia). Tests for HIV-1 and

HIV-2 yielded persistently negative results, and tests for HTLV-1 also yielded negative results. Subsequently the patient developed a pleural effusion, which was repeatedly found to contain acid-alcohol fast bacilli. Attempts to classify the species on culture were unsuccessful. Despite intensive treatment for cryptococcosis and tuberculosis the patient continued to deteriorate, and he died in February 1994. Necropsy showed systemic granulomatous disease; empyema, with the pus being positive for acid-alcohol fast bacilli; and continuing cutaneous cryptococcosis at the site of the peck. Retrospectively, it seems likely that the original lymph node disease was also of mycobacterial origin.

This case confirms other reports that severe CD4 T lymphocytopenia can occur in the absence of HIV infection. Although the case has many features in common with the recently defined idiopathic variant,^{2,3} the CD4 T lymphocytopenia was probably of acquired origin, given that the patient had a longstanding granulomatous disease, which perhaps had a role in the pathogenesis of his immunodeficiency. As in McNulty and colleagues' cases, cryptococcosis was an important manifestation. In this instance, however, it seems to have been of primary cutaneous origin since it developed at the site of the pigeon peck. Moreover, necropsy failed to show evidence of extracutaneous disease. A clinically alarming feature of the case was the inability of intensive therapeutic intervention to clear the mycobacterial and cryptococcal infection. The mycobacterial infection could well have been of avian origin, though this was not proved; this illustrates the potentially fatal complications of keeping pigeons.

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Controlling AIDS in India

EDITOR,—Zaka Imam's report on India's AIDS control programme presents a grim picture of a nation struggling to cope with rising numbers of cases of HIV infection.¹ Official figures grossly underestimate the numbers. The World Health

Details of HIV negative patients with CD4 lymphocytopenia

Case No	Age/Sex	Clinical details	Total lymphocyte count ($\times 10^9/l$) (normal range 1500-4000)	CD4 lymphocyte count ($\times 10^9/l$)		CD8 lymphocyte count ($\times 10^9/l$)		CD4:CD8 ratio (normal > 1.7)	Immunoglobulins (g/l) (adult reference range)		
				Absolute %	No	Absolute %	No		G (5.4-16.1)	A (0.8-2.8)	M (0.5-1.9)
1	39/F	Chronic diarrhoea, bronchiectasis, widespread warts, panhypogammaglobulinaemia	960	28.9	278	28.6	275	1.01	1.8	0.7	0.13
2	25/F*	Widespread planar warts	1943	8.7	169	43.8	744	0.2	14.4	3.3	0.17
3	3/M	Vasculitic rash, Raynaud's disease, recurrent candidiasis	4092	18.4	753	25.7	1048	0.72	18.5	3.6	1.3
4	35/M	Pulmonary sarcoidosis, chronic Epstein-Barr virus infection†	1430	25.6	380	32.2	460	0.83	11.5	2.3	5.5
5	28/F	Recurrent pustular rash, Bartter's syndrome	1000	30.8	300	34.5	345	0.89	11.5	2.1	1.5

*Negative for HIV antibody and p24 antigen.

†IgG antibody to viral capsid antigen 1:1280 (normal range < 1:640; IgM antibody to viral capsid antigen positive; IgG antibody to early antigen 1:40 (normal range < 1:40).

Organisation's projections suggest that 1 in every 1000 people in India will be infected by 2000.² An Indian news magazine recently highlighted the problem of cross border trafficking by prostitutes from Nepal.³ Commercial sex is an important route of transmission of HIV in Asian countries.

At the heart of this problem is the complacency shown by the central government in New Delhi. It is astonishing that, while the numbers of cases of HIV infection and AIDS are rising, the programme budget remains underspent.¹ There is no coherent national strategy on conducting safe sex campaigns. Government departments shy away from giving explicit information about the spread of HIV. Campaigns through leaflets will have no role in rural areas owing to low literacy rates. But it is not too late to reverse the rising number of cases. Satellite television is now reaching the most remote parts of India. Both the government and voluntary organisations should be keen on using this in their fight against HIV infection and AIDS.

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Ciprofloxacin in general practice

EDITOR,—The Lesson of the week by Roland J Körner and colleagues highlighted the dangers of fluoroquinolones.¹ We have also noted that patients with chest infections have been treated with ciprofloxacin in general practice; the slower resolution of their *Streptococcus pneumoniae* infection required a change of antimicrobial agent, and one patient died.

We understand, however, that ciprofloxacin is not promoted as first line treatment in general practice for community acquired chest infections, but some general practitioners in our area have provided promotional material that does. This material contains data showing that 14.4% of bacterial pathogens in acute exacerbations of chronic bronchitis are *S pneumoniae*.

Bantz and colleagues (some of whom worked for Bayer) are cited in Bayer's promotional leaflet for Ciproxin; they mentioned a >95% resolution rate but compared only doxycycline with ciprofloxacin and made no reference to bacterial pathogens. In the same supplement to the *American Journal of Medicine*, however, other papers gave less favourable views—for example, "the activity of ciprofloxacin against *Streptococci* and *Enterococci* is marginal, at best."²

The only other reference concerning efficacy that is cited in Bayer's promotional leaflet is a study of just 34 patients.⁴ Those with *Haemophilus influenzae* rapidly recovered, and these organisms were not culturable beyond three days. Of those with *S pneumoniae* infection, five still had positive results after three days, five after 11 days, and one after 25 days. Five patients had a relapse and were then treated with either amoxycillin or cotrimoxazole and clinically recovered. Six patients acquired *S pneumoniae* infection during or after treatment, and three required treatment. Two patients had rising minimum inhibitory concentrations to ciprofloxacin in *S pneumoniae*, with organisms being isolated further into ciprofloxacin treatment.

In the same issue of the *Journal of Antimicrobial Chemotherapy* a leading article on quinolones in chest infections, concludes that there is little reason for optimism about the role of quinolones in

chest infections mainly because of problems with resistance, recurrence, and reinfection with *Pseudomonas aeruginosa* and *S pneumoniae*.⁵

Clearly, ciprofloxacin is not a suitable agent for use in general practice for the blind initial treatment of chest infections and should not be so promoted.

We believe that there are major discrepancies between the promoted image and the clinically interpreted usefulness of ciprofloxacin. We hope that this sort of problem is not widespread in the pharmaceutical industry but wonder how extensive it is considering the gamut of drugs being actively promoted, often to those without the time or resources to easily and critically interpret the data presented to them.

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- 1 Korner RJ, Reeves DS, MacGowan AP. Dangers of oral fluoroquinolone treatment in community acquired upper respiratory tract infections. *BMJ* 1994;308:191-2. (15 January.)
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Fluoroquinolones in chronic obstructive pulmonary disease

EDITOR,—In their editorial Harold Hosker and colleagues suggest that fluoroquinolones are suitable second line antibiotics for infective exacerbations of chronic obstructive pulmonary disease.¹ We report two cases that illustrate our reservations about this suggestion.

Case 1—A 75 year old woman was admitted complaining of severe shortness of breath and right sided pleuritic chest pain. She had been admitted several times before with exacerbation of chronic obstructive pulmonary disease. Before this admission she had taken ciprofloxacin 500 mg twice daily and prednisolone for six days. On examination she had signs of right lower lobe pneumonia, which was confirmed on chest radiography. She was hypoxic (oxygen pressure 6.8 kPa, carbon dioxide pressure 5.21 kPa) and had a white cell count of $23 \times 10^9/l$, with 84% neutrophils. *Streptococcus pneumoniae* capsular type 4 was isolated from blood cultures, with a minimum inhibitory concentration for ciprofloxacin of 4 mg/l and for benzylpenicillin of 0.125 mg/l. She responded to amoxycillin and was discharged after seven days.

Case 2—A 72 year old man with a 30 year history of chronic obstructive pulmonary disease was admitted with severe shortness of breath. Before admission he had been treated with ciprofloxacin 250 mg twice daily and prednisolone. On examination he was afebrile, breathless, and cyanosed. There were widespread crackles and wheezes in the chest but no focal abnormality in the chest radiograph. *S pneumoniae* capsular type 15 was isolated from sputum taken after admission. The minimum inhibitory concentration for ciprofloxacin was >8 mg/l and for penicillin 0.125 mg/l. He was treated with amoxycillin and erythromycin and discharged after 22 days.

S pneumoniae is the pathogen most commonly identified in pneumonia acquired in the community and in lower respiratory tract infection seen in general practice; it is frequently isolated in chronic obstructive pulmonary disease.² Fluoroquinolones such as ciprofloxacin and ofloxacin

are not particularly active against it. Serum bactericidal concentrations after oral or intravenous dosage are minimal,³ which may lead to antimicrobial resistance. Fluoroquinolones are highly active against *Haemophilus influenzae* and some of the bacteria causing atypical chest infections, which may contribute to infective exacerbations of chronic obstructive pulmonary disease.

Failure of treatment with fluoroquinolones in respiratory tract infection has been reported.⁴ The datasheets for fluoroquinolones indicate that the drugs are not predictably active against *S pneumoniae*, yet some are heavily promoted for the treatment of chronic bronchitis in general practice. We believe that fluoroquinolones should not be used alone for blind treatment of respiratory tract infections, including exacerbations of chronic obstructive pulmonary disease. An agent effective against pneumococcus should always be included until a microbiological diagnosis is made.

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Safety of thalidomide

EDITOR,—Use of thalidomide only on a named patient basis does not necessarily mean that patients are protected from its side effects, as implied by Baroness Cumberlege, the junior health minister.¹ According to Sir William Asscher, the former chairman of the Committee on the Safety of Medicines, "the companies who supply a drug for named patient use are not required by law to provide warnings about the use of the drug" and, furthermore, "the information provided with the supplies of thalidomide [to patients with leprosy in the United Kingdom] does not specifically mention peripheral neuropathy as a side effect" (personal communication). Until 1979 patients with leprosy were not warned that the drug could cause loss of sensation in the extremities (M F R Waters, personal communication). Requests to find out whether they have now been warned have not been answered by Sir William. Early recognition of thalidomide neuropathy with immediate withdrawal offers the best chance of recovery, but this option is being denied to patients with leprosy. Even worse, the patients will assume that any loss of sensation occurring during treatment will be due to the disease.

Electrophysiological studies, particularly the recording of sural nerve action potentials, have proved valuable in detecting thalidomide neuropathy at an early stage,² but these have not been