reviews are simply uninformed, for there are none to disseminate. It takes up to five years to prepare a valid, clinically useful systematic review, and we are barely one year old. Even when our reviews start coming out next year their number will be small because they have to meet the high standards our members have created. None the less, the prospects for their wide dissemination look good. The current use of their forerunner (the pilot *Cochrane Pregnancy and Childbirth Database*) is dramatically greater than that of its predecessor (*The Oxford Database of Perinatal Trials*),³ and our arrangements with journals such as the *BMJ*, the *Lancet*, and *Annals of Internal Medicine* to avoid restrictive copyright, plus our development of versions of Cochrane reviews on the internet, will lead to unprecedented availability of the reviews.

We feel anything but complacent and welcome suggestions from supporters and informed critics alike about how we can do better.

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Transmission of tuberculosis by patients with HIV infection

EDITOR,—R J Kent and colleagues used restriction fragment length polymorphism analysis to show that three strains of *Mycobacterium tuberculosis* from patients positive for HIV at this hospital were indistinguishable.¹ The results became available to us only one year later. Our investigation could not identify a plausible route of transmission.

Case 1—The index patient (a 25 year old South American man) was on a ward remote from the AIDS unit between 15 and 25 June. He had fever, a dry cough, weight loss, and shadowing of the right middle lobe but with neutropenia and lymphopenia and antibodies to HIV. He was transferred on 25 June to a side room on AIDS ward A and walked through AIDS ward B to have a bronchoscopy on 26 June, returning on a trolley. Acid fast bacilli were seen in the bronchoalveolar lavage fluid, so treatment was started and he was isolated as a potential source of infection for at least two weeks; he was discharged on 12 August.

Case 2—The second patient (a 29 year old African woman), who had cytomegalovirus retinitis, was on AIDS ward B (separated from ward A by a corridor) from 24 June to 21 July and from 23 August to 11 October. Cultures of induced sputum (obtained on 26 August), bronchoalveolar lavage fluid (2 September), blood (6 September), and pleural fluid (10 September) yielded *M tuberculosis*.

Case 3—The third patient (a 54 year old English man), who also had cytomegalovirus retinitis, was on AIDS ward B transiently on 3, 26, and 29 June and then from 18 to 29 July and from 14 to 19 August, when he died. *M tuberculosis* was isolated from blood and faeces obtained on 17 August.

If this was an outbreak these events imply that the patients in cases 2 and 3 caught tuberculosis from the patient in case 1. So far as can be established, however, apart from walking through ward B on 26 June (which is unlikely to have led to transmission), the patient in case 1 was isolated on a different ward. The patients were unaware of each other and could not have caught tuberculosis from, say, a common staff source because the patient in case 1 was admitted with active tuber-

culosis and AIDS was diagnosed later. Staff are not shared between the two AIDS wards. Bronchoalveolar lavage was performed with different instruments many weeks apart by different endoscopists. The patients in cases 2 and 3 did not enter the endoscopy room on 26 June, and this room has negative pressure ventilation.

The epidemiology does not support the molecular biology findings and leaves us with worrying uncertainty about how best to manage patients with tuberculosis on AIDS wards. More rapid diagnosis would help, but patients infected with HIV may contract infection from people living in the same room in whom sputum smears yield negative results but sputum cultures yield positive results.² Currently we isolate patients with changes evident on chest radiography and those in whom sputum smears or sputum cultures yield positive results. None of our side rooms have negative pressure ventilation. The suggestion of unexpectedly high transmissibility of tuberculosis in patients with AIDS suggests that even more strict protocols should be adopted, including the isolation of all patients with undiagnosed respiratory disease in AIDS in negatively ventilated side rooms. The emergence of drug resistant tuberculosis would make this even more important.

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Chronic fatigue syndrome and fibromyalgia

EDITOR,—The relation between muscle pain, tender points, the chronic fatigue syndrome, and fibromyalgia are complex, and simplistic answers are inappropriate. In their paper Peter Croft and colleagues extrapolate their results to make two statements that I believe to be incorrect.¹

My conclusions are based on 100 consecutive patients seen at Raigmore Hospital NHS Trust, who fulfilled precise definitions of the chronic fatigue syndrome² or fibromyalgia.³ The importance of this definition of the syndrome is that it has the same three month cut off for length of illness as fibromyalgia.³ Of the 100 patients, 99 (74 women, 25 men) had the chronic fatigue syndrome and one (a woman) had fibromyalgia. Of the patients with the chronic fatigue syndrome, 63 had muscle pain and 28 had tender points on examination, 23 had both, and five had no muscle pain but tender points. These results do not support the authors' statement that the reason why fibromyalgia is not more common in Britain has been the acceptability of the chronic fatigue syndrome as an alternative diagnosis.

The authors also say that it is "inappropriate to define an entity as fibromyalgia." As a clinical virologist, I strongly disagree with this as the distribution and number of tender points in fibromyalgia are different from those in the chronic fatigue syndrome, and the management of the two conditions is different.⁴ Patients with the syndrome should be advised not to increase their activities gradually until they feel 80% of normal,⁵ whereas patients with fibromyalgia may benefit from a regimen of increasing activity.⁴

Muscle pain and tender points are distressing to patients. It is therefore crucial that all the infor-

mation is considered before general statements that affect patients' management are made.

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Age limits on infertility treatment and adoption

EDITOR,—C J Redgment and colleagues highlight the fact that older women face obstacles if they wish to conceive by gamete intrafallopian transfer or in vitro fertilisation.¹ Other obstacles may also be placed in the way of older women who wish to become mothers. Two recent cases have highlighted the discrimination practised against older women with regard to their wish to conceive or adopt children. In one a woman was apparently denied in vitro fertilisation solely because she was over 35 and this was the cut off age for this procedure in the health authority concerned. In the other case a couple in their 40s, considered to be too old to adopt a child in Britain, attempted to buy a child in Romania and for a time faced a jail sentence.

Barriers seem to be put up against women who wish to start a family later in their lives. It seems strange that this is the case when society is increasingly concerned that children are brought up in a stable environment, which a more mature couple are more likely to provide. Evidence for this can be found in divorce statistics, which show that couples of similar ages who marry later in life have a lower divorce rate than those who marry early and that, when the number of divorces is related to the duration of marriage at divorce, the highest numbers occur at three completed years (for divorces in 1991).² Selecting older couples thus has two advantages from the point of view of stability: if they married later in life they are less likely to divorce and if they married early they have passed the time of highest risk for divorce. Women are also increasingly choosing to devote their energies in their 20s and early 30s to furthering their careers, to the great benefit of society, rather than having children. The proportion of women born in 1960 who reached the age of 30 without having had a child was double that of those born in 1945.³ Some of these women will then have difficulty in conceiving partly because of the reduction in fertility that occurs in later reproductive life.

We think that it is a betrayal of trust if, having reaped the benefits from this generation of women, we as a society then turn round and refuse them the opportunity to raise children on the grounds that they are too old. Such a policy cannot be considered to be equitable and should be opposed. We propose that the maximum age for adoption should be raised for those who wish to adopt children under 5 from the present limit of 35-38 to 45 (women aged 45 would survive an average of about 31 years after adopting a child, while the figure for men is about 26 years (health statistics unit, Office of Population Censuses and Surveys, personal communication)).

Arguments could also be mustered for raising the lower age limit for potential adoptive parents from the current 21 to 26. If this was done many

couples would conceive naturally while waiting and those who did not would be more mature and therefore able to provide a more appropriate environment for the child. These age bands could also be used to define who would be accepted for in vitro fertilisation programmes.

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Overseas adoption

EDITOR,—My wife and I recently adopted our daughter from China after deciding not to have our own children. We are not infertile. We recognise that many couples arrive at adoption as a last resort, having tried various forms of infertility treatment. We are also aware that a general practitioner is the first point of call of such a couple. While a general practitioner may consider that adoption is a matter for local social services, many citizens are not advised of their rights regarding overseas adoption when they ask their local social services about adoption, and they proceed with infertility treatments on the advice of their general practitioner.

We think that general practitioners should present such information and, indeed, counsel couples about the options open to them. Presenting such information would not only guarantee a higher success rate in turning childless couples into families but also result in lower costs relating to antenatal and postnatal treatments as well as to infertility treatments. The costs to the patient might also be considerably lower. We are concerned that the medical profession is offering technological solutions without the full range of alternative solutions being presented to infertile couples, at a cost to the NHS, the couples, the success rates, and, of course, the tens of thousands of orphans in countries such as China.

For information on overseas adoption general practitioners and their patients may call the Department of Health's overseas adoption helpline (071 954 5536); STORK, an overseas adoption charity (0792 844329); or me (0273 454692 or fax 0273 413355).

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Young people's advice clinic in reproductive health

EDITOR,—It was disappointing that once again a new service—a young people's advice clinic in reproductive health¹—has been introduced with no formal evaluation. The authors state that one of the specific aims of the clinic was to reduce teenage pregnancy rates, one of the government's current targets.² They also state that the clinic has been an outstanding success, but no formal outcome measures are considered in their report.

For instance, rates of attendance at the clinic are not compared with those at alternative sources of advice—for example, community family planning clinics or general practice surgeries. It is well

recognised that teenagers find attending for health care difficult and that alternative and innovative provision of services may be needed.³ The paper describes such a service, but such provision needs more thorough consideration in terms of resource effectiveness.

The key outcome indicator, a reduction in teenage pregnancy, is dismissed because of difficulties in obtaining the relevant data. Although any changes in teenage pregnancy rates are notoriously difficult to attribute to any particular intervention, proxy measures can be used for small geographical areas. Such measures include maternity claims by teenagers as a proportion of all maternity claims and rates of second pregnancy, which may be a sensitive early indicator of an intervention's effectiveness.^{4,5}

The clinic seems, however, to be popular and provides an opportunity for a valuable and formal evaluation, which could also include an economic appraisal. Such evaluations are vital and should perhaps even be mandatory before innovative ideas and practices can be expanded across Britain.

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Number of psychiatric beds needed

EDITOR,—The editorial by Graham Thornicroft and Geraldine Strathdee about the number of psychiatric beds that are needed has a misleading subtitle: "the debate shouldn't be swayed by moral and political considerations."¹ The authors' argument for a broad range of services is moral, because they rightly believe that "the community" should provide good quality care for severely disabled people. It is political because such care cannot be paid for by those in greatest need. Enoch Powell's account of the development of the health and welfare plan for community mental health care in 1963 shows the central importance of moral and political motivation as well as the paucity of evidence on which the judgments were based.²

In an editorial with the same title but without the subtitle, published 23 years ago, precisely the same conclusion was reached about the wide range of alternative facilities that would be necessary if most hospital beds were to be closed.³ The evidence then available was summarised. The moral issues have remained the same over the years, but the opportunity for a planned and gradual transfer of resources from predominantly hospital care to predominantly non-hospital care, supported by bridging funds, informed by continuing health services research, and fine tuned to allow for differing patterns of community need, has been missed.

Apart from lack of funds, the problems hindering achievement of the sort of service recommended by Thornicroft and Strathdee now include poor joint working between the various agencies involved; restrictive criteria for entry to non-NHS residential care; difficulties in providing safe 24 hour cover in a dispersed service; poor sustain-

ability of community based multidisciplinary teams; and the increasing influence of those general practice fundholders for whom severely mentally ill patients are not a high priority.

The evidence provided by the authors that these obstacles can be surmounted comes from experimental services whose ability to survive the burn out of staff and the loss of committed leaders has yet to be shown. Their appreciation of the scarcity of family, occupational, and residential aids that help preserve the dignity, functioning, and wellbeing of people with longer lasting psychosocial disabilities is, by contrast, well documented.

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Aircraft cabin pressure and parkinsonian symptoms

EDITOR,—Gerald Stern's reservations about the relation between flying and improved symptoms in Parkinson's disease should be directed at decreased cabin pressure and not at increased cabin pressure as he states.¹ Although people refer to a pressurised cabin, it is pressurised only with respect to outside air pressure at a given flight altitude. In fact, internal cabin pressure in most commercial aircraft at cruising altitude approximates to an altitude of 1520-2440 m,² with oxygen concentrations ranging from 15.2% to 17.6%.³ The question should be why decreased air pressure may improve parkinsonian symptoms.

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Judicial punishments in Iraq

EDITOR,—Reports in the *BMJ* have drawn attention to a series of recent decrees of the Iraqi Revolutionary Command Council introducing amputation of the right hand as judicial punishment for theft, with amputation of the left foot for a second offence.^{1,2} Amputation of one ear is decreed as punishment for evasion of the draft, military desertion, or harbouring deserters. Amputation of the other pinna is the penalty for a second offence, and the death penalty is decreed for a third. In addition, an X is branded on to the forehead. It seems that these sentences are carried out in hospitals and that doctors are being forced to perform the operations. Similar punishment is ordered for those who attempt to remove the brand or conduct plastic surgery on the amputated limbs.

Amnesty International has received reports of 14 people who have had one ear severed since the introduction of Decree No 115, 12 of whom were subjected to the procedure at the Adnan Khairallah Hospital in Baghdad on 26 September this year. At least one of these men was branded on the forehead. Press reports have suggested that up to 800 men have had ears severed and their foreheads