meaningless. Is it not better for people to know that they have an infection, have it treated in every way possible, be accepted as any other person with any disease should be, and live to the fullest that is possible but to be aware of the restraints imposed by the condition and so prevent unwitting spread to others? For most people infected with HIV the infection will manifest at some time. They may then have on their conscience the fact that they spread the disease unknowingly.

In most countries, submitting to HIV testing is considered to be blameworthy. In Saudi Arabia all expatriates are tested as a requirement before they are employed. Rather than be seen as an invasion of a person's privacy or an infringement of his or her rights an HIV test should become as routine as any other test carried out in the interests of health promotion.

ERIC L SMITH
Head of dermatology and venereology
ALI RADDADI
Consultant dermatologist
OBAID BIN OBAID
Associate consultant
SHERIF ABDULLAH
Registrar

King Khalid Hospital,
PO Box 9515,
Jeddah 21423,
Saudi Arabia

1 Evans JA, Marriage SC, Walters MDS, Levin M. Unsuspected HIV infection presenting in first year of life. *BMJ* 1995;310:1235-6. (13 May.)

Patients with a self diagnosis of myalgic encephalomyelitis

EDITOR,—Myalgic encephalomyelitis is most commonly related to an underlying psychological or psychiatric disturbance.^{1,2} Shonagh Scott and colleagues report that when general practitioners deal with symptoms consistent with those of myalgic encephalomyelitis their attitude is likely to be influenced by the patient's perception, expectations, and social class.³ It is not uncommon for patients to diagnose myalgic encephalomyelitis themselves before they seek a consultation; this can lead to disruption of the doctor-patient relationship, unsatisfactory consultations, and possibly failure to diagnose any underlying pathological process. We report on a patient with a self diagnosis of myalgic encephalomyelitis in whom hypopituitarism was diagnosed only after a protracted period.

A 65 year old man presented with a four year history of tiredness, lethargy, and loss of weight of 13 kg. He had attributed his symptoms to myalgic encephalomyelitis, and, although he was referred for a medical opinion, he defaulted, preferring to attend a popular herbalist. Over the next five years he took a series of remedies and concoctions with only limited success. The persistence of his symptoms persuaded him to seek confirmation of his self diagnosis, and a further medical consultation was arranged. When seen he was noted to have a sallow appearance, dramatic loss of body hair, gynaecomastia, and micro-orchidism.

Subsequent investigations confirmed hypopituitarism: the cortisol concentration was 48 nmol/l basally and minimal after tetracosactrin, rising to 160 nmol/l at 30 minutes. Thyroid stimulating hormone was undetectable, with a low free thyroxine index of 18.3 nmol/l (normal range 21-36). Serum testosterone concentration was <1 nmol/l, and gonadotrophins were undetectable basally and after stimulation. Computed tomography showed a large pituitary adenoma. His symptoms resolved dramatically within 24 hours of the start of hydrocortisone replacement treatment. He continued to take full hormone replacement and resumed his normal lifestyle after resection of his adenoma.

Support groups for people with presumed myalgic encephalomyelitis publish an extensive literature. In this, intestinal *candida albicans* is strongly implicated in the pathogenesis of myalgic encephalomyelitis, within "many people, probably over half, the yeast being out of control." Among the remedies suggested are anti-candida diets, garlic, homoeopathic doses of candida, and even colonic cleansing. Such polarised publications, while providing valuable support for patients with myalgic encephalomyelitis, also lead to self diagnosis and self treatment without appropriate investigation. The use of the above remedies may provide some relief but in this case would not be a substitute for steroid treatment.

When considering the diagnosis of myalgic encephalomyelitis it is important to remain objective and exclude any underlying remediable disease. Hypopituitarism should be considered in all patients presenting with non-specific symptoms.

S J HUREL
Honorary senior registrar
BABUASHA
Registrar
P H BAYLIS
Professor of experimental medicine

Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP

P E HARRIS
Senior lecturer in endocrinology

King's College Medical and Dental School,
London SE5 9PJ

- 1 Maclean G, Wessely S. Professional and popular views of chronic fatigue syndrome. *BMJ* 1994;308:776-7.
- 2 Pawlikowska T, Chalder T, Hirsch SR, Wallace P, Wright DJM, Wessely SC. Population based study of fatigue and psychological distress. *BMJ* 1994;308:763-6.
- 3 Scott S, Deary I, Pelosi AJ. General practitioners' attitudes to patients with a self diagnosis of myalgic encephalomyelitis. *BMJ* 1993;310:508. (25 February.)

Review ignored biography of Sloane

EDITOR,—Christopher Booth's review of a biography of Sir Hans Sloane¹ overlooks a previous biography, by St John Brooks.² While the earlier book does not list Sloane's collections in detail, it has biographical merit. It seems a pity that it should be ignored.

J E COSNETT
Retired physician

Muckros,
Kesh BT93 1TZ,
Northern Ireland

- 1 Booth C. Sir Hans Sloane: collector, scientist, antiquary [book review]. *BMJ* 1995;310:1209. (6 May.)
- 2 St John Brooks E. *Sir Hans Sloane: the great collector and his circle*. London: Batchworth Press, 1954.

Guidelines to reduce x ray examinations in accident departments

Implementing guidelines may not improve outcome for patients

EDITOR,—Eugene McNally and colleagues report the effect of introducing guidelines on when to request radiographs for certain conditions presenting in an accident department.¹ Two aspects of this paper merit discussion. Firstly, the outcome measured and the data presented do not seem to support the conclusions. Secondly, one should not infer that use of the posters containing the guidelines will lead to clinical benefit for patients.

The outcome measured (the proportion of patients referred for particular series of radiological views) is not the same as the proportion of patients managed in accordance with the guide-

lines. The follow up of patients who did not undergo radiography seems inadequate: the reduction in the proportion of patients undergoing radiography may have been inappropriate. The reduction need not have been due to fewer unnecessary radiographs being obtained.

In two of the areas studied (radiography of the cervical spine and ankle) no significant change occurred. (It is not possible to calculate from the data whether a significant change occurred when all four areas are considered together.) One cannot necessarily extrapolate the results from these two areas to others. We would like to have seen data from areas not covered by posters: other factors, such as use of the Royal College of Radiologists' booklet,² may have caused the reductions seen.

The final point concerns the interpretation of such studies. These data do not show that using posters to promote guidelines benefits patients. Even if they did show increased adherence to the guidelines, we believe strongly that such data (concerning the process of care) should not be interpreted as showing improved outcomes for patients unless the guideline has previously been shown to confer benefit when followed. Increasing adherence to a flawed guideline may be harmful.

R D HARDERN
Senior registrar
D W HARMER
Consultant

Accident and Emergency,
General Infirmary,
Leeds LS1 3EX

- 1 McNally E, de Lacey G, Lovell P, Welch T. Posters for accident departments: simple method of sustaining reduction in x ray examinations. *BMJ* 1995;310:640-2. (11 March.)
- 2 Royal College of Radiologists. *Making the best use of the radiology department: guidelines for doctors*. London: RCR, 1989.

Radiology guidelines could be improved

EDITOR,—Radiologists' suggestions to help reduce unnecessary x ray examinations in patients prescribing to accident and emergency departments have been welcome. Eugene McNally and colleagues suggest that this reduction can be sustained by the use of posters.¹ I am concerned, however, about the content of the two examples of their posters shown in their paper.

The poster illustrating the guidelines for x ray examination of the skull states, "Do not x-ray patients who are to be admitted." A linear fracture is important chiefly as an indicator of potential secondary intracranial bleeding.² A patient with a head injury who is not oriented will be admitted for observation. If this patient has no skull fracture there is a 1 in 100 risk of a serious intracranial bleed. That risk is increased 25 times to 1 in 4 if a skull fracture is present.³

Reducing the threshold for performing computed tomography is one answer, but this has financial and workload implications that many units might not be able to afford. A skull x ray film can thus be a useful triage tool in determining which patients with head injury require computed tomography. It should, of course, be emphasised that patients with serious head injuries (for example, those with a score on the Glasgow coma scale of ≥ 8) need urgent computed tomography and not skull radiography.

Teaching of advanced trauma life support has greatly raised awareness of possible injuries to the cervical spine and highlighted the importance of lateral radiographs of the cervical spine in major trauma.⁴ It is thus disappointing that the poster on x ray examination of the cervical spine does not mention major trauma or multiple injuries. Similarly, the first indication on the poster is "Neck injury with pain." However, patients who are difficult to assess—for example, because of alcohol—may not always complain of pain. This and the mechanism of injury must be taken into account. If there is any doubt about a possible neck