gentlemen. The remuneration offered by this club is almost upon a par with the wages of a labourer who is employed to break stones on the road. In the first place he is to receive three-half-pence per week from each family that he attends, whether large or small. Take the average; a man and wife, with three children, in number five; and suppose there are 20 families in each parish, who may be able to avail themselves of the "benefits" of the club; that would amount to 2s 6d per week for each parish. He is next to receive sixpence for the extraction of each tooth. Presume that he extracts 20 a year; that will make 10s per year. Next comes midwifery, for which he is allowed a fee of either 3s, 5s, or 7s, according to distance provided he arrives before the birth of the child, the maximum fee being less than an uneducated old woman is in the habit of receiving. Take the medium fee of 5s, and suppose he has six cases a year in each parish, that will amount to £1 10s for each parish; so that he will have the medical and surgical charge of about 300 persons, scattered over three extensive rural parishes, for the following sums:

For 20 families in each parish, at 1½d, per week for each family, for the year	19	10	0
Midwifery, for three parishes	4	10	0
Tooth-drawing	0	10	0
	£24	10	0

the whole amounting to an average of 9s 5½d per week. It is clear that he cannot keep a horse; so that in a time of great sickness, lamentable neglect, with a probable loss of life, must be the result. Should there be two midwifery cases at the same time, he will be allowed 5s for another medical man's fee, which may be either £1 1s, or £1 11s 6d, so that, in that case he would lose £1 6s 4d, he, consequently, cannot calculate even upon 9s 5½d per week.

It is to be regretted that gentlemen holding high and responsible duties should place themselves at the head of such mean, paltry, and degrading societies; instances of this kind call loudly for medical reform. I am, sir, your obedient servant,

George Bottomley

Croydon, 8 October, 1840.

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The Journal *is grateful to the* Lancet *for permission to publish the above letter.*

British Diabetic Association educational holidays

Sir,

During my general practice training I had the opportunity to work as a medical officer on two British Diabetic Association educational holidays for children. These holidays are intended to educate children about their diabetes and how to live with it while at the same time allowing them to have an enjoyable time. The children find that they are able to participate in activities which up until then they might have thought were impossible. They learn about their dietary treatment, blood testing to monitor control of their diabetes, insulin injection and identifying the warning signs of hypoglycaemia.

The staff on the holidays are all volunteers and work together as a team. The warden is responsible for organizing the daily activities. There are usually two medical officers, three nurses, three dietitians and four or five male and female leaders. The senior medical officer is usually a consultant or registrar with paediatric experience.

Working as a medical officer on these holidays has provided me with a greater understanding of the day-to-day management of diabetes, and the potential problems that diabetics might encounter in trying to lead a normal life. This experience has been invaluable. I would suggest that potential general practitioners might also benefit from working on one of these holidays.

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INFECTIOUS DISEASES UPDATE: AIDS

Monitoring the prevalence of HIV

THIS paper sets out the case for unlinked involuntary anonymous testing for human immunodeficiency virus (HIV) infection in selected groups in the population in the United Kingdom. The introduction briefly describes current estimates of the prevalence of HIV infection: 'it is uncertain whether transmission solely by such contact [heterosexual] will produce a self-sustaining HIV epidemic throughout whole or parts of heterosexually active society in England and Wales. Such uncertainties about a major epidemic of largely fatal infection make it imperative that such surveillance methods be reviewed regularly'. The paper goes on to review present methods of ascertaining the prevalence of HIV infection: a byproduct of case finding using named tests as part of clinical investigations, at the request of patients and the mandatory test which is carried out for potential blood donors. The selection bias inherent in these methods is emphasized.

In a section on the case for the unlinked anonymous method the review cites studies in New Mexico and the United States of America where unlinked anonymous testing has been carried out. In a small study in London the prevalence of infection found in a named testing programme was less than half the 25% found in the same population when studied unlinked and anonymously. In an American unlinked anonymous sentinel hospital study of patients admitted for reasons unrelated to HIV infection, the prevalence of HIV infection was 0.3% and in the same mostly mid-western cities the prevalence among military recruitment applicants was of the order of 0.1%.

The review acknowledges the limited value of unlinked testing if the only information which accompanies the sample is sex and age group. The value would be enhanced if changing prevalence were estimated in vulnerable groups, and hence additional information should be sought about patients attending genitourinary medicine clinics and those identified as injecting drugs. The review identifies pregnant women as a stable sub-group of the total heterosexually active population and comments that the trend in HIV infection in pregnant women should mirror that in the heterosexual population. However, unless special steps are taken it will not be possible to separate women who acquired their infection through intravenous drug misuse from those who acquired it through heterosexual intercourse.

If the present estimate of the prevalence of HIV infection in pregnant women in

London is accurate at 0.1% then a sample of 30 000 pregnant women will be required in order to detect even as large a change in prevalence as a doubling in one year.

In its consideration of the legal and ethical basis for unlinked anonymous testing the review cites a large number of bodies who support this approach, ranging from the World Health Organization to the medical defence societies in the UK. The General Medical Council considers that no fundamental medical ethical principle is breached by unlinked anonymous HIV testing. However, the review does not make reference to the House of Commons Select Committee which did not think that the epidemiological information gained from unlinked testing would be valuable, nor to bodies such as the Terence Higgins Trust and the Royal College of Nursing which have opposed aspects of unlinked anonymous testing.

Although the review is a powerful document supporting the need for anonymous testing it is weakened by setting up universal named case finding as the only alternative to unlinked involuntary anonymous testing. The review mentions voluntary anonymous testing in the context of drug injectors providing saliva specimens but does not extend the potential benefits of voluntary anonymous testing to the less vulnerable groups who are to be studied: general hospital inpatients, women undergoing termination of pregnancy and pregnant women and new born infants. Voluntary testing has the advantage of bringing the subject into the open for the discussion of possible risk factors between clinicians and patients and the feasibility of the approach should be tested rather than it being assumed that the approach would not provide better epidemiological information.

(G B)

Source: Gill ON, Adler MW, Day NE. Monitoring the prevalence of HIV. *Br Med J* 1989; **255**: 1295-1298.

Heterosexual epidemic in the United Kingdom

IN recent months there has been considerable debate concerning the extent to which AIDS has spread into the heterosexual populations of the UK. While some have denied that heterosexuals are at any risk of contracting HIV, others claim that the problem is growing rapidly and constitutes a major threat to what is often referred to as the general population. So what is the current evidence which justifies or challenges the concern about heterosexual spread or potential for spread?

As of 31 December 1989, 2830 cases of AIDS had been registered to the Communicable Disease Surveillance Centre (CDSC) or the Communicable Diseases (Scotland) Unit (CDSU), of which 2288 (80.8%) were homosexual/bisexual, 118 (4.2%) injecting drug users, 169 (6.0%) haemophiliac, and only 135 (4.8%) belonged to the heterosexual contact category. A review of these figures in isolation would suggest the heterosexual problem in the UK to be of minimal consequence. However, the mistake of utilizing AIDS data alone as an indicator of the epidemic's extent, is unfortunately too frequently made.

With recent studies of incubation period now suggesting that up to 50% of persons infected with HIV will progress to AIDS within 10 years, and with the likelihood that this proportion will further increase over time, it has become clear that determining the extent and distribution of HIV infection is a superior index of the epidemic's characteristics. At present such data is mainly confined to HIV antibody positive reports sent by HIV testing laboratories to the CDSC and CDSU. Although such reports represent only those who have come forward for an HIV test, the data nevertheless is quite revealing. In contrast to AIDS cases, only 5661 (48.5%) of 11 676 HIV reports to 31 December 1989 were homosexual/bisexual. A further 1727 (14.8%) were injecting drug users, 1114 (9.5%) haemophiliac, 2051 (17.6%) belonged to the other/undetermined group and 766 (6.6%) to the heterosexual contact category. This latter figure, however, is likely to be much greater since injecting drug users, the great majority of whom are heterosexual, are understandably categorized by their injecting activity alone and not by mode of HIV transmission, which might be either needle-sharing or heterosexual contact. Even if only 25% of drug users had become infected sexually, this would have boosted the heterosexual contact total to 1198. However, perhaps of even greater importance, is the current reservoir of heterosexual infection which consists of 3721 injecting drug users, blood/blood product recipients and heterosexual contacts. While this represents 31.9% of the total 11 676 and does not include the 17.6% who belong to the undetermined category, Scotland's situation is even more striking with a heterosexual reservoir of 1119 of 1729 (64.7%).

These revealing figures which suggest that at least one-third of infected individuals in the UK are heterosexual must surely put to rest the belief that AIDS is not a heterosexual issue in this country.

(D G)

HIV infection among heterosexuals without apparent risk factors

THIS paper documents the sad saga of the civil engineer who travelled between Belgium and several countries in central Africa. After a month's stay in Africa in 1980 during which time he had sexual contact with several prostitutes he developed a febrile illness. However, it was not until 1985 that he became aware that he had HIV infection. When diagnosed, contact tracing was carried out and of 19 women identified as his sexual partners and tested for HIV, 11 were found to be infected. Two of these women had only had a single sexual encounter with the man. None of the women could be considered to be at high risk of infection from other sources in that they did not inject drugs, had not received blood transfusions nor had sex in areas where HIV is common.

The man had suffered in the past from recurrent genital herpes but could not remember any outbreak in the two years before he was diagnosed as suffering from the generalized lymphadenopathy of HIV infection. He died from HIV related encephalopathy in 1986.

Heterosexual spread of HIV is puzzling. This case demonstrates the high rate of transmission. Testing the men partners of the infected women showed only a 12% rate of transmission which is in keeping with the transmission rates found in other studies. Two of the HIV infected women also developed genital herpes and the presence of a herpes infection may enhance the likelihood of spread of HIV.

In spite of recent controversy about the extent of heterosexual transmission of HIV in the United Kingdom, this study should dispel any complacency about the risk of infection through heterosexual contact.

(G B)

Source: Clumeck N, Taelman H, Hermans P, *et al.* A cluster of HIV infection among heterosexual people without apparent risk factors. *N Engl J Med* 1989; **321**: 1460-1463.

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FILL THIS SPACE

Contributions to the Digest pages are welcome from all readers. These should be from recent papers in research journals which general practitioners might not normally read. Send to: The Editor, British Journal of General Practice, Royal College of General Practitioners, 12 Queen Street, Edinburgh EH2 1JE. Please quote the full reference to the article (authors, title, journal, year, volume, page range).