should add AIDS to this list but suggested no, not because AIDS is not transmitted through casual social contact and that therefore such a procedure would be unnecessary but because previous legislation covering sexually transmitted diseases had proved ineffective. I fear Mr Porter is missing the point.

By discussing AIDS in the same article as bubonic plague, leprosy, cholera, typhoid, and diphtheria without pointing out the important differences between these conditions and AIDS Dr Porter did little to dismiss exaggerated fears that AIDS is a deadly plague of high infectivity that only severe measures can hope to control. He then said that "one should at least consider draconian measures... to protect others"; however, he decided not to consider them but instead dismissed these very issues by saying "experience suggests that this would be unwise." I wonder what experience Dr Porter is referring to? I am sure he is well aware that the media have aired many drastic measures to combat AIDS, and here was an excellent opportunity to answer, discuss, and hopefully dismiss them, but the opportunity was passed by.

The implications behind his concluding comment that "it takes two consenting partners to spread AIDS" are offensive and insensitive to those people who have suffered and died from this dreadful condition. People may consent to sex but I am sure they do not consent to spread AIDS. And what of the haemophiliacs and other recipients of blood products for whom this concept of consent has virtually no meaning? Many people who now have AIDS may well have been infected with HIV five or more years ago—long before the public health campaigns and even before HIV was discovered.

Important points which Mr Porter failed to emphasise are that infection with HIV and AIDS itself are not the same thing, that HIV is of low infectivity and is transmitted through the exchange of blood and other body fluids and not through casual social contact, and therefore that measures such as quarantine and compulsory admission to hospital are unnecessary and unhelpful in the management of this condition.

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HIV and sexual lifestyle

SIR,—In view of the near hysteria that seems to characterise most of the media's reaction to the AIDS epidemic, Dr Caroline Bradbeer's leading article (3 January, p 5) must surely be welcome and it is to be hoped that medical journalists and politicians will heed it and bear it in mind when they produce their copy. I feel that we could with advantage see clinical parallels between two other worldwide epidemics in modern times.

The huge pandemic of syphilis in the early part of this century started to decline before chemotherapy finally made syphilis a rarity, probably because of the popularity of condom use and local prophylaxis, which improved sex hygiene for those at risk. The popularity of male circumcision in the 1920s and 1930s may also have contributed to this happier state of affairs. As the human immunodeficiency virus (HIV) seems to be a relatively delicate creature surely to ignore the use of local (and cheap) antiviral preparations and pessaries as prophylactics in any anti-AIDS campaign borders on stupidity.

The second disease of the first half of our century to be "tamed" by man is, of course, tuberculosis. That too started to decline well before chemotherapy finally once again made the disease uncommon. The hygienic principle in this case was better nutrition. Some five years ago, wandering through the streets of San Francisco, I was struck by the facies of many of the gay community. They reminded me very much of those of the often doomed young pulmonary tuberculosis victims that I saw haunting the medical outpatients of the Westminster Hospital in the 1940s. Those who were to die also had an immunity deficiency. Perhaps we should encourage groups at risk to look to their general health as well as their sexual lifestyle and hygiene.

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AIDS: a doctor's duty

SIR,—While agreeing with much that Dr Tony Smith (3 January, p 6) has to say about a doctor's duty in relation to AIDS, I would question his statement on antibody screening before surgery.

He claims that "those doctors who are calling for patients to have antibody tests before they undergo surgical procedures... are contributing to current hysteria about the disease." A surgeon is negligent if he does not perform a hepatitis screen on a patient with a history of undiagnosed jaundice. If a patient is found to be a carrier then precautions can be taken to protect medical and nursing staff during the course of the operation and aftercare.

Similarly, precautions have to be taken when operating on patients infected with the human immunodeficiency virus (HIV). As there are no clinical signs to determine the HIV carrier state the screening of people at high risk is the only method of detecting the infected patient. A careful sexual history should now become a routine part of clerking.

The "hysteria" can be prevented by education. If all patients are carefully and knowledgeably counselled at the time of venesection most will be reassured and containment of the disease may be assisted. Provision of leaflets such as that produced by the Terrence Higgins Trust[1] and the work of the support group Bodypositive are useful adjuncts.

Although I agree with Dr Smith that HIV carriage does not represent a substantial health risk for doctors, the use of screening of high risk groups before surgery not only protects against infection but also provides an opportunity to increase understanding of the disease, its transmission, and prevention among those at high risk.

Only by increased public knowledge of the disease can this hysteria, often helped by an ill informed media, be converted into a constructive appreciation of AIDS. Failure to screen patients and allow nosocomial AIDS to occur will only induce more hysterical and counterproductive reporting in the press.

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1 Anonymous. *AIDS and HIV. To test or not to test.* London: Terrence Higgins Trust, 1986.

Haematology, ethnography, and thrombosis

SIR,—Dr S Heptinstall's leading article (3 January, p 3) makes no mention of the well established association between thrombosis and particular blood groups.

I and my colleagues have analysed data published by numerous workers[1] and have shown that persons of groups A and B have a significantly higher incidence of coronary thrombosis and other clotting diseases than those of group O, while haemorrhagic conditions are commoner in those of group O. It has also been shown that clotting factor VIII content is higher in blood of group A than in group O.[2] The incidence of myocardial infarction is 29% higher in persons of group A than in those of group O on the basis of 37 studies comprising 7124 cases. However, in women taking oral contraceptives the incidence of thromboembolism is nearly three times as high in those of group A as in those of group O. This result is based on only four series, comprising 236 cases. Though this is statistically very highly significant, it is desirable that larger numbers of cases should be studied in view of the possible importance of avoiding the use of oral contraception in women of group A (as well as B and AB). I have tried to persuade colleagues, particularly in family planning centres, to carry out the necessary observations, so far without success.

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1 Mourant AE, Kopeć AC, Domaniewska-Sobczak K. *Blood groups and diseases*, Oxford: Oxford University Press, 1978: 34-5, 259.
2 Bartlett A, Dormandy KM, Hawkey CM, Stableforth P, Voller P. Factor-VIII-related antigen: measurement by enzyme immunoassay. *Br Med J* 1976;i:994-6.

Dialysis arthropathy: amyloid or iron?

SIR,—Dr N R B Cary and coworkers (29 November, p 1392) suggested that iron deposits in synovial tissue may have been the cause of arthropathy in five patients undergoing long term haemodialysis.

The role of iron in the physiopathogenesis of various arthropathies, most notably rheumatoid arthritis, was invoked several years ago. Further studies, however, showed that such deposits are commonly found in cases of chronic inflammatory rheumatism and many other joint diseases and thus appear to be non-specific.[1] Based on a study we conducted on patients undergoing long term haemodialysis[2] we are at a loss to find any evidence in support of the hypothesis proposed by Dr Cary and his coworkers.

We conducted synovial biopsies on 19 patients. Even though iron was present in 12, usually the deposits of iron were minute. Only in one case was the iron deposit substantial, and in that case we found considerable amyloidosis.

We found iron deposits in non-symptomatic joints after synovial biopsies performed with a needle. Thus, these deposits did not seem to be any more specific to diseased joints than did the amyloid deposits in one of the authors' patients. Furthermore, it is useful to recall the similarity of bone cysts observed in these patients and in patients with secondary amyloidosis. The frequency and abundance of these amyloid deposits within the cysts, as well as the nature of amyloid, which is made up mainly of β_2 microglobulin, points to a relation between bone destruction and amyloidosis.

Among 22 patients who were dialysed for over 10 years with cuprophane membranes we found no correlation between the ferritin concentrations and severity of joint pain as was reported by Brown *et al.*[3] We also could not show any association between ferritin concentrations and the extent of abnormal radiological findings (bone cysts, spondylarthropathy).

Finally, we noted a decrease of joint "algias" after a switch of dialysis membranes (unpublished results). This amelioration, which followed the