The identification of a specific food allergen is difficult and was not achieved in this patient. The persistence of her symptoms during treatment with an elemental diet does indeed suggest that there was continued antigenic stimulation at that time, which continues, as she is now receiving a normal diet and is asymptomatic.

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Aspirin as prophylaxis against migraine

SIR,—I was surprised by Dr K J Zilkha's advice (14 February, p 427) about the use of aspirin as migraine prophylaxis. It has been suggested that the platelet inhibitory effect is the important factor.[1] If this is so 300 mg on alternate days may be a sufficient dose, causing minimal gastric side effects.

Since I read Hanington's article[1] I have taken aspirin daily. Before this I suffered disabling attacks of classical migraine every three to six weeks, but since I began taking aspirin daily during the past eight and a half years I have had only one attack, which occurred when I did not take aspirin for a fortnight. Those who suffer from such frequent attacks have perhaps one worry free week in three as they are either suffering an attack or awaiting the next one with trepidation. The relief of knowing that no further attacks should occur is such that I now become quite anxious if my supply of aspirin runs low.

Are Dr Zilkha's three patients statistically significant? My own experience is supported by a controlled trial,[2] and I would certainly recommend an antiplatelet dose of aspirin to any sufferer.

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2 O'Neil BP, Mann JD. Aspirin prophylaxis in migraine. *Lancet* 1978;ii:1179-81.

Ulcerogenicity of piroxicam: an analysis of spontaneously reported data

SIR,—We are concerned that the study by Dr Allen C Rossi and coworkers (17 January, p 147) depended entirely on reported cases of drug related complications, because in the United Kingdom only a minority of such complications are reported to the Committee on the Safety of Medicines.[1] Only a prospective study that relates local ulcer complications to drug prescriptions can assess the incidence of adverse reactions to non-steroidal anti-inflammatory drugs.[2-4]

Over three years we studied prospectively all 235 serious peptic ulcer complications in south Cheshire (population 250 000). Patients were included if they died because of, or required emergency surgery for, a peptic ulcer complication. Thirty two of these 235 patients were using steroids, taking two non-steroidal anti-inflammatory drugs, or taking a non-steroidal anti-inflammatory drug that has subsequently been withdrawn, leaving 203 in our study group. Of the 203 patients, 113 were taking a non-steroidal anti-inflammatory drug, of whom 23 (20%) were using piroxicam. Of these 23, 21 (91%) were over 60 years of age. Nine of the patients using piroxicam died, and all were over the age of 60. These complications were not related to the dose, the duration of use, or the reason for the prescription of piroxicam.

During the same period a consecutive group of 1246 hospital control patients without known peptic ulceration were questioned closely about the use of non-steroidal anti-inflammatory drugs. Of these, 123 (10%) had been using such drugs before admission, and 13 of these were taking piroxicam. Thus although piroxicam was used by only 11% of the control patients who were taking non-steroidal anti-inflammatory drugs, it was associated with 23 out of 113 (20%) ulcer complications related to such drugs ($\chi^2=4{\cdot}362$, $p<0{\cdot}05$).

Our study confirmed that only a minority of drug related adverse reactions are reported to the Committee on the Safety of Medicines and showed that patients taking non-steroidal anti-inflammatory drugs who develop serious peptic ulcer complications are more likely to be using piroxicam. Piroxicam seems to be more ulcerogenic than other such drugs, possibly because of its long half life and the altered pharmacokinetics in the elderly. We would therefore advise against its use as an anti-inflammatory agent in patients over 60 years of age.

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2 Collier DStJ, Pain J. Ulcer perforation in the elderly and non-steroidal anti-inflammatory drugs. *Lancet* 1986;i:971.
3 Blower AL, Armstrong CP. Ulcer perforation in the elderly and non-steroidal anti-inflammatory drugs. *Lancet* 1986;i:971.
4 Ng J, Batey R. Ulcer perforation in the elderly and non-steroidal anti-inflammatory drugs. *Lancet* 1986;i:972.

Identity cards for patients infected with HIV?

SIR,—Recent articles in the *BMJ* concerning identity cards for carriers of the human immunodeficiency virus (HIV) (Dr A C Srivastava and others, 21 February, p 495) and in *Pulse* concerning a general practitioner's right to be informed of the HIV state of his or her patients do not, in my view, give sufficient weight to the importance of maintaining confidentiality and the consequences to the victim if confidentiality is broken.

I would like to add to this debate illustrations of the effects of the acquired immune deficiency syndrome (AIDS), and rumours about AIDS, in the small, geographically isolated community in which I work.

We have treated three cases of full blown AIDS so far. In each case the patient's identity has become common knowledge, forcing the patients to leave the area in search of anonymity. Unfounded rumour and malicious gossip have been rife. One of our patients was a businessman, and his business subsequently collapsed. Another local businessman had to publish an article in the local press to clear his own name because of widespread rumours that he also had AIDS, indeed he was said to be in hospital dying of AIDS. A relative of one of our patients has also been forced to write her story in the local newspaper in an attempt to scotch unfounded rumours and enable her to set up her own business. In addition, a "blacklist" of those said to be infectious for AIDS is being circulated locally. The motive for this seems malicious as it is a foolproof method of harming business and social rivals.

I have had to speak at a meeting of parents at a primary school, where panic was growing because of an unfounded rumour that the parent of a child at the school had AIDS.

I am sure that, having experienced the prevailing attitudes, any future sufferers will certainly refuse to carry an identity card or be labelled in any way. They will be extremely cautious about who is informed of their antibody state, no doubt trusting their general practitioner but perhaps not the receptionist.

I hope that this glimpse of the reactions of an insular community will cause those who think that they have a right to know to have second thoughts. For a disease that carries an extremely low risk of transmission to health workers but in which a breach of confidentiality can be devastating I believe that attempts to label victims are quite wrong and that those who know should be strictly limited, mainly in accordance with patients' wishes.

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SIR,—The question posed by Dr A C Srivastava (21 February, p 495) was not answered by your four experts. Surely if people know that they are carriers of the human immunodeficiency virus (HIV) it is morally wrong for them not to inform doctors who may be affected when they fall ill. Their sexual proclivities are irrelevant, and the paranoia of certain groups should not enter the discussion. Surely it is reasonable that people who know that they are HIV positive should carry a card identifying themselves as such in case an injury renders them unconscious and thus unable to communicate.

Trauma surgeons who deal with unconscious patients, with the best will in the world, often splash blood in their eyes and sustain needlestick injuries during surgery. Dr A J Pinching says that no additional measures are required by health care workers, but this is not the case in operating theatres, where a surgeon has a responsibility not only to the patient but also to staff, his own family, and himself. The carrying of cards identifying carriers (not identity cards) of HIV cannot in itself infringe any personal freedom or human rights.

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Diagnostic classification of the aetiology of mental retardation in children

SIR,—In their suggested scheme for the investigation of children with mental retardation (17 January, p 163) Drs Simon J Newell and Stuart H Green state that "routine testing is done in the hope of classifying cases in which there are no specific clues to aetiology" and cite three studies in which no unsuspected diagnosis was made. We recently undertook a study of 169 children at schools for the educationally subnormal in Southampton to assess what investigations would be valuable.[1] Biochemical screening included amino acid analysis—quantitative in mothers, qualitative in children—and testing of thyroid function in children. Results were negative, and we would agree that such tests need not be performed unless specifically indicated. Chromosome analysis, however, identified five children with previously unsuspected abnormalities of relevance (2-47, XXY, 1-48, XXYY, 1 X autosome translocation, 1 deletion in chromosome 15). None of these children had dysmorphic features, one had a behavioural problem, and two had had perinatal anoxia. Had chromosome analysis been confined to children with congenital abnormalities, or to