test or through collateral evidence, especially as human errors can so easily arise in the chain of sending specimens and reports even in the best run hospitals. We would raise the possibility of such serious disease with an unsuspecting patient only after collecting evidence and reaching a degree of certainty.

I suggest that precounselling should be omitted when HIV testing is to be done as part of differential diagnosis in a patient who is not overtly concerned about HIV infection. If the result is negative the need for repeat testing will be determined by other findings and subsequent progress. If it is positive the clinician may choose not to reveal the result immediately but rather to raise the possibility of HIV infection with the patient and proceed to a confirmatory HIV antibody test.

Doctors are paid not to obey rules but to exercise judgment in the patients' best interests. These interests are not served by raising the spectre of AIDS (or of any other serious disease) prematurely and unnecessarily.

J G DICKINSON

Queen Elizabeth Military Hospital,
Woolwich SE18 4QH

AIDS: When to test

SIR,—Your series on the acquired immune deficiency syndrome (AIDS) is both timely and helpful. It has, however, raised at least one major doubt in my mind: when to investigate.

AIDS is a polymorphic disease, as the articles show. The differential diagnosis of lymphadenopathy (which is an early feature in some patients) includes the equally serious disease leukaemia. Leukaemia is often treatable and must therefore be identified as early as possible. In general practice the order in which investigations are carried out is related to the likelihood of the test being helpful, its cause, and its invasiveness. All other things being equal, a blood film is always done before a bone marrow biopsy.

With AIDS we are told that a blood test for the presence of antibodies should not be done before the patient has been counselled and fully understands the effects of having such a test. I am aware of the limitations of the human immunodeficiency virus (HIV) antibody test, but, to some extent, similar limitations apply to many other investigations but do not prevent us from performing the tests. Nor do we always tell the patient every possible outcome of an investigation. Indeed, we ourselves are sometimes surprised when an investigation shows a possible lesion that we had not previously considered. Why should a test for HIV antibody be different?

STUART CARNE

Grove Health Centre,
London W12 8EJ

Simple thyroid cyst: cause of acute bilateral recurrent laryngeal nerve palsy

SIR,—We agree with Messrs J S Gani and J M Morrison (2 May, p 1129) that it is difficult to explain the rapid onset and sudden relief of the palsy in their patient. We think, however, that impairment of the microcirculation to both nerves is an unlikely cause.

Interruption of the microcirculation to a nerve for a short period of 20 to 30 minutes results in a palsy with no recognisable pathological lesion, and on re-establishing the blood flow there is an almost immediate reversal.[1] Longer lasting ischaemia results in demyelination with a far longer recovery period. In the reported case the microcirculation to the recurrent laryngeal nerves was probably interrupted for more than 30 minutes, making immediate recovery, when the pressure was relaxed, extremely unlikely.

In January this year we admitted a 41 year old man who had had a goitre for many years and who gave a three month history of hoarseness. Indirect laryngoscopy showed a paralysed left vocal cord, but at operation the left recurrent laryngeal nerve was noted to be in a normal anatomical position and not stretched over the gland. The left vocal cord remained paralysed in the immediate postoperative period. Histological examination of the gland confirmed the diagnosis of a multinodular goitre. At his second outpatient visit 10 weeks after surgery his voice had improved but the left vocal cord remained paralysed. When he reattended six weeks later he had further improvement with full vocal cord movement.

We believe that this patient's recovery was more typical of the pattern exhibited by patients with ischaemic demyelination injury to the recurrent laryngeal nerve.

A R QUAYLE
C H TALBOT

Royal Hallamshire Hospital,
Sheffield S10 2JF

1 Ochoa J. Nerve fiber pathology in adult and chronic compression. In: Omer GE, Spinner M, eds. *Management of peripheral nerve problems*. Philadelphia: Saunders, 1980.

Developing primary health care

SIR,—Professor Brian Jarman and Mrs Julia Cumberlege (18 April, p 1005) propose a totally organised system of community care on a geographical basis. Their system would work if all general practitioners were state salaried and their premises owned by the state. Commendably, they include the general practitioner in their primary health care team, but it is astonishing that "there is no question of one person being in charge." Really. Consensus management went out with Griffiths, and now he too is looking at community services. Furthermore, there is no word about practice nurses (there could easily be 10 000 in the country), yet the authors say, "We support attempts to evaluate different models of care."

It is surely arrogant to say that "The patient's right to freedom of choice of a doctor, however, should be retained, as it adds flexibility to the rigidity of fixed geographically based services." There is more to a patient's freedom of choice than this. A patient has allegiance to a practice, not a community, and the reference point in community care is the practice and not the community care area. Mrs Cumberlege has enhanced the role of the practice nurse enormously. Let us hope that the paper by Professor Jarman and Mrs Cumberlege has a similar paradoxical effect.

D U BLOOR

West Midlands DY6 9JQ

Clinical Algorithms: Irregular vaginal bleeding

SIR,—It is a commonly held belief that carcinoma of the cervix is always treated by hysterectomy and that some sort of adjuvant radiotherapy is sometimes given for the sake of completeness. Unfortunately, Professor Geoffrey Chamberlain seems to imply this in his recent article (11 April, p 947). He states: "If the biopsy confirms the presence of stratified squamous cell carcinoma (or, rarely, adenocarcinoma from the canal) the treatment is usually a combination of radical surgery, local irradiation, and deep irradiation," and in the algorithm box he puts "Radical surgery±deep x ray treatment."

Though a combined approach is generally accepted for the management of operable carcinoma corpus uteri, there are few cases of invasive cancer of the cervix (nearly always stage IB or earlier) in which the treatment of choice is not primary radiotherapy with external beam and subsequent intracavitary irradiation. For more advanced stages surgery is not a feasible proposition, and as yet such cases form the bulk of the caseload for invasive cancer of the cervix in most centres.

Postoperative radiotherapy is often requested for patients in whom pelvic lymph node metastases were found at surgery. In fact, very few such patients really benefit much unless the node disease is truly microscopic and can therefore be eradicated by the radiation doses which can then "safely" be given. (The place of aggressive chemotherapy deserves more serious consideration here than it commonly receives.) The opposite approach, when primary radical radiotherapy is followed by planned surgery, has its advocates, though usually for barrel shaped tumours or adenocarcinomas. I am reliably informed by gynaecologist colleagues, however, that hysterectomy after radiotherapy is rarely a radical operation, unless the radiation doses were deliberately kept low.

Planned combinations of radical treatments carry unnecessarily high risks of damage to patients and rarely improve the prognosis for the patients. "Safe" combinations, given in either order of preference, inevitably mean that the efficacy of one of the treatments is compromised; the patient's medical attendants probably gain more in reassurance than the patient gains in prognosis. Obviously, the radiotherapist must attempt what he can for a patient in whom primary surgery is inadequate, just as the gynaecologist rarely objects to attempting salvage surgery in the patient for whom radiotherapy has failed.

My complaint is that so often a radiotherapist has to answer the questions of an anxious patient, or her husband, who has been told by junior gynaecological staff, the family doctor, or a nurse to expect major surgery—whatever the disease stage—and who then understandably thinks that radiotherapy is either second best or simply wrong. I realise that Professor Chamberlain could not enter this kind of discussion for the purposes of his algorithm, and I do not wish to open up the silly surgery versus radiotherapy argument. I would suggest, however, that the algorithm box for the treatment of cancer of the cervix should more accurately be labelled "Surgery or radiotherapy."

I J KERBY

South Wales Radiotherapy and Oncology Service,
Velindre Hospital,
Cardiff CF4 7XL

Look after your heart

SIR,—Although Dr Noel D L Olsen's leading article (2 May, p 1115) contains much good sense, it conspicuously failed to mention promotion of exercise as a priority in coronary prevention. This omission is unfortunate not only because exercise is highly effective in prevention but also because attention to other risk factors has not substantially altered the overall incidence of coronary disease.[1]

Paffenbarger showed lack of exercise to be the best predictor of coronary risk in the community he studied,[2] and in May's review[3] physical conditioning was the best form of secondary prevention (Coronary Prevention Group, RSM, London, 1987). Remarkably little exercise is required to reduce coronary risk (30 minutes