The survey of British drug abusers, carried out on 1984 sera, shows that the prevalence of anti-HTLV-III already noted in this group remains low,[6] even in a selected group whose main underlying disease, hepatitis B, implies intravenous administration of drugs and therefore an increased likelihood of blood borne infection. Nevertheless, a recent study of drug abusers in New York showed 87% to be infected,[5] and HTLV-III infection might readily spread among intravenous drug abusers here, just as other viruses such as hepatitis B virus and hepatitis D virus (δ agent) have done.[12] In Central Africa, where AIDS is common and increasing in incidence, heterosexual intercourse seems to be the main mode of spread of HTLV-III.[13] In Britain, drug abusers and haemophiliacs are two groups from which it is possible that HTLV-III infection may spread by this route.

This is the second seroepidemiological survey of HTLV-III infection in Britain. It confirms the results of the first[6] and extends them in two respects: it shows that the infection has become increasingly widespread since 1980-1 in the two groups mainly affected and that HTLV-III has become prevalent in homosexuals throughout the country. The prevalence of anti-HTLV-III in the provinces is likely to increase as it has done in London, and further spread of infection can be avoided only by homosexuals very strictly limiting the numbers of sexual partners and preventing the transfer of semen. These are measures that must be urged on individuals, both through homosexual support groups and through adequate counselling services. Similarly, the potential for further spread of infection among haemophiliacs, other blood recipients, and drug abusers is a pressing problem demanding new resources to support prophylactic measures.

Because the epidemiological factors may change it is impossible to predict how many cases of AIDS there will be in Britain in the next few years. Though at first sight the outbreak is small and circumscribed, there is a constant upward trend and no signs of a plateau in the rate of increase of cases reported (M McEvoy, personal communication). Few of the seropositive individuals identified in this study are known or thought to have developed AIDS related disease, and the extent of HTLV-III infection in Britain shown by the results of two large seroepidemiological studies is not reflected in the current, uncommon occurrence of AIDS and the AIDS related complex. Nevertheless, infection can continue to spread from seropositive individuals,[14] and attempts to control this certainly cannot await the remote prospect of a vaccine. The virus seems to be transmitted only by the inoculation of blood, semen, and possibly saliva.[16] Every effort must therefore be made by the individuals at immediate risk and those concerned in their medical care to prevent these transmission events.

The needs of seropositive individuals, an unknown proportion of whom will develop AIDS related illness, must also be considered. The finding that some British patients were seropositive as long ago as 1980 should prompt investigation of their long term health. These studies, though difficult to mount, will be very important in planning for future care. At present there is insufficient provision for the advice and treatment of HTLV-III infected patients. The evidence from seroepidemiological surveys and continuing laboratory investigations of the HTLV-III epidemic point to a need for a rapid, adequate, and humane response to the predicament of those who have and will become infected.

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SHORT REPORTS

Fenclofenac induced interstitial nephritis confirmed by inadvertent rechallenge

Fenclofenac is a phenylacetic acid derived non-steroidal anti-inflammatory drug which has been in wide use for about eight years. Side effects are similar to those of other non-steroidal anti-inflammatory agents and have included a diminution of renal function and occasional proteinuria. Allergic interstitial nephritis has been frequently reported after treatment with propionic acid derivatives such as fenoprofen.[1 2] There have been only two reports of this complication after fenclofenac, however, and on each occasion additional drugs had been prescribed. We have recently seen a case of biopsy proved allergic interstitial nephritis associated with fenclofenac which recurred when the patient was inadvertently rechallenged with the drug.

Case report

A 65 year old man developed acute oliguric renal failure while on holiday in Israel. The oliguria was associated with arthralgia and an erythematous rash. The patient admitted ingestion of Enterosan (a proprietary antidiarrhoeal preparation) but denied use of any other drugs.

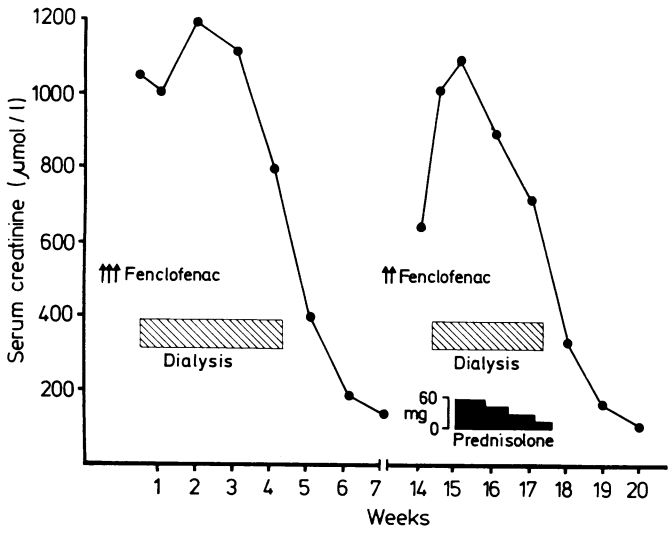
Investigation disclosed + + + proteinuria in a small volume of urine, a plasma creatinine concentration of 1045 μmol l (11·8 mg/100 ml), and an absolute eosinophil count of $1{\cdot}6 \times 10^9$/l. Intermittent haemodialysis was begun

and the patient returned to Britain 10 days later in established acute renal failure. Open renal biopsy was performed as the patient had bilateral unilocular renal cysts which had been diagnosed previously. Histological examination showed normal glomeruli, interstitial oedema, and a mononuclear cell infiltrate with tubular necrosis and evidence of subsequent regeneration. Electron microscopy of three glomeruli showed diffuse foot process fusion. Diagnosis was of a tubulointerstitial nephritis. Subsequent questioning did not elicit any further drug exposure, and the patient began intermittent peritoneal dialysis. There was spontaneous recovery of renal function 21 days later, and at discharge the plasma creatinine concentration was 141 μmol/l (1·6 mg/100 ml).

Four months later the patient was readmitted in acute oliguric renal failure. Six days previously he had ingested six tablets of fenclofenac over 36 hours for vague shoulder pain. The drug had been prescribed many months before. Three days before admission he had felt feverish and noted a rash, decreasing urinary volume, and ankle swelling. On direct questioning he admitted taking several fenclofenac tablets before the first episode of acute renal failure. Examination showed evidence of fluid retention and a vasculitic rash on the lower legs. Plasma creatinine concentration was 1167 μmol/l (13·2 mg/100 ml) and an absolute eosinophil count $1{\cdot}2 \times 10^9$/l. A 24 hour collection of urine measured 460 ml and contained 21·6 g protein/litre. Renal biopsy showed severe tubulointerstitial nephritis with a dense infiltrate of lymphocytes, plasma cells, and eosinophils and with extensive tubular necrosis. Skin biopsy disclosed perivascular infiltration with mononuclear cells consistent with vasculitis. The patient began intermittent peritoneal dialysis and prednisolone 60 mg daily (fig). Renal function returned to normal after 22 days.

Comment

Allergic interstitial nephritis is a well described, though infrequent, complication of treatment with many non-steroidal anti-inflammatory drugs. In many instances the association is based on few anecdotes and mnay of the patients were receiving multiple drug regimens.[3] The description of allergic interstitial nephritis with the nephrotic syndrome and glomerular foot process fusion as a complication of propionic acid derivatives, notably fenoprofen, seems to be a specific entity.[4 5] The histological picture in our patient was remarkably similar, and the occurrence of an identical syndrome on inadvertent rechallenge provides convincing evidence that fenclofenac was indeed implicated. It is also of interest that steroid treatment did not appear to hasten resolution (fig), though the clinical picture of eosinophilia and vasculitic rash seemed to suggest a role for steroids.



Changes in plasma creatinine concentration in relation to fenclofenac ingestion, dialysis, and treatment with corticosteroids.

Conversion: SI to traditional units—Creatinine: 1 μmol/l ≈ 0·01 mg/100 ml.

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Acute disseminated encephalomyelitis as a complication of treatment with gold

Toxic reactions to chrysotherapy are well known. Neurological complications, however, are less well recognised. We describe a case of acute disseminated encephalomyelitis associated with treatment with gold.

Case report

A 39 year old woman presented with typical features of rheumatoid arthritis. She was initially treated with adrenocorticotrophic hormone and later penicillamine, which was withdrawn when she developed mouth ulcers. Five weeks before admission to hospital she suffered an exacerbation, which was not controlled by anti-inflammatory drugs. Injections of gold were started with a test dose of 5 mg intramuscularly, followed by doses of 10 mg, 20 mg, 50 mg, and 50 mg at weekly intervals. Six hours after each injection she developed backache, wheezing, and an erythematous rash on the back of her hands, which persisted until the following day. One week after the last injection she woke with diplopia, dysarthria, and unsteadiness of gait. She had no personal or family history of allergy. On admission she was taking azapropazone 600 mg twice daily and mianserin 10 mg at night.

On examination she showed an inappropriate affect, labile emotions, and a poor memory. She was dysarthric. Her fundi were normal. She had internuclear ophthalmoplegia but no nystagmus. She showed generally reduced tone, with pyramidal weakness in her right arm. Cerebellar signs were present in both arms and legs, and she had truncal ataxia. Reflexes were brisk and symmetrical, with extensor plantars bilaterally. Sensation was normal. The spleen was palpable 2 cm below the costal margin. There was no evidence of active arthritis or a rash. Haemoglobin concentration was 10·9 g/dl; white cell count $6{\cdot}6 \times 10^9$/l, eosinophils 50%; erythrocyte sedimentation rate 24 mm in the first hour; and autoantibody, Venereal Disease Research Laboratory, and *Treponema pallidum* haemagglutination tests and blood cultures all negative. Immunoglobulin concentrations were normal. Cerebrospinal fluid contained 0·84 g protein/l with no pleocytosis and a normal ratio of IgG to albumin concentrations. Radiographs of the chest, skull, and cervical spine were normal. Radiographs of the hands were compatible with rheumatoid arthritis. Electroencephalography showed generalised abnormality suggesting encephalitis. Visual evoked responses showed bilateral delay. A computed tomogram of the head was normal.

Acute disseminated encephalomyelitis secondary to treatment with gold was diagnosed provisionally. She was treated with oral prednisolone 45 mg daily and physiotherapy. Her mental state and cerebellar signs improved, as did the pyramidal weakness in her right arm. Her eosinophilia resolved. She was discharged taking a decreasing dose of steroids. Eighteen weeks after discharge she was still dysarthric with an ataxic gait and bilateral extensor plantar response, but electroencephalography showed substantial improvement as did her visual evoked responses.

Comment

We presumed that this was a case of gold toxicity and not the first presentation of multiple sclerosis because of the interval between the onset of treatment with gold and presentation (five weeks), the eosinophilia, and the normal ratio of IgG to albumin concentrations in the cerebrospinal fluid. The only reported neurological complication of treatment with mianserin is drowsiness; none has been reported for azapropazone.