should be to ensure that whenever decisions are being made that might affect health—and there are a great many—the consequences to health are considered. Those decisions might be taken in the Cabinet, in any government department, in Brussels, in local government, in industry, or in the NHS. This is, of course, a very general aim, and several of those at the meeting thought that one more definite aim of the new organisation should be to work for the 38 specific goals for the year 2000 of the European office of the World Health Organisation.[1]

Indeed, some suggested that the new organisation might become a "British chapter" of the WHO initiative. Others had been impressed by the American and Canadian public health associations, which are large organisations with individual and group members. Without government support they produce authoritative documents on a wide range of public health topics and make sure that the information reaches decision makers. Whether or not they influence public policy is more debatable. Others preferred the model of the London Food Commission, which was founded by representatives from various relevant organisations. It takes an issue, forms a working party, produces a report, and then fulfils an educational and lobbying role. Another model might be the Maternity Alliance, which has succeeded in amplifying the voice of pressure groups concerned to improve the health of mothers and children. Agreement could not be reached at last week's meeting on the exact form of the new organisation or alliance, but a small planning group has been set up. It is expected to produce plans for a second meeting in October.

Certainly it would seem wrong to launch a new organisation without paying any attention to the thousands that already exist with some interest, no matter how small and tangential, in public health. Those organisations are too often failing, however, to move public health issues to the centre of the political stage, where they rightly belong, and some initiative is badly needed. Any new group that might be formed will be born into a hostile world and will need to be well equipped. It will need: the support of existing organisations; independence; access to high quality unbiased information and advice; and resources. All may be difficult to come by.

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1 World Health Organisation Regional Office for Europe. *Targets for health for all.* Copenhagen: WHO, 1985.

Lymphostatic disorders

The lymphatic system plays a fundamental part in regulating the physiological environment by returning protein, cells, macromolecules, and fluid to the general circulation as well as removing metabolic byproducts, dying or mutant cells, microbes, and inorganic matter.[1] Oedema may develop either from an excess of capillary filtrate with normal but overloaded regional lymphatics or from defective lymphatics with an unaltered lymph load.[2] Stasis due to obstructed lymphatics (low lymph flow failure) is characterised by oedema fluid with a high protein content; it is seen, for example, after mastectomy. Overproduction of lymph, such as that associated with chronic venous insufficiency, causes high lymph flow failure—but this may also lead to lymph stasis through secondary damage to the lymphatic system. The term "lymphostatic disorder" has been suggested as a replacement for "lymphoedema" as it refers to all types of lymph stasis and overcomes the problem that there may be no clinically detectable oedema in some late stages of the condition.[3]

A lymphostatic disorder, then, is a progressive condition characterised by four main components: excess protein, oedema, chronic inflammation, and excess fibrosis.[4] Fibrosis occurs late and reduces the perceptible pitting. Chronic peripheral lymph stasis produces thickened skin giving enhanced skin creases and deepened skin folds; it prevents the pinching of a fold of skin over the dorsal aspect of the toes or fingers (Stemmer's sign).[5] Hyperkeratosis and verrucous and condylomatous changes are also features of longstanding lymph stasis, and if severe these are termed elephantiasis.

The patient's disabilities include pain, reduced mobility, and impaired function of a limb. Psychological disturbances also occur since the gross distortion of the tissues may affect the patient's social acceptance. Chronic lymph stasis commonly predisposes to infection and more rarely to the development of tumours (as in the Stewart-Treve's syndrome). Acute inflammatory episodes, referred to as "cellulitis" or "erysipelas" may or may not be related to bacterial infection, but these invariably further damage existing lymphatics so compounding the problem.[3]

Lymphostatic disorders are considered rare, but we have no reliable epidemiological data on their prevalence. The reported incidence for lymph stasis after mastectomy varies from 9% to 63%.[6-10] This variation is due to differing operations, whether or not the patient was irradiated, and the length of follow up—and it also depends on the definitions of severity or techniques of measurement. The diagnosis of chronic lymph stasis may usually be made clinically, though malignancy must always be excluded. Lymphography is widely used, but it provides only static non-functional anatomical information, and may be harmful.[11] The best means of estimating lymphatic function is quantitative indirect lymphoscintigraphy.[12]

The management of lymphostatic disorders is unsatisfactory. The "grin and bear it" approach is as unacceptable as are mutilating surgical operations or amputations. Macrosurgery has no long term benefits, but advances in microsurgery are encouraging, particularly with lymphaticovenous anastomoses.[13] No single operation is likely to be the answer in all cases. Drug treatment has been disappointing, and despite their widespread use diuretics are ineffective. The benzopyrone oxerutins reduces experimental high protein oedema, but its effect is slow and unpredictable.[14] Physical treatment appears to be the most effective treatment; it comprises massage, compression with bandaging or pneumatically inflated sleeves, and gentle exercises.[15] The improvement needs to be maintained by elastic hosiery, and the patient should be encouraged to use the limb normally. When the disorder is secondary to cancer vigilance for recurrence must be paramount. Infection must be treated promptly with antibiotics such as phenoxymethylpenicillin. Prophylactic attention to skin hygiene is essential, but recurrent attacks of "cellulitis" may require long term treatment with antibiotics.

The aim of the recently formed British Lymphology Interest Group is to encourage clinical and scientific research programmes, to develop a platform for the dissemination of knowledge about lymphatic disorders, and to compile

a directory of specialist treatment centres. The group, comprising doctors, physiotherapists, nurses, and patient support groups, hopes to provide a coordinated strategy for the management of lymphostatic disorders.

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AIDS: act now, don't pay later

The window of opportunity—fashionable phrase—applies strongly to health education about AIDS (the acquired immune deficiency syndrome). Britain is lagging about four years behind the United States in the evolution of the epidemic. We have now had nearly 400 cases of AIDS reported to the Communicable Disease Surveillance Centre.[1] In mid-1982 the United States had had 400 cases; the total there is now around 20 000 with at least one million people infected.[2] A recent conference in Paris was told that (unless a treatment is found) 180 000 Americans will die of the disease in the next five years.[3] The Americans have learnt a lot about health education, counselling, and information services in the past four years. Most important, the numbers of dead and dying there have forced AIDS back on to the front pages.

We in Britain have a chance now to act, profiting from experience in the United States, but time is running out. Despite the publication of scores of books and what may have seemed like saturation coverage on TV and radio, misconceptions about the disease abound. In particular many people still seem to believe that it affects only homosexuals. The reality—being reported week after week in the United States—is that AIDS behaves like syphilis and hepatitis B: it is most common in the gay community and next most common among drug addicts who use intravenous injections, but it is also a risk for anyone who is sexually active, including the "innocent" partners of the promiscuous. Health education has to be explicit: you may catch AIDS from anyone with whom you have heterosexual or homosexual intercourse; and the risk is reduced by using a condom.

Clearly much more needs to be done in informing and educating the public (and the health professions, some of whose members still display prejudice and ignorance). In particular, efforts should be concentrated on drug abusers, for, unlike homosexuals, they have no articulate, energetic group representing their interests and giving them advice. Last week Lord Young of Dartington, speaking for the College of Health, called on the government to spend £61m in the next financial year on combating the disease. Of this total half would go on national publicity, £10m on the appointment of AIDS information officers in every health district, and £10m to voluntary bodies—such as the Terence Higgins Trust, which has done such a good job in providing information and counselling for homosexuals, and has now published a booklet for drug abusers (see p 400). Spending on this scale will be justified if (as it has done in San Francisco) publicity changes behaviour and slows the spread of the disease. Despite the claims by the DHSS publicity in Britain so far has been unimaginative and of little impact.

Lord Young was supported in his appeal by two prominent Conservative backbenchers, the former health minister Sir Gerard Vaughan and Sir David Price. Will the money be forthcoming? Only if more politicians are persuaded of the truth of the claim in the College of Health's booklet that with the hindsight of history this government may be judged by its reaction to the disease.[4] For if the numbers affected continue to rise within five to six years the deaths each month in Britain alone will be equivalent to the crash of a fully loaded jumbo jet. True, the virus has been isolated; but so have the viruses of hepatitis, influenza, rabies, and other fatal diseases, and we still have no treatments. All the evidence suggests that the development of a vaccine will prove immensely difficult. So Lord Young is right; for this disease prevention is not just better than cure—it is the *only* cure.

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Unwanted hair

Advertising tells us that long flowing scalp hair and no pigmented facial and body hair are essential prerequisites of femininity. But many women do have facial and body hair, and when should treatment be offered? The large familial and racial differences in the extent and acceptability of hair on various body sites make objective assessment essential. Many investigators use a scoring system for hair growth on all body sites except the forearms and lower legs.[1] A careful endocrinological evaluation of patients defined by this