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.

PETER MORTIMER

Senior Registrar,
Department of Dermatology,
Slade Hospital,
Oxford OX3 7JH

CLAUD REGNARD

Macmillan Fellow,
Sir Michael Sobell House,
Churchill Hospital,
Oxford OX3 7LJ

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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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2 Marwick C. Task force formed to coordinate study, testing of AIDS therapies. *JAMA* 1986;225:1233-5, 40, 42.

3 Newmark P. AIDS. Depressing news from Paris. *Nature* 1986;322:6.

4 College of Health. *AIDS and the government*. London: College of Health, 1986. £1.50.

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

system as hirsute shows increased androgen metabolism in up to 90%.²

Both the adrenal glands and the ovaries are a source of androgens, and one classic cause of hirsutism is the polycystic ovary syndrome, first recognised as a clinical triad of amenorrhoea, hirsutism, and obesity by Stein and Leventhal in 1935.^{3,5} Most women who complain of excess hair, however, are not obese, nor do they have menstrual disturbance, but Adams and others report in this issue (p 355) a high incidence of polycystic ovarian disease (as shown by modern ultrasound techniques) in a small sample of women with hirsutism and normal menses. They claim that the "idiopathic" label can now be removed from most patients. Nevertheless, small cysts may represent ovarian disease shared by several dysfunctional states,⁶ and, except for women complaining of infertility, they do not alter the treatment.

Amenorrhoea, oligomenorrhoea, signs of virilisation, and extensive hirsutism make referral to an endocrinologist or gynaecologist mandatory. Reassurance that a woman is endocrinologically normal may be achieved by measuring plasma androgen concentrations in the follicular phase of the menstrual cycle. A common finding will be that the concentration is at the upper end of, or just above, the normal range,² and we do not know whether the increased metabolism of androgens within the skin and plucked hairs of hirsute women is a primary or secondary phenomenon.⁷⁻⁹

Cosmetic treatments should always be advised¹⁰: bleaching and depilatory creams are both messy and expensive; electrolysis is also expensive but useful for localised problems; and shaving and plucking are excellent methods and do not encourage increase in hair growth rate or changes in colour or diameter despite widely held beliefs to the contrary.¹¹ The difficult therapeutic issue is whether to treat specifically the minor changes in plasma androgen concentrations and tissue androgen metabolism.

Apart from the specific management of adrenal and ovarian androgenic states, the treatment options include oral antiandrogens and oestrogens in various combinations.¹² I prefer a regimen of the antiandrogen cyproterone acetate combined with ethinyloestradiol. Reduction in hair growth rate, diameter, and pigmentation is usually seen in four to eight months. Cyproterone acetate works as a competitive inhibitor, and therefore relapse occurs within three to nine months of stopping the drug.¹³ Low dose cyproterone acetate combined with ethinyloestradiol in the preparation Diane may be useful maintenance treatment. Spironolactone is a potent antiandrogen with actions similar to those of cyproterone acetate, and combined with an oral contraceptive it has been shown in limited clinical trials to be equally effective.¹⁴ Topical antiandrogens do not work.

Women who complain to their general practitioners about excessive hair have usually tried cosmetic treatments. They have given great thought to their problem and are seeking both help and advice, and a good interview may be enough. Referral to a sympathetic hospital specialist may provide the extra reassurance of normality that the patient needs and is necessary if medical treatment is indicated. It is unfortunate that the increased complexity of techniques for investigating androgen metabolism and ovarian pathology have not been matched by the production of an effective long term treatment.

NICK SIMPSON

Consultant Dermatologist,
Royal Infirmary,
Glasgow G4 0SF

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Lies, damned lies, and suppressed statistics

Every 10 years the Registrar General produces a supplement to the national census in which deaths are analysed by occupation, cause of death, sex, and age. The latest one has just been published, and something strange has happened—reference to the social class differences in mortality have almost slipped out.¹ Why is this? Could it be because somebody in the government or in the Registrar General's office is anxious to play down the widening gap in mortality between rich and poor?

If so, history is repeating itself. Six years ago a similar clumsy attempt was made to play down the Black report, which showed not only that there was a large gap in mortality between social classes I and V but also that the gap was widening.² Instead of having the report properly printed and published the government made 260 typescripts available on August bank holiday Monday and accompanied it with a foreword from the Secretary of State stating that he had no intention of responding to its detailed recommendations. Not surprisingly, this attempt at suppression made the document instantly more newsworthy, and it has since been published by Penguin and become, in the minds of many, the most important medical report since the war. Rather the same happened with the government think tank report on alcohol: by refusing to publish it the government underlined its importance, and now anybody can buy a copy from Stockholm University.³

The previous decennial supplement was about twice as long as the new one, a sixth of the price, and had 60 or so pages devoted to discussing social class differences in mortality.⁴ The new report, which comprises 128 pages of commentary and a set of 87 microfiches, contains only five pages on the topic. The tables on fiche represent a substantial increase over what has previously been made available and contain a wealth of data on social class. Nevertheless, anyone interested in inequalities in health will be disappointed. Although the raw data are given on fiche, the commentary gives only passing reference to the figures and then principally to emphasise their weaknesses. The report claims that the figures for social class V are unreliable and that we should look elsewhere for a more authoritative account of recent differences in mortality among the social classes. This