drug. The five patients treated initially with nifedipine relapsed within one week of starting placebo treatment. In three patients the relapse was so severe that the code was broken and the patients began treatment with nifedipine again, with symptomatic response. In the remaining two patients in this group and the five initially treated with placebo new chilblains continued to develop and individual lesions resolved slowly over 20 to 28 days from their onset. Nifedipine reduced the pain, soreness, and irritation of the lesions; placebo was ineffective. Irritation resolved within three to five days (20-25 days with placebo), and lesions became painless after five days (25 days with placebo).

Mild dizziness, flushing, and occasional headaches were experienced during treatment with nifedipine, but only one patient required a reduction of the dose to 40 mg daily because of symptomatic hypotension. This patient continued to derive benefit from the reduced dose.

Comment

This study shows that nifedipine is effective in the treatment of severe recurrent idiopathic perniosis. Further research is needed to understand the pathophysiology of this common condition.

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Willingness of homosexual and bisexual men in London to be screened for human immunodeficiency virus

Clinicians now have ready access to tests for antibodies to human immunodeficiency virus (HIV), but, as a positive result may have major implications for the patient, there has been considerable discussion about whether those in high risk groups should be screened.^{1,2} Arguments against screening members of these groups have been advanced, but they have not been backed by data on the willingness or otherwise of these people to be tested. We investigated this as part of a study to determine the prevalence of HIV among homosexual and bisexual men attending our sexually transmitted disease clinic.

Patients, methods, and results

All homosexual and bisexual men attending the department of genitourinary medicine as new patients from November 1985 to February 1986 were asked to participate. Each patient was counselled and given an explanatory leaflet before being offered screening. Patients who agreed to be tested were given the option of being told their result. Those who wished to know were asked to return in two weeks for their result and for further counselling; those with a positive result were offered continued support. Samples from patients who did not wish to know their result were coded before testing.

A competitive enzyme inhibition assay (Wellcome Diagnostics, Dartford) was used for initial screening for HIV. Serum samples giving positive results were tested further by fixed cell immunofluorescence on infected and uninfected cells. All serum samples were also tested for hepatitis B surface antigen (HBsAg) and hepatitis B surface antibody by radioimmunoassay; samples positive for HBsAg were tested for hepatitis B e antigen (HBeAg) and antibody by radioimmunoassay, and samples negative for HBsAg were tested for antibody to hepatitis B core antigen by enzyme immunoassay. Abbott reagents (Abbott Lab, Chicago) were used for these tests.

Of 270 consecutive patients, only 13 (5%) did not wish to be tested. Antibodies

to HIV were found in 36 of the 257 (14%) tested (table), the prevalence being higher among homosexuals (17.9%) than bisexuals (5.1%). Most patients (70% overall, 66% of homosexuals and 77% of bisexuals) wished to know their result.

A higher proportion of the men positive for antibody to HIV had markers for hepatitis B virus (30/36; 83.3%) than of the seronegative men (86/221; 38.9%). The lower prevalence of HIV among bisexuals was mirrored by the prevalence of hepatitis B markers; these were present in 23 of the 78 (29.5%) bisexuals and 93 of the 179 (52.0%) homosexuals. Six of the 36 (16.6%) men positive for HIV and seven of the 221 (3.2%) seronegative men were HBsAg positive; patients with hepatitis B markers were significantly more likely to be positive for HBsAg if they also had HIV antibodies ($p < 0.05$). All six men who were positive for both HIV antibody and HBsAg were also positive for HBeAg.

Prevalence of antibodies to HIV and markers of hepatitis B virus in 257 patients who consented to be tested. (Values are numbers (%) of patients)

	Total	Positive for antibody to HIV	Positive for markers to Hepatitis B virus	Positive for HBsAg
Homosexuals	179	32 (17.9)	93 (52.0)	10 (5.6)
Wished to know result	119 (66)	20 (16.8)		
Did not wish to know	60 (34)	12 (20.0)		
Bisexuals	78	4 (5.1)	23 (29.5)	3 (3.8)
Wished to know result	60 (77)	3 (5.0)		
Did not wish to know	18 (23)	1 (5.6)		
All patients tested	257	36 (14.0)	116 (45.1)	13* (5.1)
Wished to know result	179 (70)	23 (12.8)		
Did not wish to know	78 (30)	13 (16.7)		

*11 were positive for e antigen, including all six who were also positive for HIV.

Comment

We found a lower overall prevalence of antibodies to HIV (14%) than the 17-34% reported elsewhere in London,³⁻⁵ even though our samples were obtained one to three years later. The previous studies, however, were carried out at three hospitals that see many patients with disease associated with HIV and so may attract a population unrepresentative of London as a whole.

Arguments against screening for antibodies to HIV have been promulgated widely, but arguments in favour are less often discussed. Some worried patients may wish to be tested to confirm their belief that they are antibody negative. Others may find a positive result more acceptable than fear of the unknown. Many patients regarded knowledge of their antibody state as a strong impetus for behavioural change. Our finding that after counselling 70% of homosexual and bisexual men wished to know their antibody state indicates that screening is acceptable to more people than was previously suggested.

Interestingly, in this small series patients with HIV antibodies seemed to be more likely to have active infection with hepatitis B; this may reflect underlying immunosuppression.

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