AIDS to colleagues who will perform venepunctures or open surgical procedures on that patient. Disclosure to a colleague concerned in a patient's treatment is not, in itself, improper. The dilemma arises when the patient withholds permission for disclosure. If in so doing he might jeopardise the health of another person I suggest that he has no right to refuse disclosure.

Is there, then, a manifest risk to other health care workers? Dr Gillon says that the probability is very low. McEvoy *et al* have documented seven cases of occupationally acquired human immunodeficiency virus. How would these seven colleagues feel if they knew that they had wilfully been denied the information that the patient from whom they contracted the infection had AIDS?

Someone once parodied John Stuart Mill: "Your right to swing your fist ends at my nose." I suggest that an AIDS patient's right to confidentiality stops when, in the words of the United States Supreme Court Justice Louis Brandeis, "there is a clear and present danger" to the health of another person. In the case of AIDS I suggest that Justice Brandeis's criterion is met and that the patient's right to confidentiality is, in those specific circumstances, forfeited.

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1 Gillon R. Refusal to treat AIDS and HIV positive patients. *Br Med J* 1987;294:1332-3.

2 McEvoy M, Porter K, Mortimer P, Simmons N, Shanson D. Prospective study of clinical, laboratory and ancillary staff with accidental exposures to blood or body fluids from patients infected with HIV. *Br Med J* 1987;294:1595-7.

SIR,—During the past century medicine has continued to face fatal diseases for which there has been no cure: what is so special about the acquired immune deficiency syndrome (AIDS)?

Neither of us has any hesitation in treating patients with the disease, but, as with any similar illness, it is most helpful to have all possible information relating to the diagnosis before starting treatment. The failure of any patient who knows he has the illness to inform medical staff is a gross breach of the traditional relationship of trust that exists between them.

Purely practical considerations would also seem to dictate this—principles which have traditionally held in the case of diseases such as hepatitis B, tuberculosis, and syphilis. In none of these cases has awareness of the diagnosis affected the doctor's willingness to treat the patient, and there has been no debate on whether these should continue to be notifiable. Tuberculosis is eminently treatable and of low infectivity, yet a patient with open tuberculosis can still forcibly be retained for treatment. What are the features that distinguish AIDS from these diseases, each of which, in its time, has been untreatable and often fatal?

We sympathise with anyone with a terminal illness and will continue to care for them all, regardless of the diagnosis. Our only request is for equal consideration.

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SIR,—Dr Raanan Gillon has carefully explained why he advocates, almost absolutely, the maintenance of medical confidentiality for patients infected with the human immunodeficiency virus (HIV) or suffering from the acquired immune deficiency syndrome (AIDS) (27 June, p 1675). He has, however, avoided discussion of recent developments that may soon concentrate our minds wonderfully.

The General Medical Council's standards committee has set up a working party to look into the problems of confidentiality and consent when treating patients with AIDS. One member of the working party has, however, already made his own thoughts ominously clear. Professor Ian Kennedy of the Centre of Medical Law and Ethics has given advice to the social services select committee. His predictions have been reported in the *BMJ* but bear repeating¹: suggesting that "the time was not too distant when a court action would be brought against a doctor for failing to advise the spouse of a patient who was infected with HIV and that spouse became infected. The court would be unlikely to accept a defence of confidentiality" (4 April, p 913). Referring to the specific example of the doctor who failed to warn his group partners (or presumably a consultant who failed to tell a general practitioner) of a patient with AIDS, the professor "had little doubt that if the other doctor or a third party suffered harm as a result of the omission, the first doctor could be held liable."

Despite these powerful warnings, the BMA has bravely decided to fight to the last member and has decreed that confidentiality should be upheld if patients refuse to allow disclosure. So there you have it. Professor Kennedy is surely right that a court case will soon be brought, but will it be for maintaining or breaking confidentiality? Why wrestle with knotty ethical problems? Lawyers solve Gordian knots much more simply by cutting them. Perhaps the GMC will now delay its working party's report until the result of the first case is known. Perhaps there might even be a gentleman's agreement. Doctors could be punished by the GMC for breaking confidentiality and by the courts for maintaining it.

AIDS has nothing to do with blame or punishment—unless, of course, you happen to be the messenger. The court case will be like an ancient ritual for public atonement. There will be one death (or two), one medical scapegoat destined for the wilderness, and various high priests who will come away smelling of roses.

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1 Warden J. Cautionary tales of pitfalls ahead. *Br Med J* 1987;294:913.

Testicular torsion in older men

SIR,—Mr M J S Dennis and colleagues (27 June, p 1680) acknowledge the difficulties of establishing the diagnosis of testicular torsion, highlighting the consequences of delaying exploration and, in particular, of dismissing the diagnosis in older patients. Experience at the Leicester General Hospital supports the view that age does not preclude the diagnosis of testicular torsion.

This hospital's experience of patients with testicular torsion has recently been examined. Over the 10 years since January 1977, 243 patients have undergone emergency scrotal exploration and testicular fixation for acute testicular torsion. Of these, 196 patients were aged under 20, 31% being prepubertal; of the remainder, nine men (4%) were aged 30 to 35. A diagnosis of torsion was substantiated and successfully treated with bilateral testicular fixation in two men aged 52 and 57 years. The 57 year old patient was initially diagnosed as probably having an epididymo-orchitis, but, fortunately, prompt scrotal exploration was undertaken and showed a high investment of the tunica vaginalis with a double twist of the cord. Both patients gave a history of intermittent attacks of scrotal pain. A 53 year old man was referred with a diagnosis of acute torsion after three days of testicular pain. This was again thought to be

epididymo-orchitis, but because of the lack of urinary symptoms and negative findings from a midstream urine specimen prompt exploration of the scrotum was undertaken, unfortunately showing haemorrhagic infarction of the testis with four twists of the cord. An orchidectomy was performed.

Over the same period epididymitis or orchitis was diagnosed in 389 patients, 60% being aged between 30 and 80; 90 patients (the largest single group) were in their second decade.

Torsion of the testis is a real surgical emergency for the reasons outlined by Mr Dennis and colleagues, and we agree that the diagnosis ought to be considered in any male with testicular pain, irrespective of age.

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School dinners

SIR,—Dr B A Wharton (27 June, p 1635) questions whether school meals should exist and, if so, in what form and raises fundamental issues about their effectiveness. He incorrectly, however, suggests that little or no work has been done on the nutritional value of school meals.

In fact, objective reports about the association between school meals and rate of growth in children and the nutritional state of children receiving free school meals have been published fairly recently.^{1,2} Information is also available about the factors influencing uptake of school meals in Britain, which supports Dr Wharton's suggestion of converting popular food into healthy food.³ In view of rapid changes in food policy in schools and in family social circumstances, it is essential to review the value of school meals periodically.

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1 Rona RJ, Chinn S, Smith AM. School meals and the rate of growth of primary school children. *J Epidemiol Community Health* 1983;37:8-15.

2 Rona RJ, Chinn S, Smith AM. Height of children receiving free school meals. *Lancet* 1979;ii:534.

3 Rona RJ, Chinn S. Parents' attitudes towards school meals for primary school children in 1981. *Hum Nutr Appl Nutr* 1984;38A:187-98.

Congenital cytomegalovirus infection

SIR,—Dr Jennifer M Best (6 June, p 1440) correctly emphasises that further prospective studies of cytomegalovirus infection in pregnant women will be required to establish the relative importance of primary and recurrent maternal infection as antecedents of congenital infection. Such studies will, however, be difficult to perform.

Though used in recent studies,¹⁻⁴ the detection of cytomegalovirus specific IgM antibody in maternal serum is not a sufficiently discriminatory marker of primary cytomegalovirus infection during the preceding three or four months. On the contrary, cytomegalovirus specific IgM antibody may persist for more than four months, may appear (albeit rarely) during recurrent infections, and is missing in at least 10% of primary infections.⁵ Recurrent cytomegalovirus infection cannot be diagnosed reliably during pregnancy by tests for virus specific antibody as IgM antibody and even rising titres of neutralising antibody may be absent.^{5,6} Consequently, a future prospective study of cytomegalovirus infection in pregnancy will have to investigate maternal virus excretion (in urine, for example⁷) as well as antibody response to document infection. Primary and recurrent