pain haematuria syndrome actually exists. How could anyone who believes thus have diagnosed anything other than the loin pain haematuria syndrome in the patients whom we described? We are not ready to rename their condition Hutchison's syndrome. Furthermore, we do not think that our patients had miscellaneous functional disorders, although we understand that neither does Dr Hutchison, and we agree with the important point he makes in noting that some of these patients may have frank neurotic features.

Phase contrast microscopy is certainly valuable in differentiating between glomerular and non-glomerular haematuria, and Dr Hutchison's observation of glomerular origin in the loin pain haematuria syndrome is as expected. His criticism at this point is quite justified.

His comment on C3 deposition is mere repetition of what we observed and what has been reported from North Staffordshire Hospital Centre, Stoke on Trent.¹ In this syndrome C3 deposition is observed in the cortical arteries and arterioles. In addition, in 7 out of 14 cases small amounts were reported in a fine granular pattern on the glomerular basement membrane.²

The other main criticism that Dr Hutchison makes concerns our suggestion that intrarenal arterial spasms may have a role in the loin pain haematuria syndrome. We do not deny the existence of focal or generalised vascular lesions such as microaneurysms in more advanced cases, as Dr Hutchison calls them, or in a subgroup of patients. We suggest that the mechanism for loin pain in this syndrome might be renal cortical ischaemia, caused in some patients by arterial spasm mediated by the autonomic nervous system. In other patients the same mechanism might be caused by structural changes, such as aggressive atherosclerosis leading to microembolic lesions and the formation of microaneurysms. The effects of arterial spasms would obviously depend on the extent and duration of the spasm. Earlier observations of the reduction of pain after splanchnic nerve blockade, renal denervation, and autotransplantation of the affected kidney to a heterotopic location in the iliac fossa support our hypothesis.^{3,4}

Arterial spasms are rare during renal angiography; in a series of more than 400 renal angiograms using the Seldinger technique selective angiograms in two patients showed three forms of defects attributed to renal arterial spasms.⁵ We do not believe that it would be possible, however, using the description of an angiographic technique, to derive the frequency of intrarenal arterial spasms provoked by that procedure. We still think that it is more useful to compare the frequency of spasms in patients with the loin pain haematuria syndrome with the frequency observed in patients with other conditions, studied using exactly the same angiographic technique, as we did in our report. Three of the patients had spasms and five did not, and one control had a spasm while 32 did not; Pearson's χ^2 test with Yates's correction would thus give a p value <0.05 . Even so, we agree that still more detailed description of intrarenal arterial spasm would be welcome.

YRJÖ T KONTTINEN
DAN NORDSTRÖM
VILLE BERGROTH

Helsinki University Central Hospital,
SF-00170 Helsinki,
Finland

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AIDS: a faltering step

SIR,—As a research group working on the acquired immune deficiency syndrome (AIDS) in Nigeria, we have followed with considerable interest the various political undertones that have tended to characterise opinion among professional associations, and the Euro-American society generally, regarding the unfortunate outbreak of this disease. While acknowledging the moderate posture of the British people generally about AIDS, we were particularly puzzled by the resolution that allows British doctors to test patients for infection with the human immunodeficiency virus (HIV) without consent (11 July, p 150). One important but clearly undesirable effect of this decision would be to introduce discrimination into the practice of British medicine, but this is not our main concern. Like Professor Michael Adler and Dr D J Jeffries (11 July, p 73), we believe that this decision is likely to alienate patients from their doctors, the obvious loser in the final analysis being British medicine.

There can be no professional, ethical, or legal justification for subjecting unsuspecting patients to mandatory testing for HIV infection, just as there can be no justification (as rightly pointed out by Professor Adler and Dr Jeffries) for subjecting them to mandatory treatment of any kind.

We have examined semen samples from over 12 000 Nigerian subjects from several different socioeconomic (and risk) groups for HIV, and our experience suggests that this virus is of low infectivity. We reaffirm that the risks to health workers are negligible: repeated testing of laboratory workers who carried out the screening proved negative for HIV antibodies, and the one nurse who accidentally pricked himself with a needle used to inject a patient who subsequently died remained negative a year later.

Those of us with some British training have applauded British medical practices in the belief that they are usually pragmatic, while being fair and, in most cases, right. That view has been sullied by this one decision, which is retrogressive and wrong, and which should be reversed at the earliest possible opportunity.

IDRIS MOHAMMED
JO CHIKWEM
TO HARRY

University of Maiduguri Teaching Hospital,
Maiduguri, Nigeria

Federal Vaccine Production Laboratory,
Lagos, Nigeria

A NASIDI

After safe sex, safe surgery?

SIR,—Mr Justin Cobb's article (27 June, p 1667) discussing the risks of contamination with blood in the "surgical fast lane" was both entertaining and timely. In this hospital we have recently attempted to define more clearly the risk of contamination that surgeons take each time they put knife to skin.

The general surgical staff consists of three consultants, one senior registrar, and three pre-fellowship registrars. Over five weeks each surgeon was asked to examine his hands for blood contamination at the end of each procedure after removing his gloves. If contamination of the fingers with blood was confirmed the surgeon was then asked if he was aware that a glove had been perforated during the operation.

Number of operations performed by members of surgical staff, with number of contamination incidents in parentheses

	Type of operation		
	Major	Intermediate	Minor
Consultant	54 (23)	65 (6)	11 (0)
Senior registrar	46 (21)	51 (3)	19 (0)
Registrar	51 (16)	76 (9)	22 (0)
Total	151 (60)	192 (18)	52 (0)

The operations were classified as major (including extramajor and complex), intermediate, or minor after consultation with published tables and included all planned and emergency surgery but excluded endoscopic urological procedures. The table shows the respective numbers of operations performed, together with contamination incidents.

It is an everyday occurrence for surgeons to find at least one hand stained with the patient's blood at the end of a major procedure. We were, however, surprised to find that the incidence is almost 50% and is not necessarily related to experience. Furthermore, in only 44 of a total of 78 contamination incidents was the surgeon aware that he had perforated his glove; this was a needlestick injury in every case except one, in which the assistant's scissors were at fault.

Clearly, the bigger the operation the greater the risk of blood contamination for the surgeon. In general surgery, where the "no touch technique" is largely inappropriate, this problem is not only exceedingly common but probably unavoidable as it often goes unnoticed. Unless an impervious yet sensitive surgical glove is developed the solution to the risk of transmissible disease must lie with some form of biological rather than mechanical protection.

K LAFFERTY
A P WYATT

Brook General Hospital,
London SE18 4LW

Halothane hepatitis in children

SIR,—I would like to raise several questions about the study by Dr J Gerald Kenna and coworkers (9 May, p 1209).

Firstly, Dr Kenna and colleagues report on seven patients referred to them for evaluation of postoperative jaundice and on their diagnostic criteria, which entailed an assay for halothane antibodies. As there is no clinical or pathological test to differentiate hepatitis secondary to halothane from hepatitis secondary to a viral aetiology, they used a test for halothane antibodies.¹ The antibody test itself has problems as it is not specific. In the original article the markers were absent not only in patients who had received halothane and who had evidence of liver dysfunction postoperatively but also in those who were not jaundiced postoperatively.

Dr Kenna and coworkers state that the children were tested for markers for hepatitis A and hepatitis B virus, but 5% of children admitted to the hospital for hepatitis will have non-A, non-B hepatitis. At present, there is no marker for non-A, non-B hepatitis, and thus the exclusion of patients with markers for hepatitis A and hepatitis B virus does not exclude those with non-A, non-B hepatitis.

Dr Kenna and colleagues also state that α_1 antitrypsin deficiency is considered to be a risk factor for hepatitis after halothane anaesthesia, referring to the paper by Wark.² Wark's paper, however, contains no such statement. Burke *et al*, on the other hand, mention this increased