should add AIDS to this list but suggested no, not because AIDS is not transmitted through casual social contact and that therefore such a procedure would be unnecessary but because previous legislation covering sexually transmitted diseases had proved ineffective. I fear Mr Porter is missing the point.

By discussing AIDS in the same article as bacterial plague, leprosy, cholera, typhoid, and diphtheria without pointing out the important differences between these conditions and AIDS Dr Porter did little to dismiss exaggerated fears that AIDS is a deadly plague of high infectivity that only severe measures can hope to control. He then said that "one should at least consider draconian measures... to protect others"; however, he decided not to consider them but instead dismissed these very issues by saying "experience that this would be unwise." I wonder what experience Dr Porter is referring to? I am sure he is well aware that the media have aired many drastic measures to combat AIDS, and here was an excellent opportunity to answer, discuss, and hopefully dismiss them, but the opportunity was passed by.

The implications behind his concluding comment that "it takes two consenting partners to spread AIDS" are offensive and insensitive to those people who have suffered and died from this dreadful condition. People may consent to sex but I am sure they do not consent to spread AIDS. And what of the haemophiliacs and other recipients of blood products for whom this concept of consent has virtually no meaning? Many people who now have AIDS may well have been infected with HIV five or more years ago—long before the public health campaigns and even before HIV was discovered.

Important points which Mr Porter failed to emphasise are that infection with HIV and AIDS itself are not the same thing, that HIV is of low infectivity and is transmitted through the same carriers of blood and other body fluids and not through casual social contact, and therefore that measures such as quarantine and compulsory admission to hospital are unnecessary and unhelpful in the management of this condition.

John Dunn
Department of Psychiatry, St Thomas's Hospital, London SE1

AIDS: a doctor's duty
Sir,—While agreeing with much that Dr Tony Smith (3 January, p 6) has to say about a doctor's duty in relation to AIDS, I would question his statement on antibody screening before surgery. He claims that "those doctors who are calling for patients to have antibody tests before they undergo surgical procedures... are contributing to current hysteria about the disease." A surgeon is negligent if he does not perform a hepatitis screen on a patient with a history of undiagnosed jaundice. If a patient is found to be a carrier then precautions can be taken to protect medical and nursing staff during the course of the operation and afterwards.

Similarly, precautions have to be taken when operating on patients infected with the human immunodeficiency virus (HIV). As there are no clinical signs to determine the HIV carrier state the screening of people at high risk is the only method of detecting the infected patient. A careful sexual history should now become a routine part of clerking.

The "hysteria" can be prevented by education. If all patients are carefully and knowledgeably counselled at the time of venesection most will be reassured and containment of the disease may be assisted. Provision of leaflets such as that produced by the Terrence Higgins Trust and the work of the support groups in many areas are useful adjuncts.

Although I agree with Dr Smith that HIV carriage does not represent a substantial health risk for doctors, the use of screening of high risk groups before surgery not only protects against infection but also provides the opportunity to increase understanding of the disease, its transmission, and prevention among those at high risk.

Only by increased public knowledge of the disease can this hysteria, often helped by an ill informed media, be converted into a constructive appreciation of AIDS. Failure to screen patients and allow nosocomial AIDS to occur will only induce more hysterical and counterproductive reporting in the press.

Matthew W Cooke

1 Anonymous. AIDS and HIV. To tell or not to tell. London: Terrence Higgins Trust, 1986.

Haematology, ethnography, and thrombosis
Sir,—Dr S Heptinstall's leading article (3 January, p 3) makes no mention of the well established association between thrombosis and particular blood groups.

I and my colleagues have analysed data published by numerous workers and have shown that persons of groups A and B have a significantly higher incidence of coronary thrombosis and other clotting diseases than those of group O, while haemorrhagic conditions are commoner in those of group O. It has also been shown that clotting factor VIII content is higher in blood of group A than in group O. The incidence of myocardial infarction is 29% higher in persons of group A than in those of group O on the basis of 37 studies comprising 7124 cases. This result is based on only four series, 263 cases. Though this is statistically very highly significant, it is decided that numbers of cases should be studied in view of the possible importance of avoiding the use of oral contraception in women of group A (as well as B and AB). I have tried to persuade colleagues, particularly in family planning centres, to carry out the necessary observations, so far without success.

A E Mourant
Longueville, St Saviour, Jersey


Dialysis arthropathy: amyloid or iron?
Sir,—Dr N R B Cary and coworkers (29 November, p 1392) suggested that iron deposits in the bone may have been the cause of arthropathy in five patients undergoing long term haemodialysis. The role of iron in the pathophysiology of various arthropathies, most notably rheumatoid arthritis, was invoked several years ago. Further studies, however, showed that such deposits are commonly found in cases of chronic inflammatory rheumatism and many other joint diseases and thus appear to be non-specific.1 Based on a study conducted on patients undergoing long term haemodialysis we are at a loss to find any evidence in support of the hypothesis proposed by Dr Cary and his coworkers.

We conducted synovial biopsies on 19 patients. Even though iron was present in 12, usually the deposits of iron were minute. Only in one case was the iron deposit substantial, and in that case we found considerable amyloidosis.

We found iron deposits in non-symptomatic joints after synovial biopsies performed with a needle. Thus, these deposits did not seem to be any more specific to diseased joints than did the amyloid deposits in one of the authors' patients. Furthermore, it is useful to recall the similarity of bone cysts observed in these patients and in patients with secondary amyloidosis. The frequency and abundance of these amyloid deposits within the cysts, as well as the nature of amyloid, which may also develop in the clotting factor IIIa, points to a relation between bone destruction and amyloidosis.

Among 22 patients who were dialysed for over 10 years with cuprophane membranes we found no correlation between iron deposits and the severity of joint pain as was reported by Brown et al.2 We also could not show any association between ferritin concentrations and the extent of radiological findings (bone cysts, spondylarthropathy).

Finally, we noted a decrease of joint "algia" after a switch of dialysis membranes (unpublished results). This amelioration, which followed the