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. 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.

The other main criticism that Dr Hutchison makes concerns our suggestion that intrarenal arterial spasm may have a role in the loin pain haematuria syndrome. We do not deny the existence of focal or generalised vascular lesions such as AA syndrome as an advanced case, 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, not by the non-specific 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 spasm would obviously depend on the extent and duration of the spasm. Earlier observations of the reduction of pain after splanchic nerve blockade, renal denervation, and autotransplantation of the affected kidney to the iliac fossa support this hypothesis.4

Arterial spasms are rare during renal angiography; in a series of more than 400 renal angiograms using the Seldinger technique selective angiograms showed three forms of defects attributed to renal arterial spasms.1 We do not believe that it would be possible, however, using the description of an angiographic technique, to derive the frequency of intrarenal arterial spasm provoked by this 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 χ² 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 spasms would be welcome.

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AIDS: a faltering step

StIR.—As a research group working on the acquired immune deficiency syndrome (AIDS) in Nigeria, we have followed with considerable interest the various positions, wobblerones 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 moral 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 HIV testing. In our opinion 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 seven 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 survived by this report, which is retrogressive and wrong, and which should be reversed at the earliest possible opportunity.

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After safe sex, safe surgery?

StIR.—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 skin to skin.

The general surgical staff consists of three consultants, one senior registrar, and three pre-registration fellows. Over five weeks each surgeon was asked to examine his hands for blood contamination at 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.

The operations were classified as major (including extramammary 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 needless 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 emergency surgery, where a "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.

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Halothane hepatitis in children

StIR.—I would like to raise several questions about the study by Dr Jerald 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 entail the use of 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 α1 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
sensitivity to halothane in children with $\alpha_1$ antitrypsin deficiency, but they refer to an article in the New England Journal of Medicine. Again, there is no mention of this sensitivity. This is an example of an error compounded through misreading and misunderstanding.

The authors present seven cases of suspected halothane hepatitis. In case 7, however, they found no halothane antibody, but they still classified this child as having halothane hepatitis, explaining that it is possible that the antibody was produced but was undetectable. In the case report they state that a 3/2 year old boy weighed 1800 g. This is an extremely small child.

Though halothane hepatitis may occur in children, it is extremely rare, and Dr Kenna and coworkers cannot give the incidence that might be expected in children. In a review article on halothane hepatitis Stock et al concluded that there is no diagnostic test that is specific for halothane induced liver damage and that therefore the diagnosis can be made only by excluding all other causes of postoperative liver dysfunction. Walton states that non-A, non-B hepatitis may be responsible for halothane hepatitis after a single exposure. He does not define specifically the diagnostic criteria for halothane hepatitis. If it exists it remains extremely rare in children and has an incidence less than that of non-A, non-B hepatitis in the general population. An extensive clinical study of preparative liver function in asymptomatic children who received halothane and were then followed up for a long period would be needed to provide clearer conclusions.

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References

The cost of nursing

STIR.—Wolverhampton Health Authority has recently been informed that it must implement the English Nursing Board circular 86/65/ERDB, which recommends 52 weeks of theoretical instruction for nurses during their three year training. In order to achieve even an increase from 30 to 35 weeks of such instruction in this health authority the employment of 25 additional nurses at a yearly cost of £241 000 is said to be required.

This demand has been presented to a health authority that is facing a deficit of approximately £1/m in the current year and will probably face a similar deficit in the financial year 1988-9. The consequence of not implementing these requirements is well illustrated by approval for Royal College of Nursing training. The finance for this could be found only by limiting medical or technical staff development or by cutting patient services. This dictum was presented to the health authority with no opportunity for consultation or debate, and if all professions within the health service acted in this manner the management of the service would soon become impossible.

There is general doubt whether trainee nurses need to spend one year out of three away from the wards during their training. We are worried that the radical changes to the structure of nursing generated from within the profession are being forced on the health service without due regard for their impact on other professional groups or patient services.

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Points

Telling patients about their medicines

Mr C W KOENIGSBERGER (Lincoln's Inn, London WC2A 3SU) writes: Professor CG George recommends that patients should be told more about their medicines (20 June, p 1566). Before the positive steps he mentions were taken, however, the emphasis that a patient from finding out the details for himself must be removed—for example, does Professor George know that the Association of the British Pharmaceutical Industry's Data Short Compendium may be sold only to doctors and other health workers? Accordingly, it cannot be found in an ordinary reference library. The balance sheet function is contained in the June 1972 of the Secret of Practice for the Pharmaceutical Industry (revised, 6th edition, January 1986), which requires that requests from inpatients, members of the public for information must "always be refused." This absurd provision should be abandoned immediately.

Evaluation of portable haemoglobinometer in general practice

Dr ROBERT QUINN (Rathdown, Sligo, Ireland) writes: The statement by Ms Cathy White and Dr Daisy Obeid (27 June, p 1689) that "there are very few indications for estimating a patient's haemoglobin concentration" seems to me to show how little the average hospital practitioner understands about general practice and the dynamics between the doctor and the patient in the surgery. These statements also arise from a purely haematological viewpoint. As any general practitioner knows, however, physical disease constitutes only a proportion of the daily workload, psychosocial elements looming large in many consultations. I would find an "on the spot" haemoglobin estimation helpful in allaying the unease of many patients with present with symptoms of tiredness, malaise, lack of energy, no interest in life, etc, which almost invariably have a non-physical origin. The knowledge that the haemoglobin contrarily normal helps the doctor in his or her effort to explain the symptoms and also helps to minimise prescribing.

Lyphoedema of the arm

Dr HELEN J STEWART (Scottish Cancer Trials Office, University of Edinburgh Medical School, Edinburgh EH8 9AG) writes: I was surprised that Professor N L Browne (4 July, p 3) did not mention acute onset lymphoedema secondary to minor skin trauma of the hand in the past years after postmastectomy axillary irradiation. As Professor Browne rightly stated, the combination of limited sampling of axillary lymph nodes and radiation therapy is not associated with a high incidence of secondary lymphoedema. None the less, after two to three years a subclinical reduction in the efficiency of the lymphatic drainage from the arm is likely, making avoidance of precipitating factors worth while. In my experience, acute swelling of the hand and arm may occur after, for example, a superficial burn or simple cut without clinical evidence of local infection or lymphangitis and may even present after the minor trauma has almost healed. In these circumstances prompt antibiotic treatment often leads to total and speedy reversal. In addition, prolonged piano playing, knitting, or similar activities that exercise the hand without arm or shoulder movement may be temporary precipitating factors and should be discouraged if the arm tends to swell. I am sure that most radiotherapists would agree with these comments and advise their patients at risk to take other simple precautions, such as wearing gardening gloves and not playing with cats.

Professor J D E KNOX (Westgate Health Centre, Dundee DD2 4AD) writes: Professor N L Browne (4 July, p 3) rightly focuses on the common (surgical) causes of the more common communicating phenomenon of lymphoedema of the arm because these are the more usual causal factors in secondary lymphoedema.

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References