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HTLV-I infection in British and Jamaican relatives of British patients with tropical spastic paraparesis

SIR,—The results of the study by Dr J K Cruickshank and colleagues on the seroprevalence of human T cell leukaemia lymphoma virus type I (HTLV-I) in the families of 11 Jamaican immigrants with tropical spastic paraparesis in London¹ differ from our results in the west midlands.² In our study most, though not all, of the available United Kingdom resident members of the families of seven patients with tropical spastic paraparesis agreed to testing for HTLV-I antibodies. All of the patients were women—six from Jamaica and one from Saint Vincent. Their HTLV-I state was established by using passive particle agglutination, enzyme linked immunosorbent assay (ELISA), and immunofluorescence tests.² All three husbands tested positive; one of them had adult T cell leukaemia lymphoma. Of five Jamaican born children, one tested positive.

Whereas Dr Cruickshank and colleagues did not find any of 14 children born in the United Kingdom to be seropositive, two out of 10 children born in the United Kingdom whom we tested were seropositive. They were both the daughters of a woman with tropical spastic paraparesis (onset 1980) and a man with adult T cell leukaemia lymphoma (onset 1986). One was aged 28 and had visited Jamaica for a few months when aged 13 and 25; the other was aged 21 and had never visited the West Indies. They had two seronegative younger brothers who were born in the United Kingdom and were living in the west midlands and one seropositive older sister who was born in Jamaica. Two other brothers and two other sisters who were born and resident in Jamaica were not tested. All of the children in our family study (except one seronegative son) were breast fed, and none of the seropositive relatives had received a blood transfusion.

The fact that the two daughters who were born in the United Kingdom were positive for HTLV-I antibody indicates that children of Jamaican immigrants with tropical spastic paraparesis may seroconvert in this country, not just in the West Indies. When the data for United Kingdom resident children of patients with tropical spastic paraparesis in the west midlands and London are combined five out of 14 (36%) Jamaican born children and two out of 24 (8%) United Kingdom born children were seropositive; this difference is not significant (Fisher's exact test). Although maternal transmission may not be the only route of infection in these children, these results do not support the arguments of Dr Cruickshank and colleagues against maternal transmission as the main route. The numbers in both the London and west midlands studies are small, but further testing of the available families of patients with tropical spastic paraparesis or adult T cell leukaemia lymphoma may provide an explanation for familial clustering of HTLV-I infection.

Dr Cruickshank and colleagues state that there

are no available and adequate data on HTLV-I seroprevalence in Jamaican born immigrants in Britain except their own (unpublished) study of 81 Afro-Caribbean subjects in London, in whom they found an HTLV-I seroprevalence of 2.5%. We have carried out anonymous testing for HTLV-I antibody in Afro-Caribbeans in the west midlands and found that seven out of 192 (4%) of West Indian born subjects were seropositive, but none of 403 United Kingdom born subjects of Afro-Caribbean origin were seropositive. Despite different study methods the seroprevalences in the west midlands and London groups of West Indian immigrants were not significantly different (Fisher's exact test) and are comparable with the seroprevalences reported in Jamaica.³ The difference in seroprevalence between the United Kingdom born and immigrant Afro-Caribbeans in our study is significant (χ^2 test, $p < 0.001$), but this difference has not been found in the family studies.

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Housing and health

SIR,—I would like to congratulate Stella Lowry on her thoughtful articles on housing and health.¹ May I put in a plea, however, for doctors to keep a foot in both camps—in the real if chaotic role of helping to prioritise housing applicants and as white knights crusading for decent housing.

I agree that in most cases a doctor's opinion is superfluous, and as stated in the article a medical degree is not required to spot the most needy cases. It can be helpful, however, in deciding whether a disability is permanent and stable, curable over time, or progressive.

Another reason for pleading for the continued involvement of a doctor is that over the years requests for rehousing have provided a fruitful source of case finding for young and elderly handicapped people, who have either not contacted or not been helped by the statutory services. These include those with deteriorating multiple sclerosis, people with multiple diseases living in sub-standard housing, travellers with handicapped children, and so on.

Incidentally, the new district public health annual reports are a heaven sent platform for campaigning for decent, affordable housing and for illustrating the deteriorating position vis à vis its provision.

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Cancer of the oesophagus

SIR,—Dr I C M Paterson¹ accuses Mr John Bancewicz² of being unbalanced in his article on cancer of the oesophagus and then proceeds himself to offer a most unbalanced view on the subject. The gist of his letter is that surgery has no

advantage over radiotherapy, and he quotes the reviews by Earlam and Cunha-Melo.^{3,4} In fact one of these critical reviews of surgery¹ reported a 12% and not a 4% survival at five years. In patients leaving hospital the five year survival went up to 18%. On the other hand the review of radiotherapy showed a five year survival of 6%.⁴ These figures are in line with those in most published work. Maybe this would explain why Earlam's prospective trial between surgery and radiotherapy³ failed because of inadequate recruitment, as Dr B S Mantell complained in his letter.⁵

Of course surgery can be offered only to a selected group of patients, and this has been fully recognised by us.¹ Surgery, however, gives such patients the best chance of prolonged survival. If surgery is done in a specialised unit with a low mortality and short stay in hospital then Dr Paterson need not worry too much about its cost effectiveness. Radiotherapy may be cheaper, but the patient's interest is paramount.

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Stone fish bite

SIR,—Other readers have drawn your attention to the fact that the injury produced by a stone fish is caused by the highly venomous spines^{1,2} and not a bite as suggested.³

The stone fish is extremely hard to see in the natural environment, and practically all stings reported occur on the feet or hands. In an isolated area the extreme pain and distress plus impending local tissue damage can be difficult to manage, especially in the absence of antivenom. The only stone fish antivenom available is produced by our laboratories. We receive many reports of its use and have no reason to doubt its effectiveness when given promptly with other recommended management.⁴

Advice on first aid and treatment has been under constant scrutiny for some years. We believe that the current protocols are rational and minimise injury to the patient. These protocols are modified depending on the type of venomous organism concerned. With a stone fish sting we agree that appreciable pain relief is often obtained by bathing the injured part in warm but not scalding water. Sometimes cooling water for boat engines has been used for this purpose. There is no evidence that hot water denatures the venom: indeed, the pain often returns instantly when the heat treatment is stopped. Local anaesthetics may give some relief, but in a severe case a regional nerve block may be indicated, as are systemic opiates. Antivenom rapidly reduces symptoms, especially when given early.

The use of a tourniquet after a stone fish sting will do nothing but increase the patient's discomfort and enhance the local necrotising effects of the venom. In Australia arterial tourniquets are not recommended in the management of any type of envenomation. In most cases, such as those of snake bites, the pressure immobilisation technique is used,⁵ which has been shown successfully to retard the movement of venom from the bitten or