

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

HIV infection and hepatitis B in adopted Romanian children

SIR,—In the past nine months we have been asked to test for markers of HIV and hepatitis B infection in 11 Romanian babies who had been adopted in Britain. Five were born in 1990, three in 1989, and one each in 1988, 1987, and 1984. HIV antibody was confirmed in three, all born in 1990, although in one antibody could not be detected in a second sample. Hepatitis B markers were present in five: three, born in 1987, 1989, and 1990 (the one born in 1990 was also positive for HIV antibody), were currently infected as indicated by the presence of hepatitis B surface antigen and hepatitis B e antigen in their serum; the two others, both born in 1989, had evidence of previous infection (antibody to hepatitis B core antigen present but hepatitis B surface antigen not detected). Thus seven of the 11 babies were or had been infected by one or both of these viruses.

As we do not know the number of Romanian babies adopted in Britain or whether our findings are typical we cannot estimate the size of this infected group. Our results are likely to have overestimated the proportion infected as not all the adopted children will have been tested and some may have been tested, with negative results, without having been identified as of Romanian origin. These babies were infected either by their mothers or by horizontal transmission. If horizontal transmission is the case—it has been suggested as the main route by which HIV is spread in Romania^{1,2}—then our findings in babies born since the revolution in 1989 suggest that medical and nursery practices are still deficient.

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- 1 Rudin CH, Berger R, Tobler R, Nars PW, Just M, Pavic N. HIV-1, hepatitis (A, B and C) and measles in Romanian children. *Lancet* 1990;336:1592-3.
- 2 Patrascan IV, Constantinescu SN, Dublanchet A. HIV-1 infection in Romanian children. *Lancet* 1990;335:672.

Hepatitis A virus infection among homosexual men

SIR,—The number of reports of acute infection with hepatitis A virus received by the Public Health Laboratory Service Communicable Disease Surveillance Centre increased from 2913 during 1 July to 31 December 1989 to 4087 in the same period of 1990. In the department of genitourinary medicine at the Middlesex Hospital 17 cases of acute hepatitis A virus infection were diagnosed in homosexual men between 1 July and 31 December 1990, compared with five cases in total (three of which were in homosexual men and two in women) in the previous five years. In the same six months

the Communicable Disease Surveillance Centre received 23 additional reports of hepatitis A virus infection in men known to be homosexual, compared with one during the previous year (1989).

The epidemic of HIV infection among homosexual men has led to the promotion of "safer sex" practices, a major component of which is the avoidance of unprotected penetrative anal intercourse.¹ Oral-anal contact, though "safer" in respect of the transmission of HIV, is a proved risk factor for the transmission of hepatitis A virus,² and outbreaks of sexually acquired hepatitis A virus infection in homosexual men have been described.^{3,5} Indeed, if oral-anal contact becomes more prevalent as an alternative to penetrative intercourse the risk of hepatitis A virus infection among homosexual men may be increased. The risk factors associated with the cases reported recently are being investigated.

Doctors managing suspected acute viral hepatitis in homosexual men should be aware that hepatitis A virus as well as hepatitis B virus may be sexually transmitted. They should offer close contacts, including sexual partners, passive immunisation against hepatitis A virus with human normal immunoglobulin in accordance with the Department of Health's recommendations,⁶ without waiting for a definitive virological diagnosis.

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- 1 Johnson AM, Gill ON. Evidence for recent changes in sexual behaviour in homosexual men in England and Wales. *Phil Trans R Soc Lond* 1989;325:153-61.
- 2 Corey L, Holmes KK. Sexual transmission of hepatitis A in homosexual men. *N Engl J Med* 1980;302:435-8.
- 3 Hoybye G, Skinhoj P, Hentzer B, Faber V, Mathiesen L. An epidemic of acute viral hepatitis in male homosexuals. *Scand J Infect Dis* 1980;12:241-4.
- 4 Christenson B, Brostrom CH, Bottiger M, Hermanson J, Weiland O, Ryd G, *et al*. An epidemic outbreak of hepatitis A among homosexual men in Stockholm. *Am J Epidemiol* 1982;116:599-607.
- 5 Mindel A, Tedder R. Hepatitis A in homosexuals. *BMJ* 1981;282:1666.
- 6 Department of Health. *Immunisation against infectious diseases*. London: HMSO, 1990.

Cancer and HIV infection

SIR,—In our editorial on cancer and HIV infection we suggested that there might be substantial morbidity in seropositive patients from cancers that are not currently recognised by the Centers for Disease Control.¹ Dr Charles Gilks is wrong to

say in his letter that we stated that these cancers should necessarily be reclassified as AIDS defining problems or that the surveillance definition needs to be broadened.² We are simply concerned, like Gilks *et al*, that they "are not being detected as HIV related by the aetiologically based CDC surveillance definition" or, in other words, that they are being missed.

We also believe that "the concept that AIDS is a uniform endpoint of HIV immunosuppression may need to be reconsidered" so were surprised by Dr Gilks's distinction between opportunistic and non-opportunistic infections, a distinction that tacitly reinforces this concept.

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- 2 Gilks C. Cancer and HIV infection. *BMJ* 1991;302:1275. (25 May.)
- 3 Gilks CF, Brindle RJ, Otieno LS, *et al*. Life threatening bacteraemia in HIV-1 seropositive adults admitted to hospital in Nairobi, Kenya. *Lancet* 1990;336:545-9.

Preventing the spread of HIV infection

SIR,—We would like to add to your recent correspondence on preventing the spread of HIV.¹

Despite the recommendation by the World Health Organisation in 1989 that partner notification for HIV seropositive patients should be considered,² this issue remains largely unresolved in the United Kingdom. Contact tracing for syphilis, gonorrhoea, and chlamydial infection, which is standard practice within genitourinary medicine clinics, aims to limit the spread of infection, although the effectiveness of these strategies has been questioned.³ These are treatable disorders, however, and one of the arguments against contact tracing of people with HIV infection is the unavailability of a curative treatment. But zidovudine has been shown to confer benefit in asymptomatic patients,⁴ and since the advent of primary prophylaxis against pneumocystis carinii pneumonia⁵ there are stronger clinical reasons for the earlier identification of seropositive patients so they can be offered treatment. Partner notification would seem to be a logical step in facilitating the identification of individuals who had been at a specific risk, so that they can receive counselling and decide if they wish to be tested or not.

To assess patients' attitudes towards these issues we conducted a survey with a self administered questionnaire of 150 consecutive men positive for HIV attending the Kobler Centre; 125 questionnaires could be evaluated. Patients were asked whether they would wish to have been notified and offered HIV testing after contact with an infected person.