CORRESPONDENCE

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- *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.*
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- *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.*

Zidovudine after occupational exposure to HIV

SIR,—In his editorial Professor D J Jeffries thoroughly reviewed the pros and cons of using zidovudine as prophylaxis after occupational exposure to HIV and made a compelling case for not adopting this strategy.[1] Somewhat inconsistently, he then went on to recommend entirely the opposite, seemingly on compassionate grounds. We too have weighed up the evidence and have concluded that this agent should not be prescribed for this purpose.

Zidovudine is virustatic rather than virucidal. In vitro evidence suggests that it may neither prevent cell to cell transmission[2] nor completely inhibit reverse transcriptase,[3] thereby permitting the development of latent infection with integration of provirus DNA. In primates and mice inoculated with simian HIV (B Lundgren *et al*, symposium on non-human primate models for AIDS, San Antonio, Texas, 1988; H M McClure *et al*, fifth international conference on AIDS, Montreal, 1989) and human HIV,[4] zidovudine did not prevent infection even when it was administered before challenge. Finally, there have been at least three cases of exposure to HIV in which rapid administration of zidovudine was not effective.[5-7] It seems unlikely that scientific data to support or refute the efficacy of prophylaxis with zidovudine will be obtained by clinical trials. There is currently, therefore, no firm theoretical, experimental, or clinical evidence to justify its use for prophylaxis after exposure.

Had zidovudine been shown to be safe and relatively free of side effects it might be possible to argue that although it had not been confirmed to be beneficial at least it would not be harmful. But that is not the case. Studies by scientists at Burroughs Wellcome and others have shown that adverse events are neither trivial nor infrequent.[8] In a recent report summarising five studies of zidovudine given after exposure an appreciable number of courses were stopped because of drug intolerance.[9] Furthermore, concerns about the long term effects of zidovudine in relation to teratogenicity, carcinogenicity, and sterility cannot be dismissed.

There are a further four related issues that Professor Jeffries did not address but that should be considered. Firstly, the logistics of giving zidovudine intravenously within one to two hours of exposure may prove difficult in many clinical settings. Secondly, the uncertain benefits and toxicity of zidovudine emphasise the importance of pretreatment counselling, and in centres where HIV infection and disease are uncommon it may not always be feasible to ensure that this is provided. Thirdly, as the administration of zidovudine increases, the emergence of strains with reduced susceptibility to the drug is highly likely.[10] This would almost certainly have implications for the prophylactic use of this agent. Finally, the cost of giving zidovudine to exposed people (£900 per six week course, not including the expenses arising from regular biochemical and haematological investigations to monitor toxicity) is not trivial. This would, however, not be a consideration if there was more robust evidence to support the efficacy and safety of the drug.

The Centers for Disease Control in the United States have stated: "At this time, prophylaxis with zidovudine cannot be considered a necessary component of post-exposure management."[8] After considering all the issues raised above we concluded that the use of zidovudine as a prophylactic agent after occupational exposure to HIV is not warranted, and we will be recommending this to our respective authorities.

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Guidelines for doctors with HIV infection

SIR,—Dr J A Erskine's noble stand does him credit but is of no comfort to HIV positive doctors forced to leave their careers without recompense.[1]

The General Medical Council's guidelines on HIV positivity perpetuate the hysteria and prejudice surrounding the virus and seem aimed more at saving the NHS millions in compensation awards than at protecting the public or doctors.

Barely a handful of patients are known to have been infected by health care workers. Yet the hard working surgeon who becomes HIV positive after an accident with a scalpel is expected to run to the hospital managers with the sad news. As recently happened in the north west of England, the health authority will then make his fate public knowledge by contacting all those treated by him since the accident to offer them counselling and blood testing.

In return for his honesty, therefore, the surgeon will not only lose his livelihood, and possibly his home, but be exposed to extreme social victimisation.

HIV is an occupational hazard. If infection with it is to become a reason to lose one's career the doctor who admits to such infection should expect the same rights as his patients—the right to confidentiality, to equal treatment, and to compensation. Until these can be assured the doctor who hides his HIV status does so not out of self interest but for self preservation.

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1 Erskine JA. Guidelines for doctors with HIV infection. *BMJ* 1991;**303**:784. (28 September.)

SIR,—Dr J A Erskine compares doctors forced to give up their careers because of HIV infection to those who contract other "unfortunate, debilitating, and ultimately fatal diseases."[1] The point is well made that these diseases are also tragic for the person concerned. Valid though the comparison with disseminated sclerosis and epilepsy may be, however, there are important differences.

No one demands that doctors with these diseases make the fact public. It is inability to do the job, not the result of a blood test, that forces retirement from clinical work. If those afflicted have income protection insurance the insurers are unlikely to quibble. Most importantly, epilepsy or disseminated sclerosis cannot be caught from a patient.

Sick patients bleed on us and vomit over and (occasionally) spit at us. Needlestick injuries continue to occur. As the prevalence of HIV