

What Burton and Carter say about the "many calls and letters" received from patients and doctors may be true, but as clinical psychiatrists we are unaware of any harm that has befallen patients as a result of the withdrawal of triazolam from the market and we have encountered little demand that it be returned.

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AIDS in Africa

Inflationary statistics distort the truth

EDITOR,—Watching *Dispatches* on 24 March, I predicted that medical authority would rush to silence this voice dissenting from the accepted myth of AIDS in Africa. Angus Nicholl, of the Establishment, attempted to discredit the programme by giving the impression that risky sexual behaviour was being encouraged.¹

Joan Shenton was promoting a lone viewpoint which will not change the fashionable opinion that AIDS started in Africa and will exterminate whole populations. The supposed epicentre of AIDS has survived despite this prediction. In *Dispatches*, Professor Gordon Stewart pointed out that the committee appointed by the British government in 1988 predicted AIDS figures for the United Kingdom for 1992, which are now known to have been exaggerated. The inflationary statistical methods used by the committee are, however, still being applied in the African situation.

Diagnosis of AIDS in Africa remains problematic. The clinical definition of AIDS applied in Africa leads to overestimation because differential diagnosis from prevalent diseases is impossible on clinical grounds alone. The extent of cross reactivity in AIDS tests is not fully established. Unable to explain 2400 cases of AIDS who tested negative for HIV, Dr Kevin De Cock tried to distinguish AIDS from HIV disease. In the United States, 250 000 of one million seropositive people have developed AIDS, compared with 129 000 of six million seropositive Africans. The differing ratios do not add up.

The programme correctly emphasised the self fulfilling prophecy of increasing deaths in Africa when incoming funds mainly go to AIDS prevention instead of combatting treatable conditions that look like AIDS. In Uganda, \$57 000 a year is used in the control and treatment of malaria, compared with \$6m for controlling AIDS.

The question of whether or not experts are getting the issue of AIDS wrong will only be resolved by time. For the individual, propaganda about the spread of AIDS is a major disincentive for investment, worsening the spiral of poverty and causing a reluctance to seek medical care in other wasting diseases. We should fight death from curable diseases—the mortality from "AIDS" might show a corresponding fall.

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- 1 Nicholl A. The AIDS epidemic in Africa: monster not myth. *BMJ* 1993;306:938-9. (3 April.)

HIV is having a profound impact

EDITOR,—The description of the *Dispatches* programme "Aids and Africa" by Francesca O'Brien as "an excellent addition to the debate on AIDS in Africa"¹ would be a view not shared by anyone knowing the extent of the HIV epidemic on that continent. The central argument of the presenters of the programme was that, because AIDS is sometimes diagnosed in those without the disease, estimates of the magnitude of the problem had been greatly inflated.

Facilities for, and standards of, diagnosis of clinical disease are often poor in the situations of poverty and deprivation that prevail in many parts of Africa, and estimates of the extent of the HIV epidemic are based mainly on serological data. The serological algorithms which are used nowadays have a sensitivity and specificity close to 100% and there is firm evidence that HIV infection rates among adults in many African countries are high and in excess of 20% in some of the urban centres. The World Health Organisation estimates that about 7.5 million people are infected with HIV in sub-Saharan Africa. Studies of the fate of those infected suggest that the course of the disease is more rapid than in Europe and North America. The Medical Research Council/Overseas Development Agency Research Programme on AIDS in Uganda has studied the total population of a cluster of 15 villages, approximately 10 000 people, for several years. The prevalence of HIV-1 infection among adults in this population was 8.2%. The annual mortality for those infected with HIV was 11.6%, compared with 0.8% in those not infected. More than half of all adult deaths in this population were attributable to HIV infection. It is clear that the HIV epidemic is having a profound impact on mortality in Africa.

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- 1 O'Brien F. Channel Four tackles controversy. *BMJ* 1993;306:1337. (15 May.)

Mental health in children

EDITOR,—The goal of a unified, combined child health service is indeed important, not least in the light of the fissiparous potential some see in the internal market. K L Dodd, however, makes no mention of the place of child mental health in the editorial on such a service.¹

Yet problems of mental health are one of the main and perhaps expanding categories of disorder and disability faced by children's health services.² This is borne out by the caseloads of community doctors dealing with children³: an appreciable proportion of the morbidity they face is bound up with problematic emotional and behavioural development and—said to be underrecognised by paediatricians—child mental disorder itself. To be comprehensive and to serve all the health needs of children and families, plans for the integration of child health services should surely pay full attention to mental health and envisage a central and imaginative role for child and adolescent mental health services.

Paediatricians will no doubt continue their crucial support for child and adolescent psychiatry and where possible its expansion. But they may also need to ensure that the potentially crowded curriculum for future paediatricians, who are expected to train in the community as well as in hospital, includes realistic training opportunities in child and adolescent mental health. In the expected redesignation of clinical medical officer

posts a focus on mental health might mean, for instance, encouraging supplementary training—for example, in group work in schools. Also a term like mental disorder should be used, rather than the euphemistic "behaviour problems." Somewhat more radically, a proportion of posts, at consultant or career grade, could be reoriented so that they were specifically linked with child and adolescent mental health and perhaps filled by doctors with substantial training in this speciality. Perhaps it could even be that, in the new consultant led service, a proportion of the consultants could be child and adolescent psychiatrists or even child clinical psychologists.

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- 1 Dodd KL. An old problem solved in child care. *BMJ* 1993;306:873-4. (3 April.)
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Avoiding coning in childhood meningitis

EDITOR,—In their paper on cerebral herniation in children Gordon Rennick and colleagues attempt to highlight the risk associated with lumbar puncture in children with acute bacterial meningitis.¹ The retrospective nature of this study makes it difficult to establish a causal relation between lumbar puncture and cerebral herniation. Moreover, the clinical criteria used to diagnose cerebral herniation have not been verified by previous studies. Cerebral herniation diagnosed with these clinical criteria occurred in 19 of the 445 cases reviewed; 14 of the 19 patients died. But herniation was confirmed at postmortem examination in only five of these patients, and two patients had cerebral herniation without lumbar puncture. In six of the eight children in whom coning occurred within three hours of lumbar puncture there were relative clinical contraindications to lumbar puncture such as unresponsiveness, focal neurological signs, and, in one patient, decerebrate posturing. Conceivably, therefore, herniation may have occurred in some or all of these patients before lumbar puncture was performed.

Computed tomography of the brain failed to predict imminent herniation, as reported in other series.² In certain clinical situations meningitis can be diagnosed confidently without lumbar puncture being performed. In such cases there may be no additional benefit from a lumbar puncture. Although a definitive diagnosis can be made only after microscopical examination, culture, or antigen screening of cerebrospinal fluid, other diagnostic options such as blood culture, Gram staining of a blood smear, or skin scraping from purpuric skin lesions may be informative.

In the early stage, patients with meningitis due to *Haemophilus influenzae* may benefit from steroids, given before or with the first dose of antibiotics,³ and this should be a consideration for doing lumbar puncture. The proposed clinical features of coning or imminent coning have not been time tested and may at best serve only as guidelines. Once treatment has been started and there is an improvement, however, it is illogical then to contemplate lumbar puncture, as Rennick and colleagues suggest, except in those with partially treated meningitis, when establishing the sensitivity of the causative organism is crucial.

Regardless of the patient's clinical state,

increased intracranial pressure is invariably present in acute meningial inflammation¹ and lumbar puncture should always be undertaken with caution. Theoretically, the risk of precipitating sudden intracranial pressure loss may be reduced by minimal physical restraint and avoiding neck flexion; use of a small bore needle; obtaining a minimal volume of cerebrospinal fluid (less than 1 ml); and retracting skin from the puncture site before removing the needle and thereafter generously applying collodion to prevent leakage of cerebrospinal fluid after puncture.

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- 1 Rennick G, Shann F, de Campo J. Cerebral herniation during bacterial meningitis in children. *BMJ* 1993;306:953-5. (10 April.)
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Where credit is due

EDITOR,—The obituary of R G Macbeth¹ makes no mention of his having introduced sclerotherapy for oesophageal varices into Britain. The credit for this has often been given to me. It would be a matter of great satisfaction to me for some mention to be made that the real pioneer was my friend Ronald Macbeth.

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- 1 Colman BH. R G Macbeth. *BMJ* 1993;306:1193. (1 May.)

Keeping up to date

EDITOR,—The data given by David N S Kerr and colleagues in their article on continuing medical education are useful, and the discussion is helpful for those, like me, who have budgetary responsibility for consultants' study leave.¹

Continuing education—keeping up to date—is a professional obligation; it would be reactionary for employing authorities to require this of consultants without helping by providing time and finance, but at present the use of this varies, as the authors' table I shows. The authors' concepts of auditing the use of leave and basing it on a personal plan for continuing medical education are desirable and would diminish the random element in today's use of study leave.

The cost to employers is considerable when lost sessions are added to fees and the cost of travel and subsistence; one royal college recently circulated a document to its fellows suggesting that the annual cost to each consultant of attending meetings to meet its requirements for continuing medical education might be £2000. Employing authorities will increasingly expect to have value for money shown. This is not easy when meetings—ostensibly comparable, such as annual meetings of national societies or colleges—cost widely differing sums. In my short experience daily registration fees for meetings have varied from £35 to £250. Education may not be the sole motive of all consultants taking study leave, but nor is it the entire purpose of the organisations providing it as profit may be vital for them. Employers cannot be expected willingly to subsidise societies in this way.

The concept of a costed personal plan for

continuing medical education for each consultant needs early trial.

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- 1 Kerr DNS, Jones SAM, Easmon CSF. Continuing medical education: experience and opinions of consultants. *BMJ* 1993;306:1398-402. (22 May.)

Provision of acute beds in inner London

Are all Thames regions the same?

EDITOR,—Brian Jarman notes "that of the four Thames regions, North West Thames has the lowest supply of acute plus geriatric beds and North East Thames the highest."¹ He also notes that the supply of acute beds in North West Thames is 20% below that for England and the lowest in the country. Tomlinson was asked to report on acute beds in inner London.² I am interested to know whether Jarman has data for the four Thames regions broken down for inner London compared with the rest of the regions and whether they confirm the prevailing view that there are excessive acute beds in inner London and, if so, whether this applies to all of the four Thames regions equally.

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- 1 Jarman B. Is London overbedded? *BMJ* 1993;306:979-82. (10 April.)
- 2 Tomlinson B. *Report of the enquiry into London's health service, medical education and research*. London: HMSO, 1992.

Author's reply

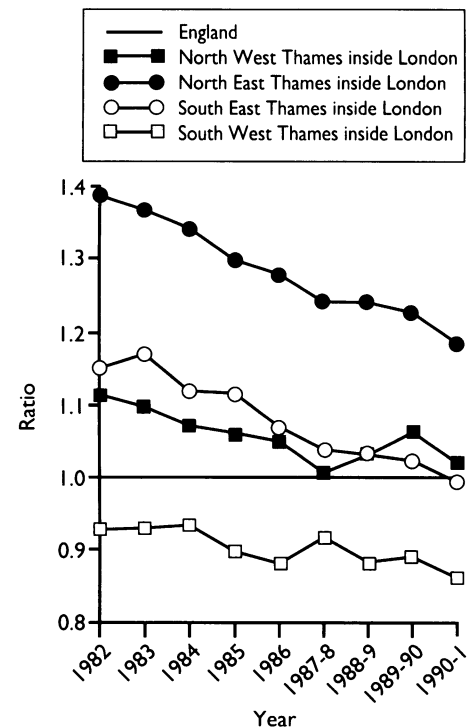
EDITOR,—The figure shows the information that R M Greenhalgh requests. It is clear that by 1991 the supply of acute plus geriatric beds per head of population in the London parts of the regions was about the national average for North West and South East Thames regions and below the average for South West Thames.

N Mays draws attention to the relative over-provision of acute hospital beds in inner London and in deprived areas in other inner cities.¹ My paper drew attention to the fact that, despite this, the use of acute plus geriatric hospital services in London differs little from the national use. In addition, for at least the past 10 years acute hospital beds in London have been closed at a much faster rate than the national average—164 acute beds per million population per year in London for the five years ending 31 March 1991 (257 per million in inner London and 112 per million in outer London), compared with 79 per million population per year in England. The number of acute plus geriatric beds per resident in London in 1990-1 was only 4% higher than the national average. Even allowing for special health authority beds, I believe that it is difficult to conclude that either the use or supply of acute and geriatric beds in London gives a good argument for bed closures faster (as Tomlinson suggests) than the national rate.

I believe that Chaand Nagpaul is correct that there is no conclusive evidence that improvements in primary care lead to lower demands for secondary care.²

Christina Victor is correct to emphasise the importance of the relatively lower provision of places in residential homes for elderly people in London.³ In unpublished analyses of hospital use at the level of electoral wards colleagues and I have shown that the number of places in residential homes per person aged 65 or over is almost as powerful as the supply of hospital beds in

explaining the variation in hospital use among wards. This factor, however, acts in the opposite direction to the supply of beds: where there are relatively fewer residential homes per person (as in inner London) use of hospital beds is greater (as opposed to the lower use of hospital beds where



Ratio of number of acute plus geriatric beds in London (parts of Thames regions in London) per 1000 population to rate in England

supply of hospital beds is lower).

I am grateful to Tony Jewell for pointing out that similar considerations are likely to apply to nursing homes for elderly people (of which there is also a lower supply in the inner London districts).⁴ It is important to note that the transfer of income support payments for residential and nursing homes to social services budgets from April will be greater in the areas with greater historical provision, thus again reducing the relative resources for institutional care (hospitals and homes) for people living in inner London.

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- 1 Mays N. Health care in London: other cities also overbedded. *BMJ* 1993;306:1474. (29 May.)
- 2 Nagpaul C. Health care in London: BMA slow to condemn Tomlinson. *BMJ* 1993;306:1474. (29 May.)
- 3 Victor C. Health care in London: inadequate provision for long term care. *BMJ* 1993;306:1474. (29 May.)
- 4 Jewell T. Health care in London: London low on residential and nursing homes. *BMJ* 1993;306:1474-5. (29 May.)

Correction

Simple treatment for night terrors

An editorial error occurred in this letter by Sean Maskey (29 May, p 1477). The wording of the title and third paragraph imply wrongly that the treatment described is for both night terrors and nightmares. This treatment is useful only in nightmares.

Antenatal screening for Down's syndrome

An editorial error occurred in this letter by K Spencer and others (12 June, p 1616). The figures in the second line of the table are the total with Down's syndrome in the population, not the number born with Down's syndrome as shown.