

distinction and specifically target the different perceptions and sexual activity of each group.

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1 Catchpole MA, Mercey DE, Nicoll A, Rogers PA, Simms I, Newham J, *et al* on behalf of the Collaborative Group. Continuing transmission of sexually transmitted diseases among patients infected with HIV-1 attending genitourinary medicine clinics in England and Wales. *BMJ* 1996;312:539-2. (2 March.)

Different diseases indicate different risks of transmission of HIV

EDITOR.—M A Catchpole and colleagues conclude that "substantial numbers of homosexual or bisexual men continue to practise unsafe sex despite being aware of their infection with HIV-1" and suggest that this may result in an increased spread of HIV.¹ We do not believe that they have given sufficient data to support this claim.

They provide a list of sexually transmitted diseases detected in this cohort but fail to supply the relative proportions and frequencies of these diseases. This is relevant as some of the diseases are more indicative than others of high risk behaviour. Scabies and pediculosis, for example, may indicate minimal (if any) sexual contact, while infective syphilis and gonorrhoea are much more likely to indicate close sexual contact. Similarly, some of the sexually transmitted diseases listed are as likely to be transmitted through orogenital contact as through penetrative anal intercourse, but penetrative anal intercourse carries a higher risk of transmission of HIV.² It would have been helpful, therefore, if the authors had also recorded the specific risk of infection.

The authors admit that some of the unsafe sexual practices may occur between partners who are both infected with HIV, but they conclude (with no direct data to support this statement) that such cases are likely to represent a minority. In our experience, a considerable number of HIV positive people state that they practise unsafe sex only with people known to be HIV positive and that they practise safer sex with those who are HIV negative or of unknown status.

Finally, the large proportion of heterosexual men and women with HIV-1 infection who are apparently unaware of their HIV status implies that these groups do not perceive themselves to be at risk of HIV infection. This emphasises the need to broaden policies on HIV testing outside sexually transmitted disease clinics and to encourage discussions about HIV testing in primary care.

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1 Catchpole MA, Mercey DE, Nicoll A, Rogers PA, Simms I, Newham J, *et al* on behalf of the Collaborative Group. Continuing transmission of sexually transmitted diseases among patients infected with HIV-1 attending genitourinary medicine clinics in England and Wales. *BMJ* 1996;312:539-42. (2 March.)

2 Tomlinson DR, French PD, Harris JRW, Mercey DE. Does rectal gonorrhoea reflect unsafe sex? *Lancet* 1991;337:501.

Non-sexual transmission of human papillomavirus

EDITOR.—The editorial on cervical human papillomavirus infection by Jeffrey F Hines and

colleagues¹ failed to address a problem which we have recently encountered and which is probably more widespread than its neglect in the literature would suggest.

On the basis of a cervical biopsy which histologically showed mild koilocytosis only, a patient was advised that she had a wart virus infection of the cervix which must have been acquired sexually. She was in considerable distress as both she and her partner denied sexual infidelity. Subsequent *in situ* hybridisation using probes for human papillomavirus types 6, 11, 16, 18, 31, and 33 proved negative.

We emphasise, firstly, that assessment of mild degrees of koilocytosis in cervical squamous epithelium is subjective. Furthermore, preliminary data suggest that koilocytosis may not be specific for human papillomavirus infection.² Koilocytosis in cervical biopsy specimens should be ascribed to human papillomavirus infection only if additional histological manifestations such as papillomatosis, binucleation, or dyskeratosis are also present (M Wells, personal communication).

Secondly, even if infection has been confirmed by objective methods (such as immunohistochemistry, *in situ* hybridisation, or polymerase chain reaction), the route of transmission will not necessarily have been sexual. Extragenital human papillomavirus infection is common and, as some types of virus can be found in both cutaneous and mucosal lesions,³ digital transfer from other sites in the same individual is a possibility. Furthermore, infection can be acquired vertically from the mother at birth, and the virus has been shown to persist in the infant for at least six weeks.⁴ The presence of anogenital warts in young children in whom sexual abuse has as far as possible been excluded suggests that vertically acquired human papillomavirus infection may persist for years. Persistence into adulthood cannot be ruled out. Thirdly, even if the infection has been acquired sexually it may have been acquired during a previous relationship. Particularly in older women, infection can persist for several months if not years in a subclinical or latent state,⁵ and current histological or cytological abnormalities may reflect infection acquired years earlier.

These uncertainties should be borne in mind when counselling patients about cervical cytology or biopsy findings. Health professionals would be well advised to be cautious in raising doubts over the sexual fidelity of a patient or partner, particularly if a diagnosis of human papillomavirus infection has been based solely on the finding of koilocytosis in a cervical smear or biopsy specimen.

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1 Hines J F, Ghim S-J, Jensen AB. Human papillomavirus infection. *BMJ* 1996;312:522-3. (2 March.)

2 Blackett A D, Conyers M G, Sharp F. The incidence of HPV and EBV DNA in normal, koilocytic and dysplastic cervical tissue. *Br J Obstet Gynaecol* 1994;101:814.

3 Herrington C S. Human papillomaviruses and cervical neoplasia. I. Classification, virology, pathology and epidemiology. *J Clin Pathol* 1994;47:1066-72.

4 Pakarian F, Kaye J, Cason J, Kell B, Jewers R, Derias NW, *et al*. Cancer associated human papillomaviruses: perinatal transmission and persistence. *Br J Obstet Gynaecol* 1994; 101:514-7.

5 Hildesheim A, Schiffman MH, Gravitt PE, Glass AG, Greer CE, Zhang T, *et al*. Persistence of type-specific human papillomavirus infection among cytologically normal women. *J Infect Dis* 1994;169:235-40.

Managing HIV disease without Delta

EDITOR.—The editorial by Anthony J Pinching gives further news of the two large randomised placebo controlled trials of combination antiretroviral therapy in advanced HIV infection. Although the apparent beneficial results have been widely publicised, neither Delta nor ACTG175 have yet been published. Are physicians therefore able to make an informed decision on the best treatment for advanced HIV infection? Peer review and debate are vital in the assessment of new data, particularly when the therapeutic and financial implications are so great. The letter columns of the *BMJ* after the premature release of data detailing the risks of venous thrombosis in women receiving the contraceptive pill bear testament to this.

Pinching writes of "evidence based medicine in health commissioning." Surely both providers and purchasers of health care are not yet in a position to consider such combination therapy with so much missing information. Vital data are as yet unknown with regard to patient selection, randomisation, drop out rates, and the level of unacceptable side effects associated with combination therapy and its applicability to the diverse groups affected by HIV infection. Should the *BMJ* not take a more conservative, sceptical approach to these unpublished data and wait impatiently with everyone else for their appearance in a peer review journal?

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1 Pinching AJ. Managing HIV disease after Delta. *BMJ* 1996;312:521-2. (2 March.)

Junior doctors should get "additional duty miles"

EDITOR.—Who cares about junior doctors' hours? It is our shoes we should be worried about. Concerned about our lack of exercise since qualifying but puzzled by our weight loss, we undertook a recent study which showed that, as two senior house officers in general medicine, we walked 6.8 miles (10.9 km) while on call for 24 hours. Using recently acquired electronic pedometers, we recorded the mileage from 0900 to 0900, over a total of seven periods on call.

Should hospital planners and administrators give more thought to the location of various wards and departments of each specialty? In our hospital there are four medical wards, two upstairs and two at ground level, at opposite ends of the hospital. The accident and emergency department is in between, and the coronary care unit is along another long corridor upstairs. Furthermore, the pathology and radiology departments, which we often visit while on call, are distant from all the medical wards. Two on call rooms are next to the coronary care unit, but the third is out of the main hospital building, on the other side of a car park.

We think that, in addition to campaigning over the new deal, juniors should be campaigning for a substantial shoe allowance or, indeed, for "crown shoes."

We thank Dr A G Chappell for his encouragement and financial contribution to our cobbler's bill.

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