Only from such full debate will both the medical profession and society be better educated.

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1 Dawson J. Vascular surgery in smokers. *BMJ* 1994;**308**:978. (9 April.)

. . . when resources are limited

EDITOR,—Julie Dawson suggests that smokers should be asked whether they should have arterial surgery because "it is their life."[1] She asks how much longer society, which funds a national health service that is supposed to be there for all, is prepared to let doctors decide who gets treatment.

It may be the smoker's life, but it is society's resources. Doctors make decisions about treatment —in discussion if they are reasonable—because they know more about (the imperfect knowledge of) disease than most other people. If resources are limited (which they are: health is not there for all) decisions have to be made unless rationing is decided by lot or on a first come, first served basis.

Julie Hotchkiss distorts a serious discussion by asking whether differential survival by gender would justify expensive interventions being offered only to women.[2] This is not a valid comparison: smoking is addictive but is a lifestyle factor, which, unlike gender, entails an element of choice.

There is a view that we are all—smokers, heroin misusers, thieves—only victims of circumstance. It is a sustainable philosophical view but unrealisable practically. If we want the right to society's resources we have a duty to respect them and must be prepared sometimes to have resources refused if we ignore those duties.

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1 Dawson J. Vascular surgery in smokers. *BMJ* 1994;**308**:978. (9 April.)
2 Hotchkiss J. Vascular surgery in smokers. *BMJ* 1994;**308**:987-9. (9 April.)

Immunodeficiency without HIV

Clinical presentations vary

EDITOR,—A McNulty and colleagues reported on seven HIV negative patients with CD4 T lymphocytopenia and clinical diseases due to defective cell mediated immunity.[1] These cases were found during a national survey in Australia in which 96 practitioners were contacted. We present information on five HIV negative patients (four adults and one child) seen in our department between 1991 and 1993 (table) who meet the criteria set by McNulty and colleagues; two of them also satisfy the Centers for Disease Control's criteria for CD4 T lymphocytopenia as defined by McNulty and colleagues. All patients had been referred to our department of immunology for evaluation of suspected immunodeficiency.

In contrast to the Australian group, our patients presented with a diverse range of clinical problems, from planar warts and vasculitis to recurrent infections. CD4 lymphocytopenia and defective cell mediated immunity may occur in medical conditions such as sarcoidosis, as in case 4. Acquired defects in cell mediated immunity may be associated with abnormalities of other parts of the immune system as in case 1; the patient was initially diagnosed as having panhypogammaglobulinaemia and was receiving replacement intravenous immunoglobulin treatment. The patient in case 2, who had the least clinical evidence of immunodeficiency, had the most profound CD4 lymphocytopenia. Interestingly, in the past she had failed to respond to BCG and hepatitis B immunisation.

Unlike McNulty and colleagues, we believe that defective cell mediated immunity without evidence of HIV infection may be uncommon but is not rare. Suspected immunodeficiency of any form should be investigated in conjunction with a department of immunology.

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1 McNulty A, Kaldor JM, McDonald AM, Baumgart K, Cooper DA. Acquired immunodeficiency without evidence of HIV infection: national retrospective survey. *BMJ* 1994;**308**:825-6. (26 March.)

Consider HIV negative immunodeficiency in cryptococcosis

EDITOR,—A McNulty and colleagues suggest that a relation exists between CD4 T lymphocytopenia and cryptococcosis.[1] We report a case that gives credence to this view.

In 1993 a 48 year old man was referred to a dermatologist with an excoriated plaque on his right wrist. The lesion had arisen at the site of a peck by a pigeon. Biopsy showed cutaneous cryptococcosis. The patient kept pigeons, and earlier blood tests as part of investigations for an exacerbation of his chronic obstructive airways disease had yielded positive results for avian (pigeon) precipitants. In addition, a lymph node biopsy for inguinal lymphadenopathy in 1988 had shown a granulomatous disease, believed to be sarcoidosis. Tests for tuberculosis at that time had yielded negative results.

Further investigations in 1992 after weight loss and pneumococcal pneumonia identified florid oesophageal candidiasis and an absolute CD4 T lymphocyte count of $0{\cdot}101\times10^9$/l (much below $<300\times10^9$ required as a criterion for idiopathic CD4 T lymphocytopenia). Tests for HIV-1 and HIV-2 yielded persistently negative results, and tests for HTLV-1 also yielded negative results. Subsequently the patient developed a pleural effusion, which was repeatedly found to contain acid-alcohol fast bacilli. Attempts to classify the species on culture were unsuccessful. Despite intensive treatment for cryptococcosis and tuberculosis the patient continued to deteriorate, and he died in February 1994. Necropsy showed systemic granulomatous disease; empyema, with the pus being positive for acid-alcohol fast bacilli; and continuing cutaneous cryptococcosis at the site of the peck. Retrospectively, it seems likely that the original lymph node disease was also of mycobacterial origin.

This case confirms other reports that severe CD4 T lymphocytopenia can occur in the absence of HIV infection. Although the case has many features in common with the recently defined idiopathic variant,[2,3] the CD4 T lymphocytopenia was probably of acquired origin, given that the patient had a longstanding granulomatous disease, which perhaps had a role in the pathogenesis of his immunodeficiency. As in McNulty and colleagues' cases, cryptococcosis was an important manifestation. In this instance, however, it seems to have been of primary cutaneous origin since it developed at the site of the pigeon peck. Moreover, necropsy failed to show evidence of extracutaneous disease. A clinically alarming feature of the case was the inability of intensive therapeutic intervention to clear the mycobacterial and cryptococcal infection. The mycobacterial infection could well have been of avian origin, though this was not proved; this illustrates the potentially fatal complications of keeping pigeons.

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1 McNulty A, Kaldor JM, McDonald AM, Baumgart K, Cooper DA. Acquired immunodeficiency without evidence of HIV infection: national retrospective survey. *BMJ* 1994;**308**:825-6. (26 March.)
2 US Centers for Disease Control. Update: CD4+T-lymphocytopenia in persons without evident HIV infection—United States. *MMWR* 1992;41:578-9.
3 Ho DD, Cao Y, Zhu-T, Farthing C, Wang N, Gu G, *et al.* Idiopathic CD4+T-lymphocytopenia—immunodeficiency without evidence of HIV infection. *N Engl J Med* 1993;**328**: 380-5.

Details of HIV negative patients with CD4 lymphocytopenia

Case No	Age/Sex	Clinical details	Total lymphocyte count ($\times10^9$/l) (normal range 1500-4000)	CD4 lymphocyte count ($\times10^9$/l) Absolute	CD4 %	CD4 No	CD8 lymphocyte count ($\times10^9$/l) Absolute	CD8 %	CD8 No	CD4:CD8 ratio (normal > 1·7)	Immunoglobulins (g/l) (adult reference range) G (5·4-16·1)	A (0·8-2·8)	M (0·5-1·9)
1	39/F	Chronic diarrhoea, bronchiectasis, widespread warts, panhypogammaglobulinaemia	960	28·9	278	28·6	275			1·01	1·8	0·7	0·13
2	25/F*	Widespread planar warts	1943	8·7	169	43·8	744			0·2	14·4	3·3	0·17
3	3/M	Vasculitic rash, Raynaud's disease, recurrent candidiasis	4092	18·4	753	25·7	1048			0·72	18·5	3·6	1·3
4	35/M	Pulmonary sarcoidosis, chronic Epstein-Barr virus infection†	1430	25·6	380	32·2	460			0·83	11·5	2·3	5·5
5	28/F	Recurrent pustular rash, Bartter's syndrome	1000	30·8	300	34·5	345			0·89	11·5	2·1	1·5

*Negative for HIV antibody and p24 antigen.
†IgG antibody to viral capsid antigen 1:1280 (normal range < 1:640; IgM antibody to viral capsid antigen positive; IgG antibody to early antigen 1:40 (normal range < 1:40).

Controlling AIDS in India

EDITOR,—Zaka Imam's report on India's AIDS control programme presents a grim picture of a nation struggling to cope with rising numbers of cases of HIV infection.[1] Official figures grossly underestimate the numbers. The World Health