itself or in conjunction with other factors is a risk factor for the sudden infant death syndrome. This is particularly so given that some groups have actively promoted bed sharing.

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Prostitution: would legislation help?

EDITOR,—Mary Hepburn cited the views of the English Collective of Prostitutes.[1] This group represents only a small section of the prostitute population; relatively little is known about the views of prostitutes in general, in particular those working on the streets. Accordingly, we conducted a survey of a sample of street working women to elicit their opinions about aspects of legalisation.

At the Glasgow Drop-in Centre, a health care and social work facility for female street prostitutes,[2,3] a short questionnaire was administered to a sample of prostitutes. Over four nights in August 1992 we invited 52 women, sequentially coming into the centre, to participate in the survey; only one refused. Of the 51 respondents 44 were injecting drug users. Their age range was 17-62, the median age of injecting drug users being 24 and that of non-users 40. Forty five of the women thought that prostitution should be legalised, three disagreed, and three did not know. One of those who disagreed thought that legalisation might encourage more young girls on to the streets, which would be undesirable as street prostitution was a dangerous way of life; another stated that more young girls on the streets would provide too much competition for existing prostitutes. Thirty four said that they would work in "brothels" if they were legalised (mainly for increased safety), 13 said they would not, and four did not know. When asked if they would continue working on the streets if prostitution were legalised, 22 said yes, 25 said no, and four did not know. All of the sample said that they would submit to regular medical examinations if that were a condition of legalisation. Finally, the women were asked if they would pay taxes if required by law. Twenty six said yes, 13 said no, and 12 were undecided.

This survey showed that most of the Glasgow street workers questioned were in favour of legalisation of prostitution, would work in "brothels," and would cooperate with medical examinations. It is encouraging to note that over half said they would cooperate in paying taxes.

These views differ from those expressed by some of the more eloquent prostitutes' rights groups, thus highlighting the importance of obtaining a wide cross section of prostitutes' views when any changes in the law are debated.

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GP facilitators and HIV infection

Heterosexual infection less common than other routes

EDITOR,—Peter Saunders rightly draws attention to the fact that an increasing proportion of newly diagnosed HIV infections in Britain is attributable to heterosexual intercourse; his statement that this is now the commonest mode of spread in Scotland merits comment.[1] Since 1985 the Communicable Diseases (Scotland) Unit has maintained a register, based on laboratory reporting, of all people known to be infected with HIV in Scotland. As it is based on voluntary testing this register cannot be seen as an indication of incidence or prevalence, but it remains the most reliable source of data on HIV infection in Scotland and is used in resource allocation under the AIDS (Control) Act and in official predictions of the course of the HIV epidemic.

The table shows the distribution of newly diagnosed HIV infections by probable category of transmission and by year of specimen (since 1985) according to the Scottish HIV register.

Distribution of newly diagnosed cases of HIV infection in Scotland by category of transmission. Values are numbers (percentages) of cases

Year	Homosexual or bisexual	Heterosexual	Injecting drug use	Other	Total
1985	71 (26)	3 (1)	162 (59)	39 (14)	275
1986	73 (22)	19 (6)	206 (63)	27 (8)	325
1987	64 (26)	28 (11)	124 (50)	32 (13)	248
1988	42 (30)	32 (23)	51 (37)	14 (10)	139
1989	44 (39)	28 (25)	34 (30)	8 (7)	114
1990	53 (40)	40 (30)	27 (20)	14 (10)	134
1991	56 (35)	42 (26)	51 (32)	13 (8)	162
1992	50 (36)	52 (38)	26 (19)	9 (7)	137
1993	56 (37)	38 (25)	49 (32)	10 (7)	153

Overall, the decreasing predominance of injecting drug use as a category of transmission and the increasing predominance of heterosexual transmission are clearly apparent, but in only one year (1992) has heterosexual intercourse been the commonest mode of spread. In 1993 sexual intercourse between men accounted for the highet proportion of cases, followed by injecting drug use.

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Shared care better for GPs and specialists

EDITOR,—We agree with Peter Saunders about the importance of general practitioners providing more of the care for HIV positive patients,[1] but facilitators are not the only means of achieving this. The departments of primary health care and genitourinary medicine at University College London Medical School have collaborated in setting up a formal shared care protocol for asymptomatic HIV positive male patients. The aim of the study is to ascertain whether shared care is appropriate for these patients.

Patients attending the genitourinary clinic at the Middlesex Hospital are invited to participate in the study. Once a patient has agreed, his general practitioner is contacted and asked if he or she is willing to provide the necessary care; if the answer is yes the patient is enrolled in the study. The patient holds a "co-op card," which contains a summary of the relevant medical history, a record of any drug prescribed, and a chart for completion at each consultation. All baseline investigations are done at the clinic; subsequently the patient attends his general practitioner at three monthly intervals for a check up and is reviewed at the hospital annually.

We believe that the advantages of this approach include the opportunity to form a therapeutic doctor-patient relationship early on, when the patient is still well; the possibility of continuity of care for the patient from his own general practitioner, which relieves the pressure on appointments at the hospital and allows specialist physicians to concentrate on patients most in need of their skill; and the fact that the general practitioner can gain both confidence and competence in caring for patients with HIV infection through a structured protocol of care.

An initial questionnaire indicated that about half the patients would be interested in increasing the involvement of their general practitioner in their care.[2] Recruitment of patients has, however, been slower than was suggested by the results of the questionnaire—reflecting perhaps both the reluctance referred to by Saunders and the strength of the doctor-patient relationship already established in the genitourinary clinic at the Middlesex Hospital.

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GPs should be involved early

EDITOR,—Peter Saunders highlights the importance of general practitioner facilitators in the context of HIV infection and indicates that the role of these facilitators will vary depending on the prevalence of HIV infection in the area they serve.[1] In areas of low prevalence the emphasis will be on prevention; in areas of higher prevalence clinical management and organisation of care at home become increasingly prominent.

The statement that "on average every general practitioner may . . . expect to have one HIV positive patient on his or her list" must, however, be qualified. In reality, most patients are concentrated in large cities. Even within these cities the prevalence of HIV infection varies considerably. This unit is in contact with several hundred general practitioners, but the 31% of our patients who are known to be registered with a general practitioner are registered with just 20 practices. In our experience, many patients move to be closer to our unit as they become more sick. This further concentrates the workload related to HIV infection into a small number of practices.

In London the care of people with HIV infection was initially provided in genitourinary clinics and community services were marginalised.[2,3] Increasingly, more care is being provided in the community, partly by specialist teams organised by hospital units and partly by general practitioners and district nurses. One of the problems with hospital based teams is that they may continue to marginalise generic services, including those provided by general practitioners,[3] despite a stated aim of increasing general practitioners' participation in these patients' care.[4,5] Although contact with a home support team increases registration with and disclosure to general practitioners, it also reduces use of general practitioners by about a quarter of the people using the service.[4]

The community liaison team at Chelsea and Westminster Hospital does not itself provide any home care as we firmly believe that the best people to provide medical and nursing care in the community are general practitioners and generic district nurses. Instead we seek to involve those

working in primary care in the early stages of illness and to coordinate the many agencies that may help patients with late stage HIV infection. It is essential that we work in partnership with general practitioners and their facilitators to encourage more general practitioners to achieve the high standards of care of patients with HIV infection provided by many of their colleagues.

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Other health professionals can be facilitators

Editor,—Peter Saunders suggests that general practitioners are ideally placed to work as facilitators in HIV infection and AIDS,[1] but so are other people. Colleagues who are primary health care facilitators in HIV infection and AIDS and sexual health come from a wide variety of professional backgrounds and are also highly qualified to understand the difficulties that primary health care teams encounter in dealing with people with HIV infection or AIDS living in the community.

Although, as Saunders says, facilitation includes an educational role, it can go much further. After diagnosis people with HIV infection or AIDS spend 80% of their remaining lives in the community[2]; thus enhancing direct treatment by primary care staff is a second key role for facilitators. Thirdly, the preventive aspect of facilitation is crucial: the *Health of the Nation* identified primary health care teams as important in promoting sexual health.[3]

We have recently reviewed the outcomes of six projects to distribute condoms in England, and the implications are clear—namely, that it is appropriate for general practices to distribute condoms and they are effective at doing this.[4] Essentially, success will depend on training staff in issues regarding sexual health; conveying straightforward information on types of condom, their use for contraception, and their application; and having clear and agreed protocols on use of condoms.[5]

The primary health care team, with the help of the facilitator, is in a unique position to be directly involved in preventing HIV infection as well as in managing its consequences and providing terminal care and bereavement counselling. But current practice is often poor. Proper procedures for needlestick injuries, standardised safe venepuncture, the use of central venous lines, shared care cards, and HIV employment policies for general practice are often neglected. Facilitators, whether doctors, nurses, or other health professionals, can bridge these gaps between primary and secondary care.

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Evaluation is needed

Editor,—Though we agree that general practitioners ought to be given more help in caring for people with HIV infection, how this help should be offered and used is unclear. In his editorial Peter Saunders promotes the idea of a facilitator without considering whether it should be evaluated.[1] Facilitators in HIV infection and AIDS have worked in a variety of funded posts for the past seven years,[2,3] and such a widely adopted initiative should now be systematically assessed. This assessment should include getting the views of patients with HIV infection and AIDS[4] and members of the primary health care team as to whether facilitation is of practical benefit. Such an evaluation should determine whether facilitation is effective and, if so, whether it requires modification to meet the needs of those it sets out to serve.

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Allergy testing in supermarkets

Misleads susceptible people

Editor,—Effective management of patients with allergic disease requires a history and physical examination followed by relevant laboratory tests, including allergy tests, which are chosen primarily on the basis of the patient's history. The tests should be selected and interpreted by the doctor who obtained the history and performed the examination, who should have been trained in, and have experience of, allergic disease. It is regrettable, therefore, that the pharmacy department of the multichain supermarket Safeway is now offering diagnosis of allergy and advice on treatment on the basis of a short questionnaire and a blood test (the Quidel multiallergen dipstick screening test).

The promotion leaflet states that: "Laboratory analysis can . . . identify exactly what you are allergic to. There is no need for a doctor's referral. . . . We give you sound, sensible advice on how to cope with your allergy."

At first sight this may seem a perfectly reasonable commercial venture, with the private sector saving the NHS time and money in diagnosing and managing "mild allergies." In reality this remote allergy testing may unnecessarily confuse and alarm susceptible people by producing positive results that are not clinically important. Likewise there is a risk of inappropriate advice being given, with overemphasis of the role of allergy in diseases such as asthma and eczema. For example, most asthmatic patients are atopic, but the role of IgE dependent mechanisms in individual patients may be uncertain and can be established only by a professional clinical history.

Can the pharmacists at Safeway give guidance on the importance of IgE antibodies in chronic asthma? Isn't there a danger that patients might put undue emphasis on the result of allergy tests and reduce or withhold lifesaving treatment such as inhaled or oral corticosteroids? People who suffer from eczema are likely to have IgE antibodies to many aeroallergens and foods, but these are rarely of practical importance, particularly in adults. Many people may go on restrictive diets for their eczema unnecessarily, without adequate supervision.

A particularly worrying allergy is that to bee and wasp stings since it can be life threatening. A history of severe or even moderate systemic symptoms after a sting, together with a positive IgE antibody level, may indicate immunotherapy. The decision whether to proceed with immunotherapy, however, requires considerable skill and is usually taken by an allergy specialist. Does the supermarket pharmacist have the experience to recognise patients at risk of death from anaphylaxis after further exposure?

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**We sent the above letter to Safeway for its response.—Ed, *BMJ*.

Tests performed by qualified pharmacists

Editor,—Safeway's pharmacists deal daily with people suffering from asthma, eczema, or allergic rhinitis. It is inconceivable that a pharmacist would compromise a patient's treatment. Already well versed in drug treatment, the pharmacists receive further training before being allowed to offer allergy tests to the public.

There is little doubt that the incidence of allergy, asthma, eczema, and hay fever is increasing,[1] and in all parts of the globe. The prevalence of IgE antibodies specific to common allergens has also increased, being almost 40% in children.[2] The cumulative prevalence of hay fever is 20%, which makes this a common and potentially serious clinical problem. Most asthmatic people (around 85%[3]) are atopic, and almost three quarters of these are sensitive to house dust as well as other indoor allergens. If animals are kept in the home there are high concentrations of allergen in the air—often 50 times higher than the concentration of house dust mite.[4] Removing allergen from the house results in a significant reduction in symptoms, both in children and in adults.[5]

A B Kay's letter contains errors. We do not mention diagnosis or offer advice on drug treatment in our literature. We do not advise patients to withhold any drugs they are currently taking. Any findings, especially findings pointing to an allergy to bee or wasp venom, would result in the patients being referred immediately to their general practitioner; this early warning of an allergy to venom might lead to earlier treatment and avert an anaphylactic attack after a bee or wasp sting.

We believe that our approach at Safeway has the highest ethical, practical, and pharmaceutical standards, and we will do everything we can to work with the medical profession to help this important and large segment of the population.

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