exploring the sexual behaviour of patients where this may be clinically appropriate or an opportunity for preventive intervention exists; and two way communication between general practitioners and consultants in genitourinary medicine.[3] Coincident infection with HIV and other sexually transmitted infections, particularly those that cause genital ulceration, has been cited as a major cause of increased transmissibility of HIV.

If only out of self interest, the insurance industry should consider the long term consequences of underwriting procedures on the important sexual health promotion activities that are possible in general practice.[4] Now that we have better epidemiological evidence about the spread of HIV, the Association of British Insurers is in a position to re-evaluate its dogged adherence to pre-existing practice. In 1993-4 the Kensington, Chelsea and Westminster health district had 1186 HIV positive residents who consulted HIV services. Their general practitioners knew of the diagnosis in only 761 of these patients.[5] If the British insurance industry still believes that it needs protection from HIV then it should recognise that the use of general practitioners at the underwriting stage is as helpful as a condom with a large hole in it.

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**We did not receive any letters in support of P H Smee's view that insurance companies should have access to patients' records. —EDITOR

Treatment with clozapine

Black patients' low white cell counts currently mean that they cannot be treated

EDITOR,—Clozapine, an atypical antipsychotic drug, has been proved to be effective in the pharmacological management of schizophrenia that is resistant to treatment. Up to 30% of people with schizophrenia may benefit from receiving this drug because of non-response to or intolerance of typical antipsychotics (J Kane *et al*, American Psychiatric Association's annual meeting, 1995).

A major side effect of treatment with clozapine is a potentially fatal agranulocytosis. As a result, patients' white cell counts have to be monitored before and during treatment. Patients can start the drug and continue with treatment only if their white cell count is $>3.5\times10^9$/l. This mandatory surveillance is administered by the drug's manufacturers through the Clozaril Patient Monitoring Service.

In reviewing the use of clozapine at Springfield Hospital we have found that these haematological restrictions are more likely to affect black African and African Caribbean patients than other patients: effectively, half of all such patients put forward for clozapine treatment at this unit have been unable either to start or to continue treatment because of a "red alert" (table 1). During the same period no red alert was issued for a white patient. This is of particular concern as in our catchment area, the London boroughs of Merton and Wandsworth, the prevalence of schizophrenia among the black population is up to four times that among the local white population.[1] Reports have indicated that some ethnic minorities are at greater risk of agranulocytosis induced by clozapine and that this may be linked to certain HLA subtypes.[2] Our data, however, raise concerns about the normal ranges for white cell counts and neutrophil counts used by the Clozaril Patient Monitoring Service.

Table 1—*Number of patients for whom "red alert" was issued because white cell count was $<3.0\times10^9$/l or neutrophil count was $<1.5\times10^9$/l during monitoring by Clozaril Patient Monitoring Service*

Time of blood test	Red alert
Before treatment:	
Black African and African Caribbean (n = 21)	5
White (n = 40)	0
During treatment:	
Black African and African Caribbean (n = 16)	4
White (n = 35)	0

It has been established that African and African Caribbean patients have an apparently low white cell count and neutrophil count because of margination.[3] Consequently, alternative normal ranges have been proposed for this population and are taken into account in ordinary haematological clinical practice. For example, for African men a suggested "normal" range is $2.8\text{-}7.2\times10^9$/l for the white cell count and $0.9\text{-}4.2\times10^9$/l for the neutrophil count.[3] Currently, counts at the lower end of these ranges would prevent a patient from starting clozapine treatment or lead to the immediate withdrawal of established treatment. Surely it is now time for the Clozaril Patient Monitoring Service to review its normal ranges so that African and African Caribbean patients are not barred from this treatment on the grounds of their ethnic background alone.

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Reply from Clozaril Patient Monitoring Service

EDITOR,—We have been aware for some time that the strict haematological limits used by the Clozaril Patient Monitoring Service may exclude patients who normally have low white cell counts from receiving clozapine. Lawton *et al* reported "normal neutropenia" in an Afro-Caribbean patient taking clozapine and expressed similar concerns to those raised by Nigel Fisher and Barbara Baigent.[1] In answering Lawton *et al* we explained why the safety limits were set so strictly and provided data to support the hope that black Afro-Caribbeans are not at increased risk of agranulocytosis while taking clozapine despite their lower neutrophil counts before treatment and higher rates of neutropenia during treatment.[2] More recently, account has been taken of ethnic origin in patients with benign neutropenia.

The Clozaril Patient Monitoring Service was established because of the unusual history of clozapine. In 1975 the drug was withdrawn voluntarily from several countries after the occurrence of 16 cases of agranulocytosis, eight of which were fatal.[3] Recognition of the drug's efficacy in schizophrenia led to calls for its reintroduction with mandatory haematological monitoring. The haematological limits used by the Clozaril Patient Monitoring Service were deliberately set with a margin of safety to protect the majority of patients irrespective of ethnic background. These limits, however, are arbitrarily defined and should not be portrayed as normal ranges.

Over the past five years this rigorous monitoring has successfully minimised mortality due to agranulocytosis. Analysis of 6316 patients taking clozapine showed a cumulative incidence of agranulocytosis of 0.8% over four and a half years, with just two deaths.[4] Recent (unpublished) analysis of 11 000 patients treated over the first six and a half years since the drug's introduction adds further reassurance, as the rates of neutropenia and agranulocytosis have remained consistent and no further associated deaths have occurred.

Now that this body of data has been established it is reasonable to start exploring whether the safety limits can be selectively relaxed under controlled conditions. It will be necessary to show that any such relaxation is not associated with unacceptable excess risk. This may open up the possibility of treatment for an important minority of patients who cannot currently receive clozapine because of presumed benign neutropenia due to their ethnic origin. In the meantime, we must ensure that the principle of the greatest good for the greatest number is not sacrificed.

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Physical therapy has little effect on acute low back pain

EDITOR,—In his article on back pain in the ABC of work related disorders Malcolm I V Jayson advocates that "physical therapy should be arranged if symptoms last for more than a few days."[1] Apart from the major impact that this would have on resources for physical therapy in the NHS, such an emphasis is ill advised in the light of evidence on the effectiveness of physical therapy. Exercise therapy does not shorten the course of acute low back pain or influence disability and absence from work.[2,3] Back schools in primary care have not been proved to have any beneficial effect, while assessment is needed of the cost effectiveness of intervention in companies along the lines of the "Swedish back school model" for patients with acute and recurrent low back pain.[4] Research into the effectiveness of manual therapy in low back pain may have shown some beneficial effect initially, but that effect disappears within weeks when comparison groups are studied.[5] This result is consistent with the generally good prognosis of low back pain.