

Laser vaporization in the management of CIN

Sirs,

One discordant sentence in the recent paper about laser vaporization in the management of cervical intra-epithelial neoplasia (CIN) epitomizes a fundamental dilemma.¹ In their discussion, the authors state, without equivocation: 'As women with lesions destined to progress cannot be identified, clinicians are obliged to treat all women with CIN'. Yet they clearly believed at the start of the study, demonstrated by their results and concluded in their summary: 'The substantial rate of spontaneous regression suggests that intervention is frequently unnecessary'.

Even in the much quoted report from New Zealand about untreated carcinoma *in situ*, the majority of cases had still not progressed to invasive cancer after observation for 20 years.² When considering low-grade CIN there is no doubt that vastly more cases regress than would ever progress to cancer.³ Put another way, CIN is more commonly a precursor of normality than it is 'pre-cancerous'. Indeed, as cancer can also arise in the apparently normal cervix, as well as in patients with CIN, the distinction between 'pre-cancerous' and 'normal' is not at all well defined.

If we can accept the logic of the discordant sentence, it is but a small step to accepting that clinicians might be obliged to vaporize every cervix, just to be on the safe side. Thence, with the current vogue for political correctness, should we not be obliged to consider applying the same logic to PIN, as 'pre-cancerous' lesions of the penis?

Masculine intuition suggests that there might be a case for re-examining the premises which lead clinicians to believe that it is obligatory to treat all cases of CIN.

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Antimalarial prophylaxis

Sirs,

I read with interest the section on antimalarial prophylaxis contained within the Quarterly Communicable Disease Review April to June 1993,¹ published in the December 1993 issue of your journal.

However, the advice on the use of halofantrine for self-medication of suspected malaria by travellers to remote malaria endemic areas is in need of correction, following the discovery that it can induce serious ventricular dysrhythmias in susceptible people. A recent World Health Organization drug alert² states that halofantrine 'should only be used as an emergency self-medication for presumptive therapy in those patients known to have normal Q-T intervals (QTc not more than 0.44 seconds). It is contraindicated in patients with a family history of congenital Q-T prolongation.' Halofantrine is also not recommended 'in combination with drugs or clinical conditions known to prolong the Q-T interval or in patients who may suffer from thiamine deficiency, and should not be administered to patients with severe electrolyte imbalance' (particularly hypokalaemia or hypomagnesaemia). Halofantrine 'should be administered on an empty stomach' and should not be given in combination with mefloquine, as the latter augments the electrocardiographic changes induced by halofantrine (particularly Q-T prolongation).³ The dosage of halofantrine 'should not exceed a total dosage of 24 mg/kg given as 8 mg/kg three times' (at intervals of six hours; maximum total dose of 1500 mg).

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Reasons for HIV diagnosis delay in Antwerp

Sirs,

In spite of new therapeutic possibilities and inform-

ation campaigns over the last six years no significant decrease in HIV diagnosis delay has been observed in Antwerp.¹ Between 1985 and 1991, at the HIV Treatment Centre of the Institute of Tropical Medicine (ITM) in Antwerp, the percentage of patients with CD4 lymphocyte counts of less than 200/mm³ at HIV diagnosis ranged from 18 to 32 per cent.¹

To determine reasons for HIV diagnosis delay, 109 consecutive patients attending the in- and out-patient department of the ITM HIV Treatment Centre from 1 February to 30 April 1993 were interviewed using a standardized questionnaire.

An important HIV diagnosis delay was defined as an HIV diagnosis made when the patient already had developed AIDS according to the 1993 Centers for Disease Control (CDC) AIDS case definition.² An avoidable HIV diagnosis delay was defined as an HIV diagnosis made at least one year after the HIV test had become commercially available in Belgium (1985) for persons with risky behaviour before 1985, and as an HIV diagnosis made at least one year after the risky behaviour for persons with a risky behaviour after 1986.

Eighty-three (76.1 per cent) patients were males, 26 (23.9 per cent) were females. Seventy-seven (70.6 per cent) were Belgians, 22 (20.2 per cent) Africans, eight (7.3 per cent) non-Belgian Europeans, and two (1.8 per cent) Asians. Fifty-five (66.3 per cent) acquired HIV infection through homosexual contact, 24 (28.9 per cent) through heterosexual contact, one (1.2 per cent) through blood transfusion, one (1.2 per cent) through intravenous drug use, and two (2.4 per cent) patients did not know how they were infected.

At HIV diagnosis, 77 (70.6 per cent) patients were in CDC stage A, 18 (16.5 per cent) in CDC stage B and 14 (12.8 per cent) in CDC stage C.² Forty-nine (45 per cent) had a CD4 lymphocyte count of less than 200/mm³ at HIV diagnosis, 42 (38.5 per cent) a CD4 lymphocyte count between 200/mm³ and 500/mm³, and 18 (16.5 per cent) a CD4 lymphocyte count above 500/mm³.

An important diagnosis delay was observed in 27 (31.8 per cent) patients and an avoidable delay in 84 (77 per cent) patients. An avoidable diagnosis delay was found in 54 (70.1 per cent) of the Belgians and in 30 (93.8 per cent) of the non-Belgians ($p < 0.05$); there was not a significant difference in number of homo- and heterosexuals with an avoidable diagnosis delay.

Reasons for avoidable diagnosis delay were: unawareness of risky behaviour (44, 50.0 per cent), lack of information on HIV-AIDS (20, 24.4 per cent), fear of the test result (18, 22 per cent), fear of breaches in confidentiality (nine, 11.0 per cent), feeling there was no treatment (six, 7.3 per cent), the test being not proposed

by the physician in spite of symptoms (five, 6.1 per cent), fear of losing one's job (two, 2.4 per cent), lack of money (one, 1.2 per cent), the test being not available (one, 1.2 per cent) and lack of time (one, 1.2 per cent).

Unawareness of risky behaviour as a reason for diagnosis delay was reported less frequently by Belgians (21, 39.6 per cent) than by non-Belgians (20, 69.0 per cent) ($p < 0.05$), and less frequently by men (26, 41.9 per cent) than by women (15, 75 per cent) ($p < 0.05$). The percentage of patients being unaware of their risky behaviour did not significantly differ according to HIV risk group or marital status.

A considerable delay in diagnosis of HIV infection has also been observed in other countries.^{3,4} In a study performed in San Francisco, 29 per cent of the patients examined between 1989 and 1991 had a CD4 lymphocyte count of less than 200/mm³ at HIV diagnosis. The fact that a high proportion of patients was symptomatic at HIV diagnosis suggests that symptoms may have been the stimulus for antibody testing and subsequent medical care.⁵ In a study performed in London, over the period 1989-1992, 49 per cent of the patients with AIDS did not know their seropositive status for nine months or less.⁴ Lack of risk awareness was more often observed among heterosexuals, men, non-whites, persons living outside the Thames region, persons diagnosed before 1992 and persons aged 15-24 years and ≥ 50 years. So far, only in a study performed in Perth, among patients diagnosed with AIDS over the period 1988-1991, were reasons for diagnosis delay reported.³ Thirty-nine per cent of the patients presenting with AIDS defining condition had known their seropositive status for eight weeks or less. Reasons for diagnosis delay included unawareness of HIV treatment advances, concern about confidentiality and the belief that safe sex was practised.

In Antwerp, the main reason for HIV diagnosis delay seems to be unawareness of a risky behaviour. Further monitoring the degree of HIV diagnosis delay among newly diagnosed patients and studying the reasons for diagnosis delay certainly will provide useful information for the planning of HIV prevention and information campaigns.

References

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Non-notification of food poisoning – whose fault?

Sirs,

Salmonella food poisoning is one of the least notified of all infections and is estimated to be between 1 and 5 per cent.^{1,2} We carried out a survey to find out the reason for the low notification rate.

Description of the outbreak

Thirty-eight of the 50 people who attended the annual dinner of a shooting club were ill which diarrhoea, vomiting and fever within 72 h – an attack rate of 76 per cent (Fig. 1). Only two (5 per cent) were notified as

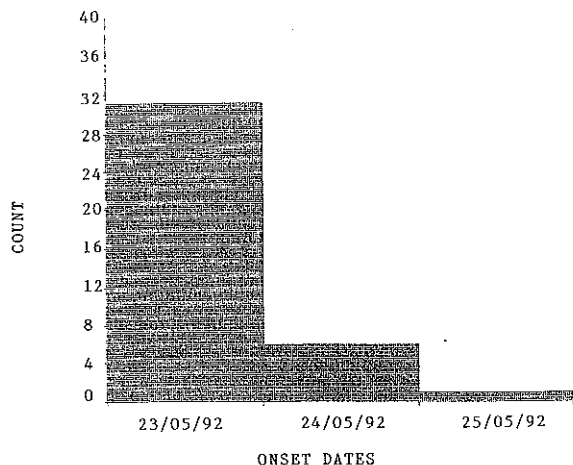


FIGURE 1 Histogram showing dates of onset.

food poisoning. The cases were aged between 30 and 50 years, and all were in full-time employment. After the party, the attendees took home extra food in doggy bags and preserved it in the fridge. Analysis of the food histories strongly suggested chicken as the source (RR = 6, C.I. 1.7-21.2). This was confirmed by isolating *Salmonella virchow* of identical phage types from the chicken portions and faecal specimens of the notified cases. The local borough was approached by the victims to initiate legal proceedings against the supplier. This ended with the defendant pleading guilty and an out-of-court settlement for a large sum.

Survey to find out reason for non-notification

Questionnaires were sent to 36 attendees who were ill but not notified. Eight choices of answers were given: not ill enough, did not wish to bother general practitioner (GP), difficulty in obtaining an appointment, too busy to see GP owing to work and other commitments, did not wish to blame the club, self treated with fluid and soft diet, fear of social stigma and any other reasons for not reporting illness. Thirty (83 per cent) responded. Only four (14 per cent) contacted their GPs but were neither notified nor screened. The remaining 26 (87 per cent) stayed off work but did not report to their doctor on the grounds shown in Table 1.

Discussion

The cohort, though small, was well defined. The information obtained during the investigation was highly reliable, as it could be corroborated by other members of the cohort. The fact that a short spell of sickness absence did not require a doctor's note deprived the doctors of the opportunity to notify cases. Several papers have blamed doctor's ignorance as the principal cause of failure to notify.³⁻⁵ That may be true. However, this survey shows that patients should also be educated to report illness to their doctors early.

TABLE 1 Reasons for not reporting illness to GP

Reason	Number	Percentage
Decided self-treatment	16	53
Did not wish to bother doctor	13	43
Difficulty in obtaining appointment	6	20
Thought trivial illness	6	20