sperm. There should be a mandatory quarantine storage and, even more important, the semen should not be used until the donor is retested for HIV-1 6 months after the donation, and proven to be HIV-1 antibody negative.[2]

*R S Ross, M Elgas, *M Roggendorf*

Institute of Virology, Essen University Hospital, D-45122 Essen, Germany, (email: roggendorf@uni-essen.de)

1 Matz B, Kupfer B, Ko Y, et al. HIV-1 infection by artificial insemination. *Lancet* 1998; **351:** 728.

2 Centers for Disease Control and Prevention. Semen banking, organ and tissue transplantation, and HIV antibody testing. *MMWR Morb Mortal Wkly Rep* 1988; **37:** 57–58.

Isoniazid versus rifampicin and pyrazinamide for prevention of tuberculosis in HIV-1 infection

Sir—We question the use of short-course rifampicin and pyrazinamide for tuberculosis prevention in developing countries that Neal Halsey and colleagues (March 14, p 786)[1] report. The use of such a regimen outside a research setting, without a careful investigation to exclude active tuberculosis, without supervised treatment, without home visits, and without incentives such as the monthly nutrition supplements could lead to rifampicin resistance.

With the increasing tuberculosis burden in developing countries this is a risk we cannot take. Even in regions with a high HIV-1 seroprevalence, the traditional tuberculosis-control strategies—improving compliance with short-course rifampicin regimens, directly observed treatment, and improved case finding—should remain the cornerstone of control programmes. Community-wide screening for HIV-1 followed by tuberculosis prophylaxis could even be counter productive because it may increase stigmatisation, is costly, and will certainly overstretch poor health-care delivery systems.

A rifampicin and pyrazinamide tuberculosis regimen for individuals with HIV-1 infection in developed countries is also questionable, because the use of rifampicin is contraindicated in people treated with protease inhibitors.[2]

**R Colebunders, E Florence*

Department of Clinical Sciences, Institute of Tropical Medicine, B2000 Antwerp, Belgium

1 Halsey NA, Coberly JS, Desormeaux J, et al. Randomised trial of isoniazid versus rifampicin and pyrazinamide for prevention of tuberculosis in HIV-1 infection. *Lancet* 1998; **351:** 786–91.

2 Centers for Disease Control and Prevention. Clinical update. Impact of HIV protease inhibitors on the treatment of HIV-infected tuberculosis patients with rifampicin. *MMWR* 1996; **45:** 921–25.

Increase of allergy in East Germany

Sir—Erika von Mutius and colleagues (March 21, p 862)[1] report that the prevalence of positive skinprick tests (SPT) and allergic rhinitis increased between 1991–92 and 1995–96 in East German schoolchildren.

We did a similar study in three rural areas 100 km from Leipzig in 1992–93 with 769 children aged 5–7 years (response rate 84·0%) and in 1995–96 with 725 children of the same age-group (response rate of 74·6%).[2] Because of difficulties with the standardisation of the Stallergènes multitest device used in von Mutius' study with insufficient quality-control information from the manufacturer, visible colour differences and variable radioallergosorbent-test (RAST) inhibition between different precoated batches,[3] we decided to use a serum RAST test for the cross-sectional comparisons. All frozen serum samples were analysed at the end of the second survey by the CAP-FEIA system for specific IgE with the same reagents (table). SPT and RAST seem to be interchangeable for a diagnosis of allergic diseases, whereas individual specific serum concentration of IgE may not always correspond to SPT reactivity.[4]

Physician-diagnosed asthma did not increase significantly, but there was a significant increase in the prevalence of any physician-diagnosed allergic diseases. However, we found no increase in hay fever, allergic symptoms, or serum markers. Thus, we believe that a real increase in the prevalence of allergic diseases is unlikely at the moment. The observed increase in the prevalence in physician-diagnosed allergic diseases seems more likely to be due to changes in physicians diagnostic patterns and the increased awareness of the public about allergic diseases. Heinrich and colleagues[5] have also reported a similar effect of increased self-reported prevalence of allergic rhinitis in East German adults.

	1992/93	1995/96
Physician diagnoses (ever)		
Asthma	2·9	4·1
Any allergy	10·1	16·5*
Hay fever	2·8	2·6
Bronchitis	56·6	41·8*
Allergy symptoms (last year)		
Conjunctivitis	6·1	6·4
Sneezing	6·8	8·6
Running nose	8·6	10·2
RAST sensitisation (at examination)†		
Dust mite (der p1)	8·8	9·1
Cat	3·7	4·4
Grass pollen	15·4	14·0
Birch pollen	5·7	6·8
Cladosporium	3·1	2·9
At last one allergen	22·1	20·3

Prevalence in % (number of children/those with data). *p<0·001. †RAST class ⩾2 (0·70 kU/L) used. Similar results were obtained for RAST class ⩾1 (0·35 kU/L).

Allergy in East Germany

**Joachim Heinrich, Matthias Wjst*

Institut für Epidemiologie, GSF Forschungszentrum für Umwelt und Gesundheit, D-85764 Neuherberg, Germany (e-mail: joachim.heinrich@gsf.de)

1 von Mutius E, Weiland SK, Firtzsch C, Duhme H, Keil U. Increasing prevalence of hay fever and atopy among children in Leipzig, East Germany. *Lancet* 1998; **351:** 862–66.

2 Wjst M, Trepka MJ, Wellmann J, Heinrich J, Stiller-Winkler R, Wichmann HE. Serum immunoglobulin level and skin prick test response. *Eur J Med Res* 1997; **2:** 177–81.

3 Wjst M, Reitmeir P, Dold S, et al. Road traffic and adverse respiratory health effects of children. *BMJ* 1993; **307:** 596–600.

4 Kelso JM, Sodhi N, Gosselin VA, Yunginger JW. Diagnostic performance characteristics of the standard Phadebas RAST, modified RAST, and pharmacia CAP system versus skin testing. *Clin Exp Allergy* 1990; **20:** 175–79.

5 Heinrich J, Richter K, Magnussen H, Wichmann HE. Is the prevalence of atopic diseases in East and West Germany already converging? *Eur J Epidemiol* 1998; **14:** 239–45.

Sir—Many studies have been done to analyse the increasing prevalence of atopic diseases, but a satisfactory explanation still has not been found. On the basis of a recent cross-sectional study of schoolchildren from East Germany, Erika von Mutius and co-workers[1] present some interesting data. They claim that the development of atopic sensitisation and hay fever is affected by environmental factors that occur after infancy. However, the study's methods merit further discussion and the investigators' conclusions cannot be absolutely confirmed.

To understand the potential effects of variables that affect the prevalence of atopic disorders, a prospective cohort study would be most suitable.[2] The study by von Mutius and co-workers is limited because of the two different study populations with different sample sizes. Furthermore, they provide no information about the, possibly increasing, prevalence of hay fever in schoolchildren from West Germany during the observation periods. These baseline data would make it possible to