financial saving" that they refer to is not nearly as large as they suggest.

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SIR,—Your readers might like to know what impact this clinic made on the general practitioners and their patients in the area. When the service started we received a short card stating briefly that "there is now a colposcopy department at the Royal Northern Hospital to deal with abnormal smears." Shortly afterwards general practitioners began to receive much modified cervical cytology reports referring to "dysplasia," "koilocytosis," "dyskeratosis," and some containing the added suggestion "Colposcopy referral recommended." We were besieged by anxious patients who wanted to know what the "dysplasia" was and what to expect at the clinic. It was a most harrowing experience for any woman to be told that an abnormality had been found on the cervix which would need colposcopic assessment, and that her appointment was to be in six weeks' time. Quite soon some of our patients were destined for "laser ablative therapy," and again had to wait several weeks.

As time went by letters from the hospital began to acquire some meaning, there was a lecture by the consultant, and GPs began to comprehend the ease with which cervical pathology could be assessed and the treatment tailored to the patient's needs. Many of our patients had their carcinomas in situ evaporated by the laser in less than 10 minutes, as outpatients and without general anaesthesia, with a cure rate of 95%. This was most welcome and we are very grateful for the clinic. We hope there will be many more throughout the country, but please remember when setting up a clinic to devise an informative letter about the clinic for the referring doctors and their patients.

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Colposcopy and ablative therapy

SIR,—I was disappointed with the discussion on local ablative therapy in the leading article by Dr J Elizabeth Macgregor (20 October, p 1024). Although she emphasised the importance of long term follow up as the only way to justify local ablative therapy, many of the references included only short term follow up of patients. The outstanding exception, unfortunately omitted, is Chanen's series from Melbourne, in which he used electrodiathermy after colposcopy, on a day case basis. Results have been published of a 15 year follow up (1966-81), with a 97·3% cure rate.[1] This method is safe and proved to be effective by the length of the follow up. Laser therapy has yet to achieve these results, and a word of caution is necessary amid the euphoria of your leading article. At Barnet General Hospital we have followed the Chanen regimen since 1976 without cause for regret, but our follow up is relatively short (eight years).

Incidentally, no one has to wait for more than one week to be seen in the colposcopy clinic. One of the reasons for this is that treatment is not carried out in the clinic—just diagnosis—and arrangements are made thereafter for day case diathermy destruction when the results of repeat smears and biopsies are available.

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1 Chanen W. Electrocoagulation diathermy for cervical dysplasia and carcinoma in situ—a 15 year survey. *Obstet Gynecol* 1983;**61**:673-9.

"Are you doing your job?"

SIR,—As a general practitioner in a district of London where there are people of many races, I assume that the advertisement on the second page of last week's *BMJ* (10 November, clinical research edition) is aimed at me. Comments from my colleagues in the past few days tell me that I am not alone in finding it dishonest and offensive.

"All the evidence shows that ethnic minorities are regularly denied access to treatment by the health service." Does it? Are immigrants being turned away by hospitals and general practitioners? To what evidence does the advertisement refer? I know of none, but it is relevant that a recent and thorough study of the question of access to doctors in London showed that of the few people who had problems in finding a doctor, coloured people actually fared better that whites in this respect.[1]

"If you take no account of your patient's [sic] religious customs or diets, how can you treat them effectively?" asks the anonymous advertiser. The answer is that you cannot; but who does not take account of them so? The advertisement contains several questions like this, all implying that doctors in London treat immigrants badly. This is grossly unfair to the doctors in hospital and in the community who are working hard to deal with the complex problems—medical and social—of patients from abroad. Being on the district management team for Tower Hamlets and the family practitioner committee for East London, I know of the great amount of time and effort devoted to catering for the special needs of these patients. Apart from hundreds of daily consultations, we have notices, leaflets, audiotapes, and videotapes in various languages, special antenatal classes, and so on.

We doctors, nurses, and administrators in London do not expect praise for our work but we do ask that we should not be offered a gratuitous insult by a whole page of the *BMJ*. (Incidentally, this is the only advertisement in the journal which does not give the name or address of those responsible for it.)

JAMES N DOCHERTY

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1 Bone M. *Registration with general medical practitioners in inner London.* London: HMSO, 1984.

**The advertisement was placed by the Greater London Council as part of its anti-racism campaign.—ED, *BMJ*.

AIDS: an old disease from Africa?

SIR,—I would like to reply to some of the thoughtful points raised by Dr R Colebunders and others (22 September, p 765) in response to my article (4 August, p 306). No certainty exists about the origin of the acquired immune deficiency syndrome (AIDS). The causative agent, however, must have come from somewhere, and the discovery of its origin would greatly increase our understanding of the syndrome. That AIDS is an African disease is a more plausible hypothesis than any other that has been proposed. The Belgian workers must see at least some merit in it, or they would not be carrying out such extensive research on AIDS in central Africa.

It is true that only a few cases of possible AIDS in Africans were reported before the current Western epidemic.[1 2] This is inevitable, since the syndrome has only recently been defined, and retrospective diagnosis is fraught with difficulty. Nevertheless, these early African cases of opportunistic infections in previously healthy people sound very much like real cases of AIDS. Such cases would not have gone unreported in the West. Without well documented cases elsewhere, it is difficult to see how AIDS could have been introduced into central Africa from outside.

Sporadic cases of obscure infections such as central nervous system cryptococcosis have certainly occurred world wide. There is a great difference, however, between occasional and isolated cases of unusual infections and the current epidemic of AIDS. To suggest that isolated instances of cryptococcosis might have been cases of AIDS is speculative. Again, the question arises: where would such infections with the AIDS agent have come from? Apart from their geographical links with the current African outbreak, the early African cases were also characterised by multiple opportunistic infections rather than individual ones.[1 2]

Dr Colebunders and his colleagues comment that AIDS in Rwanda has been recognised most often in an urban environment.[3] Sexual promiscuity and prostitution seem risk factors. These observations do not exclude a rural origin for the disease. Hospitals in developing countries are often concentrated in urban centres, and epidemiological conclusions drawn from hospital records can be notoriously misleading. It is easy to see how promiscuity and prostitution could amplify the spread of a sexually transmitted disease like AIDS within a city population. The epidemics of AIDS in Kinshasa[4] and Kigali[3] may be new phenomena, but that simply suggests that the AIDS agent has only recently entered these cities. Yellow fever offers an example of a condition with a rural origin which can produce epidemics in urban populations.

Too much may have been made of the fact that most Western patients with AIDS are homosexuals. A virus is unlikely to infect selectively on the basis of race, nationality, or sexual preference. The risk factors for AIDS are not being homosexual, African, or Haitian; they are having sexual intercourse with, or being exposed to blood from, another individual infected with the AIDS agent. A high carrier rate of hepatitis B virus infection among male homosexuals is the result of sexual promiscuity within an enclosed ecosystem, as well as male predisposition to becoming a carrier. It does not result simply from homosexuality. Your correspondents' suggestion that homosexuals may have introduced AIDS into Africa seems improbable. Homosexuality has existed throughout history, but the AIDS epidemic is new. It is more likely that the AIDS agent has recently gained entry into the homosexual community, and that homosexual practices have since then amplified its spread.

The Belgian workers comment that classical Kaposi's sarcoma is clinically, immunologically, and epidemiologically different from the more aggressive variety seen in AIDS. With their extensive African contacts they have experience and information not generally available, but I am aware of only one published report on the relation (if any) between classical Kaposi's sarcoma and AIDS.[5] Reports from Zambia suggest that aggressive Kaposi's sarcoma is being seen more often,[6] and that Zambian patients with the tumour have reversed ratios of T helper to T suppressor cells.[5] Some patients, especially children, have always had the aggressive variety of Kaposi's sarcoma,[7] and immunological abnormalities have been noted in such cases.[8 9] Studies to establish the relevance of classical Kaposi's sarcoma to AIDS should have a

high priority. Your correspondents observe that the prevalence of Kaposi's sarcoma in African AIDS is lower than in homosexual patients. The same is true when one compares AIDS in American heterosexuals and children with that in homosexuals.[10]

My final point is more general. Kaposi's sarcoma was described in Africa as early as 1934,[11] and its high incidence is well documented.[1 2] It is a poor reflection on the outlook of Western medicine that it took an outbreak of a relatively small number of cases in American homosexuals for anyone to take any notice. The AIDS epidemic is yet another illustration of the importance of the study of geographical medicine. With their historical connections in central Africa, the workers from the Institute of Tropical Medicine in Antwerp are in a unique position to carry out important investigations. We should wish them well, and await their findings with interest.

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End of static decade for coronary heart disease?

SIR,—Geoffrey Cannon (29 September, p 833) declares that high consumption of refined sugars represents a public health problem, seemingly in the major context of cardiovascular disease. The association made by Yudkin between *sucrose* consumption and cardiovascular disease[1] has been refuted almost as many times as experts have reviewed the evidence,[2] but Mr Cannon now appears to be asserting that total consumption of refined sugars is associated with cardiovascular disease or some other health problem.

Firstly, Mr Cannon has previously said about sugar consumption, "On average every British man, woman and child eats 100 lb of processed sugars every year."[3] As he now apparently acknowledges, this is absurd, since considerably more sugar—that is, the 100 lb referred to—enters the food supply than is actually eaten. Sugar used in the fermentation industries and in home brewing is consumed predominantly as alcohol, and substantial sugar losses occur, particularly in food manufacturing, in catering establishments, and in the home. These energy losses in food supply are general and do not relate to sugar alone.[4] Sugar entering the food supply through imported goods is almost completely offset by that in exported foods. Assessment of actual consumption of refined sugars is not straightforward, but the available data suggest that in most developed countries, including the United Kingdom, they account for some 10-15% of calories. Individual intakes will vary, but at these levels the average intake would be about 75 lb per person per year.[2 5]

Secondly, data from other countries belie an association between consumption of sugars and heart disease. In Mr Cannon's own words, "In the last 15 years, the rate of death from heart disease in the USA (and Australia) has decreased by more than 25%,"[3] but, as in the UK, total consumption of refined sugars (as judged by disappearance) has remained static in both countries over this period at or above UK levels (Australian Sugar Industry Associations, Brisbane).[6]

Thirdly, there are no differences between the biochemical utilisation of refined and naturally occurring sugars,[7] and in a free living population groups with high and low sugar consumption have been shown to have equivalent intakes of vitamins and minerals.[5] It could be argued therefore that any proposed sugar content labelling should apply to all foodstuffs, which incidentally would mean that virtually all fruits and some vegetables would have to be classified as "high sugar."[8] Food composition tables show that grapes, grapefruit, melons, and oranges all contain more than 95% of their energy as sugars.

In the salt-hypertension debate Brown *et al* have harsh words for those engaged "in an evangelistic crusade to present a simplistic view of the evidence which will prove attractive to the media."[9] One wonders whether Mr Cannon's past and present comments on refined sugars should be regarded in this light.

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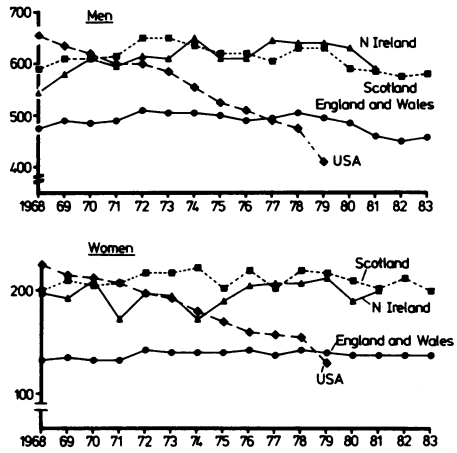
SIR,—Professor Philip R J Burch (27 October, p 1142) has pointed out that coronary death rates in England and Wales fell between 1979 and 1983. We have noted similar trends in Scotland and Northern Ireland. These are shown in the figure as age standardised rates for men aged 40-69 years using the European standard population,[1] which was used previously to investigate trends in cardiovascular mortality.[2] This figure also shows that death rates fluctuate from year to year so that the importance of a fall over a short period, five years, should not be overemphasised. None the less, the occurrence of a simultaneous fall in mortality among men in the countries of the United Kingdom suggests that this is not simply year to year fluctuation. The analogous data for women indicate that, for this age group, the decline is much less pronounced than that for men (figure).

The long term time trends have to be interpreted with some care because of the change from the eighth to the ninth revision of the International Classification of Diseases in 1979. Thus, it is possible that the disproportionately large fall seen in the American



Death rates (standardised mortality rate per 100 000 population) for ischaemic heart disease in men and women aged 40-69.

rates in 1979 could be, in part, due to the changes in coding practices between the two revisions. In particular, cardiovascular arteriosclerosis was transferred out of the coronary heart disease codes 410-414 in the ninth revision so that some fall in coronary disease death rates is not unexpected. Nevertheless, although it is curious that the fall in death rates from coronary heart disease in the United Kingdom started after the adoption of the ninth revision, it is difficult to see how this could account for the trend. We suggest that the recent trends in coronary death rates in the UK should be interpreted with caution. Although a decrease is beginning to become apparent, it would be preferable to await data from subsequent years before concluding that a downward trend had been established.

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1 International Agency for Research on Cancer. *Cancer incidence in five continents.* Vol 3. Lyon: IARC, 1976:456.
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Marketing policies for neuroleptic drugs

SIR,—I would like to bring to the attention of your general practitioner, neurologist, and psychiatrist readers an anomaly in the marketing policies of the manufacturers of neuroleptic, anticholinergic, and modern anticonvulsant drugs—viz, that the manufacturers seem deliberately to refrain from actively promoting these products to GPs. I asked all the major neuroleptic manufacturers (nearly all of whom replied) and the companies producing anticholinergics and valproate and carbamazepine about their policies; they were unanimous in confirming that they send no literature or representatives to GPs unless the GP asks for it. They publicise these particular wares only to hospital doctors.

This policy is not only anachronistic but also potentially dangerous. Most psychotic patients are no longer in hospital, and it is probable, given the steadily falling admission