

are already under considerable pressure. Apart from the need to give additional support to primary care, there is likely to be an increase in workload resulting from improvement in primary care of diabetes because this generally causes an increase in referrals to secondary care.<sup>4</sup> The recently published Diabetes National Service Framework is also likely to generate more referrals as a result of the increased pursuit of quality targets.

Thus, ABCD believes that to achieve Streets' proposed adjustment of roles and skillmix will require a substantial and rapid increase in consultant numbers. This will depend on an immediate increase in the number of specialist trainees. Whilst ABCD welcomes this year's increase in the number of National Training Numbers allocated to Endocrinology and diabetes, we are disappointed that most are unfunded, which will lead to difficulties in placing trainees in many of the best training centres. Moreover, even if all the posts are successfully established, the number is too small and the training programme too long to make a significant difference in the short term, if ever.

Thus, it seems to us that it is most unlikely that there will be enough consultants to support these primary care initiatives and that there is a real risk of two standards of practice developing which could adversely affect patient care. We would urge caution and wish to emphasise the importance of the preservation (and strengthening) of existing specialist services because we believe that this is crucial if we are to avoid the evolution of lower quality care for many of our diabetic patients.

#### References

- 1 Winocour PH, Ainsworth A, Williams R. Association of British Clinical Diabetologists (ABCD) survey of secondary care services for diabetes in the UK, 2000. 1. Methods and major findings. *Diabet Med* 2002;**19**: 327–33.
- 2 Williams DRR, Baxter HS, Airey CM, Ali S, Turner B. Diabetes UK funded surveys of the structural provision of primary care diabetes services in the UK. *Diabet Med* 2002;**19** (Suppl.4):21–6.
- 3 Pierce M, Agarwal G, Ridout D. A survey of diabetes care in general practice in England and Wales. *Br J Gen Pract* 2000;**50**:542–5.

- 4 Foulkes A, Kinmonth A-L, Frost S, Macdonald D. Organised personal care – an effective choice for managing diabetes in general practice. *J R Coll Gen Pract* 1989;**39**:444–7.

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#### Diagnosing HIV infection

Editor – I enjoyed reading Susan Forster's well-written article in the CME Section on Genitourinary Medicine (*Clin Med* May/June 2003, pp 203–5). However, I feel that her suggestion to consider HIV infection in the context of a diagnosis of lymphoma needs further clarification.

The incidence of non-Hodgkin's lymphoma (NHL) is indeed 60 to 200 times higher in patients with AIDS.<sup>1</sup> However, such an association is restricted specifically to high- and intermediate-grade histological types, rather than to NHL as a whole. Such patients are more likely to exhibit extra-nodal involvement.<sup>2</sup> Furthermore, there are particular lymphomas which show a striking correlation with HIV/AIDS, such as primary cerebral lymphoma (1,000-fold increase compared with background population rate<sup>3</sup>), Burkitt's lymphoma, Burkitt-like lymphoma and large B-cell lymphomas.<sup>4</sup> There is also increasing recognition of unusual types, such as the human herpes virus 8 (HHV-8) associated primary effusion lymphoma.<sup>4</sup>

To a lesser extent (up to eight-fold relative risk) there is an association between HIV infection and Hodgkin's disease.<sup>4</sup>

Common to all forms of HIV-associated lymphoproliferation is a comparatively worse prognosis than for immunocompetent patients.<sup>2,4</sup> This relates not only to the fact that the lymphoma is more likely to be at an advanced stage at diagnosis,<sup>4</sup> but also that such tumours are often a late manifestation of HIV infection. Given the survival benefit of highly active antiretroviral therapy (HAART) to HIV infected patients, it is likely that the incidence of AIDS-related lymphoma will increase with time. However, what seems less certain

presently is the impact HAART will have on survival of AIDS patients with lymphoid malignancy.<sup>2</sup>

In summary, whilst I endorse Dr Forster's views on heightened awareness amongst physicians of HIV-related illnesses, I feel that HIV screening can only be justified in patients with lymphoma whose disease fits into the above histological and clinical categories.

#### References

- 1 Biggar RJ, Rabkin CS. The epidemiology of AIDS-related neoplasms. *Haematol Oncol Clin North Am* 1996;**10**: 997–1010.
- 2 Tulpule A, Levine A. AIDS-related lymphoma. *Blood Rev* 1999;**13**:147–50.
- 3 Knowles DM. Epidemiology and pathogenesis of AIDS-related non-Hodgkin's lymphoma. *Haematol Oncol Clin North Am* 1996;**10**:1081–109.
- 4 Bain BJ. Lymphomas and reactive lymphoid lesions in HIV infection. *Blood Rev* 1998;**12**:154–62.

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#### In response

I absolutely agree that it is essential to perform HIV testing in patients who have the form of lymphoma which Dr Murrin describes. Many physicians would also at least consider an HIV test in any malignancy where the presence of HIV infection would influence the management or prognosis of the malignancy, or where a less strong association with HIV infection has been suggested, eg anal cancer, cervical cancer, various skin and testicular tumours, myeloma and adenocarcinoma of the lung. My impression is that as our patients (fortunately) live longer as a result of antiretroviral treatment, this will become increasingly important. There are very few patients for whom a negative HIV test will do them harm, whereas missing a diagnosis of HIV infection may have devastating consequences.

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