

letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by email to: Clinicalmedicine@rcplondon.ac.uk

Antituberculosis drug resistance

Editor – Chapman's excellent editorial on tuberculosis (TB) drug resistance is a salutary reminder that this is likely to be an increasing problem (*Clin Med* October 2008 pp 478–9). It does, however, beg the question as to how a clinician is to manage such cases. The problem with drug resistant TB is that it is still relatively uncommon. Individual clinicians will therefore have little experience in managing cases. To help this situation, the Multi-Drug Resistant Tuberculosis (MDR-TB) Service has been established at the Cardiothoracic Centre in Liverpool and has been operational since 1 January 2008. The service has the support of the relevant professional bodies, including the British Infection Society, the Department of Health and the Health Protection Agency. Funding for this service has been provided by an unrestricted educational grant from Genus Pharmaceuticals. Essentially it is an electronically linked instant reaction expert group, which includes chest physicians, infectious disease physicians, paediatricians, public health specialists and microbiologists, who can give advice and direct management of cases across the country. It has already done so in some 26 cases from across the UK. By helping clinicians in the management of cases of drug resistant TB this national service offers our best hope in overcoming the increasing problem of drug resistance until new drugs become available. The Baltic states have operated a similar system for some years with good success in reducing their cases.

The second function of the service is to collect data on all cases of multidrug resistant TB identified in the UK, with a view to developing a consensus on the most effective methods of treatment in this emerging area. The data collection will also help assess patient outcomes. The service can be contacted by email (MDRTBservice@lhch.nhs.uk) or by phone (0151 600 1427).

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A life in the day of Mrs W

Editor – David Kerr's paper captures perfectly the experience of many patients in the modern health service (*Clin Med* October 2008 pp 515–6). It is reminiscent of the recent Romanian film *The Death of Mr Lazarescu* in which a dying patient is kept on a trolley overnight and shunted around several different anonymous hospitals. The huge concern is that our focus has been taken off the obvious – patient care. Commonsense has increasingly been pushed aside in our protocol-driven, production line approach to hospital treatment in the 21st century.

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Following the publication of 'A life in the day of Mrs W' the Editorial Office received the following letter from a member of the Patient and Carer Network who has experience as a national charity chief executive.

I have recently been involved as a relative during the last three months of the life of my 91-year-old mother. She had a stroke some five years ago followed by a vascular dementia and had been in a care home for two years. In March 2008 she sustained a fractured hip requiring two operations with multiple complications including pneumonia, myocardial infarction and *Clostridium difficile*. She developed renal failure, bed sores and couldn't eat or drink. It was agonising to watch someone you love suffer in such pain and distress

My reason for writing this letter is to highlight two issues. I have no complaints about her nursing care but what I do find difficult to understand is the lack of communication with the medical staff looking after her. On no occasion did I or my sister receive any information without first arranging an appointment. We did this on two occasions but with different consultants at different stages of her illness. Surely communication with relatives should be of paramount importance when a person is at the end of their life? One needs to know the situation, what can and can't be done. Just a little time and consideration can mean a great deal but it seems that no time is allocated for this important function. I live a distance away and was visiting about three times a week, therefore it was important to me to find out as much as I could.

Towards the end I asked for an appointment to see the consultant to discuss the situation. He was very understanding. My main concern was why were they still treating my mother when the end was near and she was asking to die? He explained that they were prolonging the inevitable. My sister and I both agreed that we just wanted Mum to be pain free and have a dignified death. He agreed and a Macmillan nurse came to look after her. She was put on a morphine pump with no other medication other than for her diabetes and any plan to force feed her was abandoned.

She died quietly three days later. I know that each consultant has a large case load, but I do feel that relatives should be involved in any decisions of this nature but how can they without close communication with the medical team? There should be dignity in death with each person being treated individually. A treatment plan could have been made much earlier if someone had listened to us. Mum and her next of kin could have avoided so much pain and distress.

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The significance of early HIV testing (1)

Menezes *et al* present a salutary lesson of the month regarding the consideration of early HIV testing (*Clin Med* October 2008

pp 550–1). However the discussion around HIV risk factors is somewhat flawed. In their paper they refer to intimate family members as separate to sexual partners implying that HIV is transmitted by close family contact other than sexual intercourse. This is unlikely, for example once mother to child transmission during pregnancy has been ruled out we do not consider children to be at continued risk from normal day to day intimate contact with their infected parents. There have been isolated cases of transmission between siblings and non-sexual family members, but these are few and far between.¹ The authors suggest that the patient was infected during a period of time when she was caring for her sister who, unbeknown to her, was dying of an AIDS-related illness. This would be an unlikely method of HIV transmission. Acquisition of HIV by caring for a family member with the virus, even when not taking any precautions for intimate caring activities, is extremely rare.^{2,3}

In a significant minority of people diagnosed with HIV in the UK it is difficult to ascertain an obvious risk factor.⁴ It is most likely that a seemingly low-risk sexual partner did, in fact, have a high risk and was HIV positive. By incorrectly classifying this patient's risk for HIV the authors miss the real point about early HIV testing, which is that the decision whether to test should not be based on a history of risk factors but rather on whether the symptoms or condition being investigated could be HIV related. If one constantly asks oneself could this be HIV related and tests patients irrespective of the presence of risk factors (with their consent) then we will start to make some headway in the quest to diagnose HIV infection earlier.

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References

- 1 French MA, Herring BL, Kaldor JM *et al*. Intrafamilial transmission of HIV-1 infection from individuals with unrecognized HIV-1 infection. *AIDS* 2003;17:1977–81.
- 2 Courville M, Caldwell B, Brunell PA. Lack of evidence of transmission of HIV-1 to

family contacts of HIV-1 infected children. *Clin Pediatr (Phila)* 1998;37(3):175–8.

- 3 Biberfeld G, Bottiger B, Berntorp E *et al*. Transmission of HIV infection to heterosexual partners but not to household contacts of seropositive haemophiliacs. *Scand J Infect Dis* 1986;18(6):497–500.
- 4 Health Protection Agency. *United Kingdom HIV new diagnoses to end of June 2008*. London: HPA, 2008.

The significance of early HIV testing (2)

Editor – The recent lesson of the month by Menezes *et al* raises a number of issues (*Clin Med* October 2008 pp 550–1). Clearly, early consideration of HIV infection as a possible diagnosis is vital in unusual, undiagnosed cases if one is to prevent severe and serious consequences. This becomes even more important in a non-genitourinary setting, as in this case, and I am pleased to note that the authors emphasise this in their paper.

The article highlights the fact that while HIV may be an early consideration in certain marginalised groups and in individuals with certain behaviours, it still needs to be explored in cases with no obvious risk factors or in those who deny risky sexual behaviour. Clinicians need to take a non-judgemental and empathic approach to differing lifestyles when offering HIV testing and not an exceptional one as this creates further barriers. Non-HIV specialists challenging the exceptionalism associated with HIV testing will further allay patients' fears and concerns (which are real) and hopefully stop perpetuating the discrimination and stigma associated with an HIV diagnosis.

I am, however, disappointed that the authors made little attempt to trace the source of their patient's infection, concentrating instead mainly on the neurological issues. I am also concerned that disclosing the HIV status of the patient's sister and the fact that the patient cared for her during the terminal stages of her (sister's) illness, seems to suggest that the patient's HIV infection may have been contracted from her sister! This simply perpetuates one of the vast plethora of myths surrounding HIV infection. Equally disappointing is that no mention is made of whether the HIV specialist team was involved post-diagnosis. Something that may have happened years ago and been forgotten or something

that the patient is in denial about or genuinely unaware of, always remains a possibility. Though rare, these instances do occur and highlight the need to involve the specialist team post-diagnosis who ensure that risk assessment and partner notification/contact tracing is dealt with in an appropriate manner. This, we know, is extremely important to prevent further transmission.

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In response to both letters

The main objectives of our lesson were to focus on the need for early HIV testing in those patients with an unusual disease course, whether in a neurological or general medical setting, even in the case of an initial denial of a specific risk factor, and to emphasise the prolonged diagnostic course and the delay in management that can result in its absence.

I have been made aware as a result of the responses obtained in relation to our article that our lesson seemed to suggest that our patient had contracted HIV infection by caring for her sister who had died of AIDS and that no source-tracing had been performed, and for this I, on behalf of all the authors of the article, would like to apologise. However, I have to state that the regional HIV specialist team was involved once our patient's diagnosis was confirmed and an attempt to trace the source of the infection was indeed made. This revealed that the patient had been, at some point, in sexual contact with her sibling's spouse (who had been HIV positive at the time) and had contracted the disease sexually and not by caring for her ailing sister as our article seemed to suggest.

I would also like to take this opportunity to reiterate that in such a setting, the absence of an early HIV test might result in a prolonged and tortuous investigatory course, a delayed definitive diagnosis and a delay in treatment of HIV/AIDS and its associated conditions.

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