

that were related to ciprofloxacin by the treating doctors (personal communication). Apart from the seven patients reported here, we are also following up three patients who received ciprofloxacin inadvertently during the first trimester of pregnancy; one of these women has delivered a healthy baby who has had normal linear growth for first 6 months. Although we cannot make any definite conclusions from our limited data, we believe use of ciprofloxacin in patients with MDREF in second-trimester and third-trimester pregnancies may be justified when no clearly safe and effective alternative is available.

Parvaiz Ahmad Koul, Javed Iqbal Wani, Abdul Wahid
Department of Internal Medicine, Institute of Medical Sciences, Soura,
Srinagar 190 011, Kashmir, India

- 1 Koul PA, Quadri MI, Wani JI, Waheed A, Shaban M. Haemostatic abnormalities in multidrug resistant typhoid fever. *Acta Haematologica* (in press).
- 2 Karande SC, Kshirsagar NA. Adverse drug reaction monitoring of ciprofloxacin in pediatric practice. *Indian Pediatr* 1992; 29: 181-88.
- 3 Schuller G. Ciprofloxacin: oxicoloc evaluation of additional safety data. *Am J Med* 1989; 87 (suppl 5A): 37S-39S.
- 4 Buth N, Shah GN, Raina V. Critical limits for birthweight and placental weight. *J Biol Chem Res* 1990; 9: 424-29.

Evidence for HIV-1 group O infection in Nigeria

SIR—Dada and colleagues (June 3, p 1436) report that no HIV-1 group O infection was found in Nigeria. We report here the preliminary data of a study in the Cross River state in Nigeria. This region, one of 30 Nigerian states, is located in the south-eastern part of the country and borders Cameroon. Most HIV-1 group O infections have been reported from Cameroon and a few cases from Gabon.^{1,3}

Between 1992 and 1994, a total of 2083 serum samples were obtained for a sentinel surveillance study from pregnant women, patients with tuberculosis, infectious diseases, sexually transmitted disease, and commercial sex workers. Of these samples 183 were positive for HIV—ie, a positive reaction with the Wellcozyme HIV-1/HIV-2 test (Murex Diagnostics, UK) and HIVCHECK (Ortho Diagnostics, USA) tests; 87 were indeterminate for HIV antibodies—ie, only antibodies to gag and/or pol proteins by western blot; and 1813 were negative for HIV. All samples were tested for the presence of HIV-1 group O antibodies by an ELISA based on synthetic peptides derived from the V3 loop of the envelope proteins representing group O viruses (ANT70 and MVP5180).^{1,2} Samples reactive by ELISA were retested in a line immunoassay (LIA), in which different biotinylated V3 peptides (consensus, MAL, ANT70, VI686 [a Gabonese HIV-1 group O isolate⁴], and MVP5180) were applied as a Streptavidin complex in parallel lines on nylon strips (Innogenetics, Belgium). Samples reactive in ELISA and LIA were also retested on a specific western blot for the presence of antibodies to gp120 of HIV-1 ANT70, as previously described.³ 12 of the 2083 serum samples were reactive in the V3 ELISA; ten had optical density (OD) values around the cut-off, and only two had a higher OD value (OD/cut-off ratio 3.5). The ten weakly reactive samples showed no reaction with the group O V3 peptides in LIA. One of the two other reactive samples had a reaction with the ANT70 peptide but reacted simultaneously with the consensus and the MAL peptide and had antibodies to the gp120 envelope proteins on a specific HIV-1 ANT70 western blot. The other serum with a high OD value in ELISA reacted on LIA only with the V3 peptides from group O with a strong reaction to the ANT70 peptide and a

weaker reaction with the VI686 and MVP5180 V3 peptides, which clearly indicates the presence of HIV-1 group O infection. Both samples were from Nigerian AIDS patients.

These preliminary data indicate that, by contrast with Dada and colleagues' report, HIV-1 group O infection is present in Nigeria, especially in the Cross River state. Despite the geographic location of this state, bordering Cameroon, where a prevalence of up to 2% has been reported, we showed that HIV-1 group O prevalence was low. The spread of these viruses in this and other states of Nigeria should be examined to see whether strategies for blood screening and serodiagnosis need modification.

Claire Mulanga Kabeya, Eka Esu-Williams, Eko Eni,
Martine Peeters, Eric Saman, *Eric Delaporte

*Laboratoire Retrovirus, ORSTOM, BP 5045, 34032 Montpellier, France;
Laboratory of Biology, University of Calabar, Nigeria; and Innogenetics, Ghent, Belgium

- 1 Vanden Haesevelde M, Decourt JL, Deleys P, et al. Genomic cloning and sequence analysis of a highly divergent African immunodeficiency virus isolate. *J Virol* 1994; 68: 1586-96.
- 2 Gurtler L, Hauser PH, Eberle J, et al. A new subtype of human immunodeficiency virus type (MVP 5180) from Cameroon. *J Virol* 1994; 68: 1581-85.
- 3 Peeters M, Nkengasong J, Willems B, et al. Antibodies to V3 loop peptides derived from chimpanzee lentiviruses and the divergent ANT-70 isolate in human sera from different geographic regions. *AIDS* 1994; 8: 1657-61.
- 4 Janssens W, Nkengasong J, Heyndrickx L, et al. Further evidence of the presence of genetically very aberrant HIV-1 strains in Cameroon and Gabon. *AIDS* 1994; 8: 1012-13

Surveillance of heterosexually acquired HIV infection and AIDS

SIR—For surveillance purposes, the US Centers for Disease Control and Prevention (CDC)¹ have recently restricted the definition of heterosexually acquired HIV infection: heterosexual contact cases are those who report specific heterosexual contact with a person known to be HIV-infected, irrespective of his(her) exposure category, or with a person at an increased risk of HIV infection—ie, intravenous drug users, male bisexuals, haemophiliacs, or other recipients of HIV-contaminated blood products. People from countries where heterosexual transmission is presumed to be the predominant mode of HIV transmission and those who have sex with a person from such countries are no longer reported in the USA as having acquired AIDS or HIV infection through heterosexual contact. The French Direction Générale de la Santé (DGS) has maintained this last category in the definition of heterosexually acquired HIV infection.²

The impact of various definitions of heterosexually acquired HIV infection has been evaluated in the hospital-based surveillance system of HIV infection in place in Aquitaine, south-western France (2.8 millions inhabitants), since 1985.³ HIV-positive patients aged 13 years or older who give informed consent are reported by the participating physicians, whatever their clinical stage of infection. This system accounted for 84% of the cases of HIV infection diagnosed in the region from 1991 to 1993.⁴ Once reported, all patients are included in the Aquitaine cohort, and all exposure categories are represented. Epidemiological data obtained by interview and from medical records were updated during follow-up. Heterosexually acquired infection were considered according to the CDC definition,¹ the DGS definition,² probable and possible cases, and two sub-categories of the no risk reported or identified category: probable cases are those subjects who report heterosexual



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EDITORIAL

- 259 **The final autonomy**

COMMENTARY

- 260 **US science on the slide** R Horton
260 **Toxic gas trauma** M J World
261 **AMA rewrites tobacco history** A Blum, H Wolinsky
262 **Preventing AIDS: have we lost our way?** A R Lifson
263 **On line for digital mammography** C J D'Orsi, A Karellas
263 **Pott's paraplegia today** J D Miller

ARTICLES

- 265 **Maximum androgen blockade in advanced prostate cancer: an overview of 22 randomised trials with 3283 deaths in 5710 patients** Prostate Cancer Trialists' Collaborative group
270 **Manganese and chronic hepatic encephalopathy** D Krieger, S Krieger, O Jansen, P Gass, H Theilmann, H Bichtenecker
274 **3849+10 kb C→T mutation and disease severity in cystic fibrosis** R C Stern, C F Doershuk, M L Drumm
277 **Donors' attitudes towards body donation for dissection** R Richardson, B Hurwitz

SHORT REPORTS

- 280 **Objective passive-smoking indicators and respiratory morbidity in young children** C G Bakoula, Y J Kafritsa, G D Kavadias, D D Lazopoulou, M C Theodoridou, K P Maravelias, N S Matsaniotis
281 **Association between clozapine response and allelic variation in 5-HT_{2A} receptor gene** M Arranz, D Collier, M Sodhi, D Ball, G Roberts, J Price, P Sham, R Kerwin

GRAND ROUND

- 283 **Raynaud's phenomenon** Report of a Meeting of Physicians and Scientists, University College London Medical School, London

PUBLIC HEALTH

- 290 **Sarin poisoning in Matsumoto, Japan** H Morita, N Yanagisawa, T Nakajima, M Shimizu, H Hirabayashi, H Okudera, M Nohara, Y Midorikawa, S Mimura

PERSONAL PAPER

- 293 **Practising obstetrics and gynaecology in areas with a high prevalence of HIV infection** D A A Verkuyl

Bookshelf

- 296 Antiviral chemotherapy
297 Oxford textbook of sports medicine

News

- 298 Political skies start to brighten for NIH
Insurance reform issue returns to Congress
299 US health policy and research agency fights for life
FDA takes aim at financial bias in research
300 Canada to define essential medical care
ELSI's good for HUGO
Less hassle and paperwork planned for US doctors
301 UK report targets "gender-bending" pollution
India urged to rethink family planning programme
302 WHO begins staff cuts to save \$54 million
Visible man available on disc
Kenya to use crustacean to eradicate bilharzia
Sexual contact between doctors and patients
303 EC changes approach to health and safety
UK Shariah Council approves organ transplants
News in brief
304 **Letters to the Editor**
see contents list inside



PM 18

31 JUL. 1995