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.

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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 isolate[4]], 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.

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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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