

Woestyn and Afschrift's figures may overestimate the true incidence of this finding. In all our 13 patients, the nodules were smaller than the resolving power of the gamma camera (ie, they were less than 1.5 cm). Furthermore, in 6 cases (45%) the nodules previously been revealed on the radionuclide scintigraphy were being followed up.

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TRIAL TO PREVENT FIRST OCCURRENCE OF NEURAL TUBE DEFECTS BY PERICONCEPTIONAL MULTIVITAMIN SUPPLEMENTATION

SIR,—Your June 9 issue (p 1308) carried an account of the launch of the UK Medical Research Council's large international double-blind trial, in which women who have already given birth to a child with a neural tube defect are randomly allocated to one of four regimens (minerals alone, minerals and folic acid, minerals and multivitamins, and minerals, multivitamins, and folic acid). Hungary has an Optimal Family Planning Programme supported by the World Health Organisation for women aged 18–35 who are planning their first pregnancy. In this programme the fitness of the parents-to-be is assessed and improved if necessary. During a three-month preparatory period, before the planned conception, multivitamin supplementation is being evaluated in a double-blind study of the Roche formulation 'Elivit Pronatal' (vitamins A, B₁, B₂, B₆, B₁₂, C, D, and E, nicotinamide, calcium pantothenate; folic acid; Ca, P, Mg, Fe, Cu, Mn, and Zn) with a placebo control (vitamin C, calcium ascorbate, Cu, Mn, Zn, and lactose). A single capsule has to be taken from the first days of the third menstrual period during the three month preparation period until 12 weeks' gestation. Our aim is to study 10 000 women in 1984–86 and to compare the expected 24 neural tube defect cases with the number of observed ones. So far 400 couples have been recruited.

This programme is supported by the World Health Organisation and Hoffman La Roche.

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RICE WATER IS NOT RICE CEREAL ORAL REHYDRATION SOLUTION

SIR,—Glucose or sucrose in oral rehydration solution (ORS) has been effectively replaced by cereal rice powder.^{1–3} Rice water drained from cooked rice has also been reported to be effective.⁴ Since then many communications have appeared in *The Lancet* referring to cereal-based ORS as both rice water ORS and as rice powder ORS. We would like to make clear the distinction between these two kinds of ORS.

Rice powder ORS is made by grinding dry rice, then boiling it for 5–7 min in water to make a thick but drinkable solution. Salts are then added to achieve the same concentrations as in the currently recommended glucose or sucrose based ORS. These salts can be measured by weighing out 3.5 g sodium chloride, 2.5 g sodium bicarbonate, and 1.5 g potassium chloride. When all the salts are not available, table salt may be substituted and measured by a calibrated spoon or by one three-finger pinch for half a litre of rice powder solution. Starchy water obtained by draining boiling rice is, with added salts, called rice water ORS. Complete salts or table salts only are used depending on availability. We have analysed samples of rice water from thirty urban households and found a considerable range of both carbohydrate and electrolyte concentration (see table). Clearly rice water alone is not an ideal and dependable solution.

Rice powder has been used in ORS, initially 20 g/l and subsequently 50 g/l.^{1,3} In Bangladesh rice is cheaper than glucose or sugar, it is available in virtually every home, and it is a readily

COMPOSITION OF RICE WATER AFTER IN-VITRO HYDROLYSIS COLLECTED FROM 30 DIFFERENT URBAN HOUSEHOLDS

Components	Mean±SD (and range)
Glucose (g/l)	25.5±8.0 (10.4–39)
Protein (g/l)	1.3±0.5 (0.8–2.4)
Electrolytes (mmol/l)	
Na ⁺	2.7±1.1 (1.2–5.0)
K ⁺	7.3±2.0 (4.2–13.6)
Cl ⁻	2.5±1.1 (1.2–5.0)

accepted traditional food that provides calories and reduces stool volume.³ Rice powder and an ORS based on it are easy to prepare and the technique is easily understood by village mothers. Boiling is necessary for making both rice water and rice powder ORS, and thus eliminates any confusion about which water to use since all boiled water will be free of bacteria. While rice water ORS has a variable carbohydrate content, it may still be a useful home remedy for early or mild diarrhoea. Since the amount of rice water available from the average family pot will rarely exceed one litre in a day and is often far less, adequate quantities for severe diarrhoea will probably not be available. Rice powder ORS is effective both as a home and hospital rehydration solution. It provides important nutrients during diarrhoea, reduces stool output, and, with proper preparation through boiling, makes a safe solution regardless of water source.

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- 3 Molla AM, Ahmed M, Khatun M, Greenough WB III. Rice based ORS reduces stool output in acute diarrhoea. *Bull WHO* (in press).
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HIGH PREVALENCE OF LYMPHADENOPATHY VIRUS (LAV) IN EUROPEAN HAEMOPHILIACS

SIR,—Haemophiliacs in the United States and in Europe have been identified as having an increased risk of acquired immunodeficiency syndrome (AIDS). Cryoprecipitated factor VIII concentrate is considered the probable route of exposure for a transmissible agent causing this disease. Reversal of the T-helper/T-suppressor ratio has been used as a marker for AIDS risk, and a high proportion of haemophiliacs have been reported to have this abnormality.¹ However, haemophiliacs resident in Australia, an area with few AIDS cases and one that manufactures its own cryoprecipitate, also have a high prevalence of helper-to-suppressor ratio abnormalities.² This finding has led to the suggestion that the ratio abnormalities may be unrelated to AIDS among haemophiliacs.

A human retrovirus, lymphadenopathy virus (LAV), has been described in France³ and it is probably the aetiological agent of AIDS.⁴ LAV is very similar to, if not identical with, the human retrovirus HTLV-III isolated from many AIDS cases in the United States.⁵ The availability of sensitive serological tests for this agent now permits investigation of the degree of exposure to the virus among haemophiliacs.

We have tested 22 haemophiliacs from Denmark for the antibody against LAV, using an enzyme-linked immunosorbent assay. 14 (64%) of the 22 were clearly positive (borderline cases excluded) for antibodies to this agent, including the only haemophilia B patient. In contrast, only 1 of 12 blood donors at the same hospital and bled in the same month (April, 1984) were seropositive for antibodies to LAV. All patients had been on treatment for many years and had all been exposed to factor VIII.

Our results demonstrate a high prevalence of LAV among healthy haemophiliacs. While it is unclear that having antibody to LAV places a person at increased risk of AIDS, most AIDS patients do

have antibody to this agent and such antibodies are clearly not protective. In Denmark, cryoprecipitate concentrate may be purchased from the United States or European commercial sources. However, since the cryoprecipitate concentrate commercially manufactured in Europe uses large quantities of sera purchased from the United States, the distinction about place of manufacture is likely to be important only if it is also certain that sera used in the manufacture are obtained solely from populations at low risk of AIDS.

Clinicians caring for haemophiliacs should consider alternative forms of therapy for the care of new patients not yet exposed to cryoprecipitate concentrate. We anticipate that, with developments in retrovirus research, exposure to LAV through cryoprecipitate may be only a temporary situation, but until screening tests or techniques to neutralise the agent are in widespread use commercially available cryoprecipitate products should be considered as probably contaminated.

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IDIOTYPES AND AIDS

SIR,—Dr Hsia and colleagues' hypothesis (June 2, p 1212) is based on a concept which is highly improbable, on current knowledge of idiotypes. They propose expression of an identical major cross-reacting idiotypic (IdX) on antibodies directed against viruses or sperm (VST antibodies) in different individuals.

It is presumed that 1% of the total immunoglobulin repertoire may bear this idiotypic. Suppose VST antibodies make up 2% of the total antibody repertoire. The alleged IdX would then be expressed on 50% of VST antibodies. This, however, is unlikely. Available evidence indicates extreme idiotypic heterogeneity of immune responses,¹⁻³ especially for immune responses against complex immunogenic particles such as viruses or sperm. There are major cross-reacting idiotypes—the IdX on 20-70% of anti-arsenate antibodies in A/J mice⁴ is but one example. That, however, is a restricted immune response against a hapten and is very different from the immune response against a human pathogen where idiotypic heterogeneity, not idiotypic restriction, is the rule.³

Expression of IdX in the mouse is genetically controlled.⁵ In the unlikely event of a dominant Id on VST antibodies in a given person, it is even less probable that a genetically distinct person (in Hsia's hypothesis a contact with acquired immunodeficiency syndrome) would be capable of expressing an identical IdX. This is required, though, if the IdX is significantly to upset immunoregulation, since this implies the existence of IdX and anti-IdX bearing regulatory T lymphocytes.

Moreover, there is little to suggest that manipulation of idiotypes significantly alters overall immunocompetence. Even the specific immune response is usually maintained after, for example, suppression of an IdX. In the anti-arsenate response of A/J mice,

suppression of the major IdX can be achieved by anti-IdX antibodies. This, however, is associated with an increase of anti-arsenate antibodies bearing other idiotypes. Thus the anti-arsenate antibody titre is maintained.⁶ Idiotypic expression can readily be manipulated with anti-idiotypic, but the overall level of the immune response cannot.

Idiotypic-specific immunoregulation is a fact. It provides a mechanism for maintaining a highly dynamic antigen-specific immune response. Idiotypic heterogeneity would seem to be beneficial to that effect.⁷ Existence of a major IdX in the immune response to a pathogen could probably interfere with pathogenesis—but the chances that such an IdX exists in an antiviral or anti-sperm immune response in genetically distinct individuals are very small indeed.

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AIDS AND AUTHORS

SIR,—I am sure that many scientists believe that the elucidation of the epidemiology, cause, and pathogenesis of the acquired immunodeficiency syndrome (AIDS) will advance our knowledge of immunology considerably. AIDS appeared out of the blue a few years ago and, apart from causing immunodeficiency, it has been responsible for two other syndromes—the "minimum publishable unit syndrome" (MPUS) and the "how many authors can I cram onto one paper syndrome" (HMACICOOPS). These syndromes may well be responsible for as many deaths as AIDS itself. Many important medical papers must have been squeezed out by the interminable reporting of AIDS, and, more importantly, a great deal of useful and potentially more beneficial research has not been funded or carried out because so many scientists have jumped on the AIDS bandwagon knowing that most of their work, whatever the results, will be published in reputable journals, which seem to be AIDS struck.

In your June 23 issue (p 1415) 18 authors publish a letter stating that they are doing an experiment with 23 monkeys. I am pleased to hear that all the monkeys are well and send them my regards, but I cannot believe that it takes 18 people to do these experiments on 23 monkeys or that 18 people in six centres can write a letter.

It is this sort of publication that has encouraged MPUS and HMACICOOPS to such an extent that they threaten to strangle our journals and stop good work being done or published. It is time journals of international repute took a stand and stamped these malignant syndromes out.

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DIAGNOSING FAMILIAL MEDITERRANEAN FEVER

SIR,—We agree with Dr Cattani and colleagues (May 19, p 1130) that in most cases of familial Mediterranean fever (FMF) the diagnosis is not difficult for clinicians familiar with the disease. This does not mean that an objective test would not be useful, and FMF, which is most often encountered among ethnic groups from the Middle East and from Mediterranean countries, will often be a