MORO ON OFFICE-BASED TESTING FOR HIV

To the Editor: Recently, Geller and colleagues expressed strong concern about office-based testing for HIV, believing that such tests will compromise effective programs of AIDS surveillance and prevention. We question their judgment. As the AIDS epidemic continues to rage out of control, it is not clear that current prevention strategies are effective. It is imperative that new approaches be tried — ones that also serve to protect uninfected persons from infection. By focusing on the handful of effects of misclassification among those who test HIV-positive, Geller and colleagues overlooked the importance of office-based or home testing for personal decision making by those who want to avoid infection. Using the example of Geller et al., an uninfected person could have lowered his or her risk of selecting an HIV-infected partner from 0.4 percent without testing to a low of 0.004 percent among those who test negative — a reduction of 99.9 percent. The reduction would be even greater with confirmatory testing. As the epidemic inexorably affects homosexuals, many search desperately for ways to reduce their risk of HIV infection. In addressing the heterosexual spread of HIV, Hetzler and Hafemann argue that the single most important recommendation for their patients is to avoid choosing a sexual partner who may be at risk of carrying HIV.1 Because there are no discernible signs or symptoms for an average of 10 years, testing for HIV infection in blood or saliva2 is the only practical way to detect HIV carriers. Although carriers performing both confidential and anonymous tests have been established for this purpose, many heterosexual couples may be reluctant to come to terms, out of concern that they might be labeled as homosexuals, drug abusers, or prostitutes. When there are no incentives other than a vague concern about the risk of HIV, the discomfort of taking a blood test or discussing intimate sexual practices may be too much to endure. For such persons, office-based or home HIV-antibody testing would be a welcome alternative as a means of greatly reducing their risk of infection.

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Saliva Diagnostic Systems


2. N. Halley NE. Preventing the heterosexual spread of AIDS: are we giving up our patients the best option? JAMA 1992;268:2428.


To the Editor: The letter by Geller et al. raises "serious concern about clinical or operational feasibility" with respect to the use of visually interpreted antibody assays to detect HIV infection. Unfortunately, the authors have done their readers a disservice by discussing two different assays in a misleading way. Their letter reveals a fundamental mis- conception of the basis on which the Food and Drug Admin- istration has granted approval to Fluorognost 1-IFA, the only indirect immunofluorescence assay for HIV antibody licensed to date. Fluorognost has been licensed primarily as an additional, more specific test for validation testing in reference centers. As such, it can be used to provide conclusive information on the HIV-antibody status of serum or plasma specimens, whether the only approved use of the "microscopic ex- amination immunassay" mentioned is in the primary testing (or screening) of previously uncharacterized specimens. The potential of Fluorognost to resolve "false negative" Western blot results has been demonstrated.1 This fact alone is suffi- cient to invalidate any direct comparison between these two assays: they belong to entirely different, well-defined categories. An additional licensed use (to screen uncharacterized specimens in physician's offices, clinics, emergency rooms, and other settings in which enzyme immunoassays are impractical or unavailable) was granted to Fluorognost only because it has been proved to be as sensitive as, but more specific than, standard enzymelmmunoassays, on the basis of data from a multicenter trial and a clinical study of 1000 subjects at high risk of acquiring HIV infection.2 Only 1 (false positive result was seen in 10,000 blood donors. The notion that "false positive results [will result] per 1000 tests, 4 of which are false positive results" is therefore incorrect with respect to Fluorognost. Furthermore, by stating that "in both assays . . . the interpretation of the test results depends purely on visual skills and judgment that visual reading, by definition, the results obtained fail to take into account that those for the determina- tion of HIV serologic status have always relied exclusively on such evaluation." On studying the product insert for Fluorognost, Geller et al. would have found detailed summaries of the extensive clinical studies on which the FDA has based its license.

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The authors reply:

To the Editor: We do agree with the perspective offered by Drs. Ferrich and Seymour on the importance of office-based or home testing for personal decision making in HIV prevention. Because of the latency period between the ac- quisition of the virus and the appearance of antibody to HIV, this approach to disease control, in which people would conduct tests at home before engaging in sexual rela- tions, offers little real security to the public. Who use the test but persist in high-risk behavior can be insincerely self-identified as uninfected when in fact they are HIV-positi- ve. Furthermore, given the reality that many people who

