German homosexual community and may increase exponentially. The incubation period of AIDS infection suggests that the increase will parallel that observed in 1981-82 in the USA but with a time lag of 1½-2 years (figure, B). This assumption is also supported by the observation of clusters in those cities (Munich, Frankfurt, Berlin) where the first AIDS patients with direct contact with the US AIDS epidemic lived.

Cases with unexplained lymphadenopathy, fever, weight loss, malaise, and laboratory-proven dysfunction of cellular immunity, mainly in homosexual males, have also been brought to our attention. The number of such cases in West Germany is estimated to be 5-10 times higher than the number of all-known AIDS cases. Patients with these symptoms, that have preceded malaise, and laboratory-proven dysfunction of cellular immunity, to be AIDS in some cases, are again most frequently seen in these cities.

HAEMOPHILIA AND AIDS IN THE UK

Sir,-In their otherwise clear account of a fatal case of acquired immunodeficiency syndrome (AIDS) in a haemophiliac in the UK ('Daly and Dr Scott (Nov 19, p 1190), referring to our account of AIDS surveillance,1 state that: "No definite case of AIDS in a haemophiliac has yet been reported in Britain although one patient may have early features of the syndrome". The Communicable Disease Surveillance Centre (CDSC) does indeed collect data on patients who may have early features of AIDS, but our paper included only those cases which met the definition of AIDS compiled by the Centers for Disease Control, Atlanta, on March 15, 1983. The information kindly provided to us about the haemophiliac has yet been reported in Britain although one patient may have early features of the syndrome. The Communicable Disease Surveillance Centre (CDSC) does indeed collect data on patients who may have early features of AIDS, but our paper included only those cases which met the definition of AIDS compiled by the Centers for Disease Control, Atlanta, on March 15, 1983. The information kindly provided to us about the haemophiliac has yet been reported in Britain although one patient may have early features of the syndrome.

May we thank all clinicians and microbiologists who have reported suspected cases to CDSC and to appeal to all doctors to report such cases. We have received 35 reports, 26 of which fit the Centers for Disease Control's definition of the syndrome.

LOCAL RECURRENT AND RECTAL CANCER

Sir,-We agree with Mr Upleby and colleagues (Oct 29, p 1020) that, besides remaining epithelial and venous tumour, implantation of exfoliated cancer cells may be one factor causing rectal tumour recurrence. It is curious, however, that some recurrences happen in early (Dukes grade A) tumours or in tumours with an apparently adequate margin of resection.89 Our experience with chemically induced colonic carcinomas in the rat has shown that, besides residual lymphatic and venous dissemination, a mucosal wound may undergo neoplastic change. We are now testing the idea that suture material may be one of the promoting factors in this mucosal transformation. If so, the choice of suture material and staples for rectal anastomosis may be a factor in local anastomotic recurrence.

The formula for famotidine, the third H2-receptor blocker studied so far, was 1-[(2-[[4-amino]ethyl]amino]-4-thiazolyl)methyl]thio-N-sulfamoylpropionamide. Division of Gastroenterology, McMaster University, Hamilton, Ontario L8N 3S5, Canada.

PREDNISONE AND METHYL-PREDNISOLONE DISPOSITION IN THE LUNG

Sir,-Dr Braude and Dr Reubuck (Oct 29, p 995) have introduced a novel approach to the management of lung disease with systemic corticosteroids. However, prednisone is converted to its biologically active metabolite prednisolone in the liver. If both prednisone and prednisolone had been assayed the results may well have been different. A comparison of the results for two drugs administered by different routes and in non-equivalent doses must be interpreted with caution, especially when the plasma availability of a drug may not be reflected by just one plasma level.6 The use of 20 ml volumes of saline may preferentially sample airways rather than peripheral lung,7 so the lung surface may not always have been consistently washed out. Furthermore, Braude and Reubuck do not give technical details, such as lavage recovery rates; nor do they explain why creatinine rather than albumin was used to standardize drug recovery.

Whilst welcoming the idea of studying drug availability in the lung, we believe that Braude and Reubuck's results should be interpreted with extreme caution.