our society believe that acknowledging and accepting gayness is equivalent to encouraging it. To such persons, nothing that concedes the reality of gayness — or needle sharing, or extramarital heterosexual sex — is permissible. Our public health institutions will not do the best job of preventing the transmission of the human immunodeficiency virus until they are willing to risk the anger of those who find such acknowledgments an anathema.

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LYMPHOMA IN AN HIV-POSITIVE MAN AFTER DISAPPEARANCE OF A PARAPROTEIN

To the Editor: Paraproteinemia has been observed in 9 to 45 percent of persons infected with the human immunodeficiency virus (HIV).[1-4] The mechanism or mechanisms responsible for the induction of these paraproteins is unclear but may be related to polyclonal activation of B cells and aberrant B-cell immunoregulation after HIV infection.[5-8] It has been suggested that HIV-induced polyclonal B-cell activation may predispose patients to the expansion of a paraprotein-producing B-cell clone and the subsequent development of high-grade B-cell lymphomas.[9] In contrast to the aforementioned hypothesis,[9] we recently observed a patient in whom the disappearance of paraprotein coincided with the development of a primary biliary lymphoma.

We report on a 41-year-old HIV-seropositive homosexual man with night sweats and fatigue of several months' duration, who was admitted to San Francisco General Hospital in May 1987 for an episode of severe depression. The physical examination was normal; laboratory values were unremarkable except for an elevated total protein level of 91 g per liter and a globulin level of 58 g per liter. Serum protein electrophoresis demonstrated a large paraprotein spike migrating toward the cathode from the application site (Fig. 1, Lane A); immunofixation electrophoresis[10] demonstrated that the spike was composed of IgG lambda. The patient was next seen in July 1987. The physical examination was again normal, and the paraprotein (Fig. 1, Lane B) was still present. In September 1987 the patient presented with acute obstructive cholestatic jaundice, and primary biliary lymphoma was diagnosed by the examination of tissue obtained at choledochojejunostomy. Serum protein electrophoresis performed on two samples obtained on separate occasions now revealed a normal pattern (Fig. 1, Lane C), with no evidence of the paraprotein that had been observed on the two previous occasions.

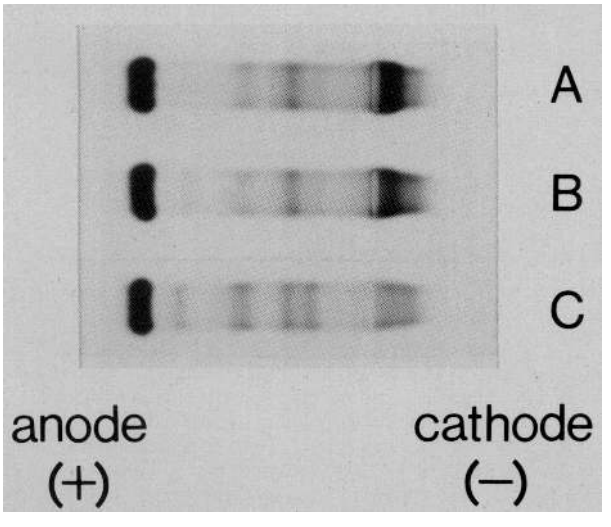

Figure 1. Results of a Chronologic Serum Protein Electrophoresis in Our Patient.

Lane A shows serum obtained at the patient's first admission in May 1987, Lane B serum obtained at a follow-up visit in July 1987, and Lane C serum obtained at the time of diagnosis of a primary biliary lymphoma. The paraprotein is clearly present just on the cathode side of the application site. The beta-2 globulin band is present only in the sample of July 1987; the beta-2 globulin bands in the other two samples had deteriorated with storage.

The disappearance of this patient's paraprotein coincident with the development of a primary biliary lymphoma suggests that the patient's lymphoma did not arise from paraprotein-producing B cells. We characterized a paraprotein from another HIV-infected patient and demonstrated it to be polyclonal in origin and directed against HIV *gag* and *pol* gene products.[11] Similar polyclonal origins and multiple antigenic reactivities have been demonstrated for an additional three paraproteins from HIV-infected persons (Ng VL, et al.: unpublished data). These findings support our hypothesis that paraproteins represent a normal, albeit vigorous, immune response to HIV infection, and suggest that the presence of a paraprotein does not predispose the patient to the development of B-cell lymphoma.

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RACIAL DIFFERENCES IN CARE OF PATIENTS WITH HEMOPHILIA

To the Editor: As of March 1987, the Centers for Disease Control had received confirmed reports of the acquired immunodeficiency syndrome (AIDS) in 303 patients with coagulation disorders. Two hundred fifty-eight of these patients (85 percent) were white, 20 (7 percent) were black, and 25 (8 percent) were of other racial or ethnic groups. Blood products had been received by 263 of the patients (87 percent). Black patients were significantly more likely than whites to have received locally produced single-donor blood products (13 of 19 [68 percent] vs. 86 of 221 [39 percent]; $P = 0.02$). Blacks were also more likely than whites to have received packed red cells (9 of

19 [47 percent] vs. 61 of 221 [28 percent]; P = 0.11). Our study sought to determine whether the difference in the receipt of these products reflected the coexistence of hemoglobinopathies related to race or ethnic background or were due to race-related differences in the patients' receipt of medical care.

We contacted the reporting physicians and nurses of 21 black and 42 white patients with hemophilia and AIDS (reported as of June 1987). The patients were matched in a 1-to-2 ratio with regard to their coagulation disorder, their age (±5 years), and the date of their AIDS diagnosis.

One black patient and no white patients had a hematologic disorder other than hemophilia (not significant); that black patient had sickle thalassemia and had received red cells. Only 7 of 21 of the black patients with hemophilia and AIDS (33 percent) had received care at a hemophilia treatment center, as compared with 30 of 42 of the white patients (71 percent) (odds ratio for whites as compared with blacks, 5.5; 95 percent confidence interval, 1.5 to 19.9; by logistical analysis for matched data).

Hemophilia treatment centers were first established in the mid-1970s to provide optimal and coordinated medical care to patients with the disorder. Our study suggests that blacks with hemophilia may be receiving less coordinated care and less appropriate blood-product therapy than whites with hemophilia. Differences in health care, therapy, and exposure to blood products should be considered when one is comparing HIV-associated morbidity and mortality between black and white patients with this condition.

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SPRING-LOADED LANCETS

To the Editor: This letter is to warn health care providers who obtain capillary-blood samples to comply with guidelines for preventing the transmission of blood-borne diseases. Such specimens are usually obtained with use of devices with spring-loaded lancets. These devices are anchored to patients' fingers by means of a platform, through which the lancet punctures the skin. The aperture in the platform is approximately 0.5 to 1 cm in diameter, and the platform may be soiled by blood from the skin puncture. I recently surveyed several health care providers and found that they did not routinely replace the platform between uses in different patients. Obviously, if the bottom of the platform has been contaminated by the blood of one patient and is then moved tangentially across the skin of a second patient before being positioned for the puncture, a parenteral blood exposure could occur. This practice is out of line with recently published guidelines for the prevention of blood-borne diseases.*

I urge practitioners who obtain capillary-blood samples with spring-loaded devices to change the platforms after each patient to avoid the possibility of an iatrogenic infection.

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*Recommendations for prevention of HIV transmission in health-care settings. MMWR 1987; 36:Suppl:3S-18S.

THE GENTLE ART OF SWALLOWING PILLS

To the Editor: The oral intake of medication is often inconvenient because of the tendency of swallowed pills, tablets, or capsules — especially large ones — to lodge in the vallecula on their way down to the esophagus. We draw attention to a simple physiologic maneuver that circumvents this difficulty.

Normally, in the second stage of deglutition, elevation of the larynx accompanied by counterpressure from the tongue, which is arched against the hard palate, helps to force the hyoid bone forward and the epiglottic tubercle backward. This distorts the base of the epiglottis and inverts the epiglottic cartilage to form a cone that caps the occluded entrance to the larynx.[1] A loose pill on the tongue can presumably hinder the counterpressure and prevent the inversion.

The problem is averted by putting the pill on the tongue and taking two successive gulps of liquid without pause. With the first gulp, swallow some liquid but not the pill. With the second gulp, swallow the pill with some more liquid. The first gulp causes the epiglottis to fold down,[2] and the second washes the pill past the downturned epiglottis. It is important not to pause between gulps, or the larynx will redescend and the epiglottis spring back up, frustrating the maneuver.

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MICROSCOPY MOTION SICKNESS

To the Editor: As part of the gastroenterology training program curriculum at William Beaumont Hospital, the fellows participate in a monthly review of microscopic slides shown through an Olympus BH2 teaching microscope. A faculty member presents about 10 to 15 slides per session, and each session is an hour and a half long.

Starting about halfway through the review and persisting after its completion, there was a general complaint of apathy, malaise, yawning, lightheadedness, and nausea. These symptoms were initially ascribed to a variety of causes, including "bad lunch," poor circulation of air in the room, and "just the season." It wasn't until one of us recommended to the faculty member that the slides be moved more slowly that the symptoms stopped occurring. Apparently, the rapid movement of the slides had been causing a phenomenon similar to motion sickness. This observation may be of interest to those involved in teaching with microscopic slides.

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BOOK REVIEWS

LABOR AND DELIVERY: IMPACT ON OFFSPRING

By Emanuel A. Friedman and Raymond K. Neff. 522 pp. Littleton, Mass., PSG, 1987. $65.

This new book is recommended reading for all professionals and paraprofessionals engaged in the care of pregnant women. It should be required reading for those resistant to the standardization of perinatal records and the collection of perinatal data.

This book calls for careful study. Those who have studied statistics but have not fallen in love with that field will be compelled to refer to a statistics textbook while reading this book. Doing so will reward the student with a better understanding of the pitfalls inherent in comparative clinical investigations. In *Labor and Delivery*, the reader will see excellent examples of how to examine and handle collected data and apply statistical analyses to derive trustworthy conclusions.

This book addresses the problem of determining the effects of the course of labor, the use of drugs, intrinsic prelabor factors, and events and procedures related to delivery on the fetus and surviving infant. The National Collaborative Perinatal Project (NCPP) of the