negative effects, then painful, elective surgery should not be allowed without adequate anaesthesia.

Second, since parental consent may not be adequate for painful, unanaesthetised, cosmetic surgery on infants,[3-5] I suggest that circumcisions be done on consenting adults. Adults could describe the pain associated with unanaesthetised circumcision and, therefore, the pain assessment would be less inferential. Although the pain assessment in an adult study would be less abstract, I fear volunteers would be hard to find.

Christopher J Cold
Marshfield Laboratories, 1000 North Oak Avenue, Marshfield, WI 54449, USA

1 Taddio A, Katz J, Ilersich AL, Koren G. Effect of neonatal circumcision on pain response during subsequent routine vaccination. *Lancet* 1997; **349**: 599–603.
2 Shelton DL. Trying to overcome the Tuskeegee legacy of distrust. *Am Med News* 1997; **40**: 6–12.
3 Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. *Pediatrics* 1995; **95**: 314–17.
4 Storms MR. Controversy surrounding newborn circumcision continues. *J Am Osteopath Assoc* 1996; **96**: 273–75.
5 Van Howe RS. Consent for circumcision. *Can Med Assoc J* 1997; **156**: 17–18.

HIV testing in developing countries

SIR—During a study on the gastrointestinal problems associated with HIV infection, Chintu and colleagues (March 1, p 650)[1] noted very high rates of false-positive (30%) and false-negative (37%) self-reports of HIV status in Zambia. They suggest that these high rates are caused by the perception of the Zambians with respect to HIV infection. We are not sure that this is a sustainable explanation for this finding. We are not told in the description of the recruitment procedures whether participants had previously been tested for HIV or whether participants simply reported their perceived HIV status in order to become enrolled and receive compensation and medical attention. It is also possible that an adequate explanation of the HIV test result was never provided. Other possibilities are that HIV-seronegative individuals became infected with HIV, or that there was a laboratory error, either during the first test or the second test.

Generally there is very little quality control on HIV testing in African countries. During October, 1996, we evaluated HIV testing in transfusion centres in Kinshasa. Errors in the HIV-testing procedures were noted in many centres, including, for example, the inadequate use of the ELISA reader, performance of ELISA tests without a washing machine, the use of machines that were out of order, as well as the incorrect interpretation of test results and administrative errors. 236 samples tested by transfusion centres in Kinshasa were also tested at the AIDS reference laboratory of the Institute of Tropical Medicine in Antwerp, Belgium. The HIV testing strategy in Antwerp included two ELISA tests, the Virognostika HIV Uniform II plus O test (Organon Technika, Netherlands) and the Enzygnost anti-HIV ½ plus test (Behringwerke AG, Germany). The Inno-Lia confirmation (Innogenetics, Belgium) and the HIV blot 2.2 (Genelabs Diagnostics, Singapore) were used for confirmation. With the results of this laboratory as the gold standard, the rapid tests done in Kinshasa (HIV spot, Genelabs Diagnostics, Singapore) had a sensitivity of 100% and a specificity of 85% (51 samples evaluated) and the ELISA tests (Enzygnost anti-HIV ½) a sensitivity of 70·9% and a specificity of 61·1% (212 samples evaluated).

Before introducing large-scale HIV testing in poor resource countries, one should make the establishment of a sound programme of quality control of HIV testing and counselling a priority.

**Robert Colebunders, Greet Beelaert, Rita Wellens*
*Institute of Tropical Medicine, Antwerp B-2000, Belgium, and Washington State University, Pullman, WA, USA

1 Chintu Ch, Kumar SB, Gould SS, DuPont HL, Murphy JR. False-positive self-reports of HIV infection. *Lancet* 1997; **349**: 650.

VRE and meat

SIR—The question of whether or not vancomycin-resistant enterococci (VRE) have entered the community via the food chain is much debated,[1-3] and has led to investigations into livestock bred for their meat and, finally, to the European ban on glycopeptides used as a food additive.[1,2,4] Nevertheless, the evidence is only circumstantial; even the fact that the raw meat presented in shops is highly contaminated with VRE[5] is no final proof because it is unclear whether VRE would escape destruction during the process of food preparation.

If VRE enters the community via the meat-lover's gastrointestinal tract, it would be logical to conclude that strict vegetarians should not be colonised, especially if they had not eaten meat for a long time. We therefore approached a home for elderly vegetarians (3–86 meat-free years, mean 46 years) and another home whose residents ate meat daily. Faecal samples from residents of both homes were examined for the presence of enterococci by selective enrichment broth. We used standard microbiological techniques for identification and susceptibility testing, including confirmation of true vancomycin resistance. We collected samples from 42 vegetarians and 62 meat-eaters. Enterococci were found in 33 vegetarians and 48 meat-eaters; 23 vegetarians and 32 meat-eaters were positive for *Enterococcus faecium*. None of the vegetarians were colonised with VRE, whereas six (9·7%) meat-eaters carried VRE in their faeces ($p<0·05$). All VRE strains were identified as *E faecium* with minimum inhibitory concentration for vancomycin of greater than 256 mg/L. Our findings suggest that the consumption of meat is associated with colonisation of the gastrointestinal tract by VRE.

*M A Schouten, *A Voss, J A A Hoogkamp-Korstanje*
Department of Medical Microbiology, University Hospital St Radboud, PO Box 9101, 6500 HB Nijmegen, Netherlands

1 Bates J, Jordens JZ, Selkon JB. Evidence for an animal origin of vancomycin-resistant enterococci. *Lancet* 1993; **342**: 490–91.
2 Bates J, Jordens JZ, Griffiths DT. Farm animals as a putative reservoir for vancomycin-resistant enterococcal infection in man. *J Antimicrob Chemother* 1994; **34**: 507–16.
3 Donnelly JP, Voss A, Witte W, Murray BE. Does the use of antimicrobial agents, including glycopeptide antibiotics, influence the efficacy of antimicrobial therapy in humans. *J Antimicrob Chemother* 1996; **37**: 389–90.
4 Editorial. Monitoring antimicrobial resistance in humans and animals in Europe. *Eurosurveillance* 1997; **3**: 21–22.
5 Chadwick PR, Woodford N, Kaczmarski EB, Gray S, Barrell RA, Oppenheim BA. Glycopeptide-resistant enterococci isolated from uncooked meat. *J Antimicrob Chemother* 1996; **38**: 908–09.

DEPARTMENT OF ERROR

Wasting as an independent risk factor for mortality in chronic heart failure—In this article by S D Anker and colleagues (April 12, 1997, p 1052) the key to the figure should have appeared as shown below.