LETTERS TO THE EDITOR

Limited access to antiretroviral therapy for intravenous drug users in Europe

Editor,—M P Carrieri et al reported that in France, among people infected by intravenous drug use, those who continued their intravenous drug use were less likely to receive antiretroviral treatment.

We have evidence that in Europe persons who acquired their HIV infection through intravenous drug use, regardless whether they stopped their intravenous drug use or not, have less access to antiretroviral treatment than persons who acquired their HIV infection through homosexual contact.

An anonymous questionnaire was distributed to inpatients and outpatients in HIV treatment centres in 11 European countries, from August 1996 to August 1997. A total of 1366 persons with HIV infection participated in the study, more than half (53%) were infected through homosexual contact and 14% through intravenous drug use (26% in southern Europe).

Bivariate analysis and multivariate logistic regression, adjusting for other factors like gender, age, CD4 lymphocyte count, clinical status, income, education and region, showed that intravenous drug users were significantly less frequently treated with antiretroviral therapy than homosexual men (table 1).

In another European study (the Euroisida study), performed in 1994 among 3122 persons with HIV infection, homosexual men were also found more likely to receive combination therapy than intravenous drug users (41% versus 22% respectively).

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Reply

Our Belgian colleagues bring evidence from a European study that confirms a fact that has been already established in the US context: HIV infected drug users have significantly less access to antiretroviral treatment than other groups of HIV infected people. Socio-economic barriers of course play an important part in this situation but unfortunately clinical recommendations may also contribute to it; for example, recent HIV treatment guidelines suggest delaying prescription of HAART to active injection drug users until drug maintenance treatment is administered.

The goal of our study, which is complementary to evidence such as the one presented by Schrooten et al, was to show that delayed access to treatment of active intravenous drug users can also happen in the context of a health system where free of charge care is guaranteed for HIV infection and by comparison inside the group of persons infected through injection drug use between those who stopped and those who continued active use. Conveying results of research may help fighting discriminatory problems faced by intravenous drug users in the context of recent therapeutic progress.

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Table 1

<table>
<thead>
<tr>
<th>Number of respondents</th>
<th>Patients with ARV therapy n (%)</th>
<th>Bivariate analysis OR (95% CI)</th>
<th>Multivariate analysis OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual contact (n=733)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IVDU (n=192)</td>
<td>493 (67)</td>
<td>0.47 (0.33, 0.65)</td>
<td>0.51 (0.35, 0.75)</td>
</tr>
<tr>
<td></td>
<td>94 (49)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexual patient containing protease inhibitor n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0.75 (0.47, 1.20)</td>
<td>0.98 (0.58, 1.66)</td>
</tr>
<tr>
<td>Homosexual contact (n=493)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IVDU (94)</td>
<td>229 (46)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>37 (39)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| IVDU = Intravenous drug users.

Biochemistry. While there are legitimate questions concerning the validity of impact factors as a measure of quality, we feel that if they have to be used, they should be properly adjusted using a method such as the one proposed here.

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Correspondence to: Professor Jin-Ling Tang.

5 Institute for Scientific Information (ISI). 1996 Journal citation report: a bibliometric analysis of biomedical journals such as the British Medical Journal and the Lancet. The viewpoint of the editors is always important: sometimes, they could be forced to read your manuscript and to take a decision about it. You the author perhaps would like to know that the editor of the British Medical Journal does not like very much Alice in Wonderland quotations in scientific papers (chapter 2: Introductions). Or that, once you have it finished, it is a good idea to read aloud the title and the abstract of your manuscript to someone unfamiliar with the work (as “that is easy to read is hard to write”; chapter 6: Titles, abstracts, and authors). Some recent debate issues, such as authorship versus contributorship (chapter 15) and electronic publishing (chapter 18) are also presented in the book. A suggestion for the third edition: to include a chapter on “How to answer the reviewers’ comments”. Many authors, editors and manuscript assessors could benefit from it.

BOOK REVIEWS


Professional practice (both in clinical, managerial or public health settings) frequently is not based on the best available scientific evidence. The reduction of this gap between professional practice and scientific evidence is central for the “new paradigm” of evidence-based medicine, which emphasises the application (and not only the generation) of results from research. In this book, Haines and Donald have joined a group of leaders of the evidence-based medicine movement to tackle the causes of this gap and the ways to reduce it. Despite its multiple authors, the chapters are arranged around a solid logic structure, so the coherence of the book is well preserved (with some minor exceptions such as the chapter of economic evaluations). The book suggests the steps that should be followed for the implementation of research findings. The topics considered in the book include the sources of information; strategies for finding and filtering the information; interventions for promoting the implementation of research findings; critical appraisal of the literature; evidence-based policy making; barriers and bridges to evidence-based clinical practice; conceptual frameworks for changing health professionals’ behaviour; role of lay people in the implementation of health care research; role of decision support techniques in the implementation of research findings; and the specific problems of the implementation of results from economic evaluations.

The spectrum of topics covered, the actualised bibliography, and the readable format make this book useful for a wide audience, from clinicians interested in practice or teaching evidence-based medicine to purchasers, managers and health services researchers interested in promoting evidence-based care.

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Who is going to write their first paper? Who has to write a paper soon? Who is in a sweat now writing a paper with the hope of catching the attention from that (perhaps too much?) high ranking journal to their last arduous piece of research? All of them will have some help in this book. At a glance, How to write a paper looks like a basic guide for junior authors, and research degree students seem the best suited public for it. The original intention of the editor was to appeal to authors for whom English was not the first language. However, I think that many kind of authors would find something to learn in this book.

This is the second edition of a successful short book first published in 1994. Some new contributors and additional chapters have been added to the already attractive contents of the first edition, featuring experienced editors from some major British biomedical journals such as the British Journal of Anaesthesia, the British Medical Journal and the Lancet. The viewpoint of the editors is always important: sometimes, they could be forced to read your manuscript and to take a decision about it. You the author perhaps would like to know that the editor of the British Medical Journal does not like very much Alice in Wonderland quotations in scientific papers (chapter 2: Introductions). Or that, once you have it finished, it is a good idea to read aloud the title and the abstract of your manuscript to someone unfamiliar with the work (as “that is easy to read is hard to write”; chapter 6: Titles, abstracts, and authors). Some recent debate issues, such as authorship versus contributorship (chapter 15) and electronic publishing (chapter 18) are also presented in the book. A suggestion for the third edition: to include a chapter on “How to answer the reviewers’ comments”. Many authors, editors and manuscript assessors could benefit from it.

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**Table 1** Unadjusted and adjusted impact factors of top five international journals in five disciplines (unadjusted impact factors are extracted from the 1996 Journal Citation Report)

<table>
<thead>
<tr>
<th>Top five journals</th>
<th>Public, environmental, occupational health</th>
<th>Biochemistry and molecular biology</th>
<th>Cardiac and cardiovascular system</th>
<th>Mathematical physics</th>
<th>After adjustment</th>
<th>Public, environmental, occupational health</th>
<th>Biochemistry and molecular biology</th>
<th>Cardiac and cardiovascular system</th>
<th>Mathematical physics</th>
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<tr>
<td>1</td>
<td>4.11</td>
<td>41.0</td>
<td>5.99</td>
<td>1.72</td>
<td>1.18</td>
<td>1.47</td>
<td>1.41</td>
<td>1.09</td>
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<tr>
<td>2</td>
<td>3.31</td>
<td>22.1</td>
<td>3.47</td>
<td>1.56</td>
<td>0.95</td>
<td>0.79</td>
<td>0.82</td>
<td>0.99</td>
<td></td>
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<tr>
<td>3</td>
<td>3.00</td>
<td>20.3</td>
<td>3.26</td>
<td>1.46</td>
<td>0.86</td>
<td>0.73</td>
<td>0.77</td>
<td>0.97</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2.59</td>
<td>13.8</td>
<td>2.87</td>
<td>1.37</td>
<td>0.75</td>
<td>0.50</td>
<td>0.68</td>
<td>0.87</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>2.44</td>
<td>13.3</td>
<td>2.79</td>
<td>1.16</td>
<td>0.70</td>
<td>0.48</td>
<td>0.66</td>
<td>0.73</td>
<td></td>
</tr>
</tbody>
</table>
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W Schrooten, Y Fleerackers, R Andraghetti, C Dreezen, R Finazzi, L Caldeira and R Colebunders

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