

Richard's medicine cabinet

David Croser pays tribute to an American that very few dentists will have heard about

ON June 5, 1981, the first case study detailing an unusual cluster of pneumonia cases among gay men alerted the world to Aids as a new sexually transmitted disease.

Case studies are an important way of assembling data when a new disease comes along, but I would like to take a moment to remember the individuals behind that data.

When this killer disease first arrived out of the blue, with no known cure, panic was rife. Sadly, those initial case studies are all that remains of those early patients who died from a disease that was considered sufficiently lethal that special precautions had to be adopted for the disposal of their remains.

Prepared

I want to tell you about just one of those patients. He was a gay man called Richard.

During the 1970s he lived in New York where he developed a condition called Grid (Gay Related Immune Deficiency).

When it came to his health, Richard was both responsible and well-informed; every condition was researched and a suitable remedy kept on-hand in the spacious medicine cabinet in his bathroom. In addition there was a splendid array of the latest oral hygiene devices purchased on the advice of the hygienist that he visited every month. Acute periodontal disease rapidly develops as the immune system is depleted.

He had recently taken part in a hepatitis vaccine trial when it was offered to a group of gay men in New York. Sex has never been free of attendant risks, but Richard was keen to keep risk to a minimum. But not this time – the 30-year-old, who was usually the very picture of health, had now been admitted to St Vincent's Hospital with pneumonia.

No Internet

A group of gay doctors and dentists living in London (the Gay and Lesbian Association of Doctors and Dentists, or GLADD as it is known) were already aware of many similar cases in New York and although there was still very little known about the disease, it

was clear that gay sex now carried an additional risk.

With the availability of cheap mass air travel, Grid recognised no boundaries – in effect it was as close as the nearest airport. But if healthy young men in New York were suddenly getting sick, wasn't this something that sexually active men everywhere should be made aware of?

These days, e-mail and social networking sites like Facebook would have been a great way to distribute some of the key health messages about Grid. In its absence, members of

GLADD used a copy shop and printed piles of A4 sheets which volunteers distributed to bars and clubs in London. My own experience of handing out these sheets was quite sobering. Every time I handed one out, I felt rather like a

member of a temperance movement who has just told an alcoholic that they had just had their last vodka.

Practical

Eventually the British Government responded to the public health aspects of the epidemic and created a campaign featuring icebergs and later tombstones. But if you can see an accident waiting to happen, sometimes valuable time can be lost by waiting for a committee in the Department of Health to decide how best to address the problem.

The advisory committee involved would undoubtedly need to research the underlying medical science and consider the data and the costs – all of which would take time to collect. The instinct of those doctors and dentists who wanted to speak directly to the individuals who they perceived to be at risk demonstrates how common sense can provide very practical solutions when there is no other guidance available.

It was the same group of doctors and dentists who rallied in support of Richard when he arrived in London unannounced and in a state of panic. He looked awful and was searching for a trial drug that was supposedly available in the UK. It was wishful thinking – no such medication was available. With only counselling

and kindness to offer him, Richard returned to New York and died there three weeks later.

Discrimination?

In time, the same symptoms appeared in British patients – and the term Aids (Acquired Immune Deficiency Syndrome) was regularly seen in the media here. Insurance companies now asked their clients if they were at risk of Aids or had been for a blood test – the answer "yes" meant that special conditions would be applied to the policy.

Many dentists did a similar thing and adopted special precautions if the patient was at risk. On top of this, many patients were simply refused access to these services. In the absence of any evidence to provide a reasonable sense of balance, such discrimination must seem something of a knee-jerk reaction. The Disability Discrimination Act 1995 has since given these patients the protection of the law.

In the intervening years there were many HIV patients who were unable to obtain dental treatment. Periodontal disease is a common problem for patients with reduced immunity and there was an ever-increasing demand among them to see a dentist – my own practice would commonly receive a dozen calls a week from new patients in this situation.

Before doing anything else, I needed to understand a little more about the disease and wondered if a dental colleague in New York could enlighten me.

Seeking advice

With Richard's death still in my mind, I contacted his partner and asked for the name of their dentist. It didn't take long before I had made contact with Dr Jack Rosenberg in his mid-town office and he told me all I needed to know. "Standard infection control for every patient – and don't stick yourself with the needle," was the essence of his advice when he showed me round his practice.

That and some more specific treatment protocols was the sole

premise for the 20 years that I ran a dental service dedicated to treating patients living with HIV. Latterly, with the introduction of multiple anti-retroviral drug therapy (HAART), the patients now have much the same treatment needs as any other member of the population at large, even with a tendency to a dry mouth induced by these medications.

Meeting Richard had allowed me to create something positive out of an otherwise totally negative situation. The service has now closed and the patients are treated by local NHS contractors. The evidence base has shown us that we can rely on infection control to eliminate risk when dealing with HIV in the dental setting.

There is also evidence to suggest that anti-retroviral medication can reduce the viral load to the point that further transmission is eliminated provided the medication is taken regularly¹.

When the dentist tests positive

But what happens when the dentist is also the patient? At present any dentist who is diagnosed HIV positive is required to stop practising immediately. This is the end to any professional career and also their

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income. With the unusual and unproven case of Dr Acer in Florida, there has been no evidence of HIV transmission in a dental setting since the condition was first named 27 years ago.

The advisory panels that inform the Department of Health reviewed the evidence base last year to see if, with suitable precautions, this valuable group of colleagues can continue working in their chosen profession, but no decision has yet been announced. The chief dental officer received a request to make public the evidence base which will inform that decision.

Although a quarter of a century has now passed, I wonder if it will ever arrive and if it will be as practical as the contents of Richard's medicine cabinet?

1 www.aidsmap.com/en/news/4E9D555B-18FB-4D56-B912-2C28AFCCD36B.asp