

does not include bleomycin for the treatment of advanced Hodgkin's disease. The Cancer and Leukemia Group B and the Dana-Farber Cancer Institute are investigating a regimen containing etoposide, vinblastine, and doxorubicin as a substitute for the traditional regimens in the hope of circumventing some of the disadvantages of treatment with ABVD.<sup>1</sup>

In response to the question concerning infertility raised by Dr. Martino et al., we have separately reported the results of psychosocial and psychosexual studies from a sample of 93 survivors from the prospective trial.<sup>2,3</sup> An infertility index derived from responses to questionnaires from patients known or believed to be infertile showed no significant difference in this complication between the regimens.

GEORGE P. CANELLOS, M.D.

Boston, MA 02115

Dana-Farber Cancer Institute

1. Canellos GP, Anderson JR, Peterson BA, Gottlieb AJ. EVA: etoposide, vinblastine, doxorubicin (adriamycin) — an effective regimen for the treatment of Hodgkin's disease in relapse following MOPP: a study of the Cancer and Leukemia Group B. *Proc Am Soc Clin Oncol* 1991;10:273. abstract.
2. Komblith AB, Anderson J, Cella DF, et al. Hodgkin disease survivors at increased risk for problems in psychosocial adaptation. *Cancer* 1992;70:2214-24.
3. Komblith AB, Anderson J, Cella DF, et al. Comparison of psychosocial adaptation and sexual function of survivors of advanced Hodgkin disease treated by MOPP, ABVD, or MOPP alternating with ABVD. *Cancer* 1992;70:2508-16.

### THE CONSEQUENCES OF TESTING FOR HUNTINGTON'S DISEASE

*To the Editor:* The report by Wiggins and colleagues (Nov. 12 issue)\* provides valuable information on the psychological outcomes of persons undergoing presymptomatic DNA testing for Huntington's disease. One important issue is not addressed, presumably because it is of little consequence in Canada: the problem of cost. At our institution, this testing, including laboratory analysis and necessary genetic and psychological counseling, frequently costs people more than \$2,500. Persons at risk for Huntington's disease often feel obligated to meet this expense from their personal funds because they are reluctant to let insurance companies and employers gain access to the results. Hence, many families with Huntington's disease who want testing in this country do not obtain it because they cannot afford it. Any studies of presymptomatic testing for Huntington's disease that requires payment by patients will, therefore, have serious socioeconomic biases of ascertainment. We also suspect, but cannot prove, that people who learn that they are at high risk for Huntington's disease or have uninformative test results will be even more disappointed than expected, because they have borne a substantial financial burden to obtain the unhappy news.

THOMAS D. BIRD, M.D.  
Seattle, WA 98108  
Veterans Affairs Medical Center

ROBIN L. BENNETT, M.S.  
Seattle, WA 98195  
University of Washington  
School of Medicine

HILLARY P. LIPE, A.R.N.P.  
Seattle, WA 98108  
Veterans Affairs Medical Center

\*Wiggins S, Whyte P, Huggins M, et al. The psychological consequences of predictive testing for Huntington's disease. *N Engl J Med* 1992;327:1401-5.

The authors reply:

*To the Editor:* Bird et al. raise interesting points about the costs of predictive testing for Huntington's disease and the possible reluctance of prospective candidates to pay for the test through health insurance programs financed privately or by an employer.

Our study of the psychological consequences of predictive testing for Huntington's disease was not designed to examine the effect of the source of payment; all the candidates were tested through the research protocol and therefore without charge. However, a survey of our cohort in October 1991 (unpublished data) indicates the extent to which the problem of payment could restrict participation in the program. Responding to the question "Would you be willing to pay up to \$2,000 for the predictive test?" 44 percent of 162 respondents said yes, 7 percent said they would not be willing to pay, 38 percent that they would be unable to pay, and 1 percent that they would not want the test under any circumstances. Clearly, with 38 percent of respondents indicating that they would not be able to pay up to \$2,000 for the test, socioeconomic bias will be an issue when people do not have access to, or are unwilling to pay for the test through, a health insurance plan.

In Canada this is unlikely to be a major issue, because approximately 5 of the 10 provinces have now accepted predictive testing for Huntington's disease as an insurable service under the universal health insurance program.

Whether payment for the test by the person at risk would raise the level of disappointment for those receiving news of an increased risk or an uninformative result is likewise unknown. However, psychological theories, such as cognitive-dissonance theory, might suggest otherwise. According to this theory,\* people who pay to receive the predictive test and then find themselves receiving news that is ambiguous or, in their view, "bad" will attempt to affirm the correctness of their decision. Thus, rather than admit that the results received were not worth the investment, such people may be more likely to resolve the dissonance by reconfirming their reasons for wanting the test. The extent to which this theory is true in practice requires investigation, particularly in jurisdictions where people feel obliged, either for lack of an alternative or through concern for the privacy of the information obtained, to pay for the test themselves.

SANDI WIGGINS, M.A., M.Sc.  
MICHAEL R. HAYDEN, M.B.,  
Ch.B., Ph.D.  
Vancouver, BC V6T 1Z4,  
Canada  
University of British Columbia

\*Penrod S. *Social psychology*. 2nd ed. Englewood Cliffs, N.J.: Prentice-Hall, 1986.

### MALARIA IMPORTED FROM SOMALIA

*To the Editor:* Malaria should be considered in the differential diagnosis of fever in any patient returning from an area where the disease is endemic.<sup>1</sup> During the Vietnam War, there were more than 14,000 cases of imported malaria among U.S. military personnel.<sup>2</sup> We are concerned that U.S. troops who served in Somalia in Operation Restore Hope may present with imported malaria after returning home.<sup>3</sup>

A 21-year-old Marine was deployed to Mogadishu, Somalia, on December 15, 1992. The patient received a third-