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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

A case of Lassa fever

SIR,—In the description of the experience at St Thomas's Hospital of a case of Lassa fever (9 October, p 1003) we read that, happily, there were no unfortunate consequences for staff or patients. This is not an uncommon experience[1] and therefore gives no cause for a premature reappraisal of the precautions that should be taken in the event of a case, or likely case, of Lassa fever being admitted to hospital. What the report does show, however, is that hospitals should have an established policy for the recognition and management of patients with a febrile illness who give a history of having been, within three weeks of the onset of illness, in an area where viral haemorrhagic fever may be a risk.

Several years ago the control of infection committee at this hospital established a procedure whereby any patient with pyrexia of unexplained origin arriving from Africa (but possibly also from other areas where viral haemorrhagic fever is known to exist) is examined by a senior doctor and no specimens are sent to a laboratory until the likelihood of viral haemorrhagic fever has been assessed. Such assessment is made in terms of low, moderate, or high risk,[2] and all request forms are signed by a senior medical officer or signed and then countersigned by two junior medical officers and are identified by red labels on the specimen and the request form. Cases with a low risk of viral haemorrhagic fever are processed with the same care as is accorded to specimens from patients who are known to be positive for hepatitis B antigen. Those of moderate risk or higher are processed in secure circumstances, and we are fortunate to have the high-security laboratory for Scotland situated in this hospital, in which such specimens can be handled.

This system has worked fairly well, although occasionally even with this seemingly simple arrangement staff have omitted to label a specimen correctly. Nevertheless, we believe that our system, which is easy to operate and understand, affords a useful measure of protection against the inadvertent introduction of potentially hazardous material into laboratories. Perhaps if some such similar system had been in operation in St Thomas's Hospital members of staff would not have been put in a situation where, although in the event all was well, a tragedy might well have ensued.

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[1] Westwood JCN. *The hazard from dangerous exotic diseases*. London: Macmillan, 1980.
[2] Emond RT, Smith H, Welsby PD. *Br Med J* 1978; i:966-7.

Postexposure immunoprophylaxis against B virus infection

SIR,—Following the publication by Boulter *et al*[1] and the ensuing correspondence (9 January, p 113; 23 January, p 271; 6 March, p 746) we would like to make some suggestions about the procedure to be adopted when a monkey handler is exposed to the risk of infection with monkey B virus (*Herpesvirus simiae*). We hope that this letter will be of assistance to occupational physicians who