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- What do you work with? W R LEE ..... 1846
- Psychogenic cough in childhood A D MILNER ..... 1847
- The Education Act 1981 J A MACFARLANE ..... 1848
- Prevention of hazardous drinking: the value of laboratory tests RICHARD D JOHNSON, ROGER WILLIAMS ... 1849
- Regular Review: Antisecretory drugs and gastric cancer M J S LANGMAN ..... 1850
- Correction: Resuscitation needed for the curriculum? 1852

## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

- Hepatitis B virus DVA in saliva, urine, and seminal fluid of carriers of hepatitis B e antigen P KARAYIANNIS, D M NOVICK, A S F LOK, M J F FOWLER, J MONJARDINO, H C THOMAS ..... 1853
- Chronic ulceration of the leg: extent of the problem and provision of care M J CALLAM, C V RUCKLEY, D R HARPER, J J DALE ..... 1855
- Effect of treatment with botulinum toxin on neurogenic blepharospasm J S ELSTON, R W ROSS RUSSELL ..... 1857
- Relation between consumption of alcohol and fatty acids esterifying serum cholesterol in healthy men JEAN-MICHEL WARNET, FRANÇOIS CAMBIEN, VIVIANE VERNIER, MARTINE PECORARO, CLAUDIE FLAMENT, PIERRE DUCIMETIERE, ALAIN JACQUESON, JACQUES-LUCIEN RICHARD, JEAN-ROGER CLAUDE ..... 1859
- Clinical importance of the renin-angiotensin system in chronic heart failure: double blind comparison of captopril and prazosin JOHN BAYLISS, MICHAEL S NORELL, RUDOLPH CANEPA-ANSON, COLIN REID, PHILIP POOLE-WILSON, GEORGE SUTTON ..... 1861
- Honey in the treatment of infantile gastroenteritis I E HAFEEJEE, A MOCSA ..... 1866
- Do sex hormones affect colorectal cancer? MICHAEL DAVIDSON, CARL N YOSHIZAWA, LAURENCE N KOLONEL ..... 1868
- Risk profile of soldiers aged under 40 with coronary heart disease PETER LYNCH, NEIL INESON, K P JONES, A W SCOTT, I C CRAWFORD ..... 1868
- Tolerance of elemental diet administered without starter regimen R G P REES, P P KEOHANE, G K GRIMBLE, P G FROST, H ATTRILL, D B A SILK ..... 1869
- Psoas abscess: unusual complication of effective chemotherapy for teratoma J MAGUIRE, S B KAYE ..... 1870
- Non-capsulate Haemophilus influenzae: a neglected pathogen in adults P ISPAHANI, E R YOUNGS ..... 1870
- Adenocarcinoma of the ileum presenting as non-traumatic clostridial myonecrosis in cystic fibrosis ANDREW N REDINGTON, ROBERT SPRING, JOHN C BATTEN ..... 1871
- Intestinal perforation associated with Yersinia enterocolitica infection GAVIN G P BROWNING, WILLIAM R C WEIR ..... 1872
- Practice Research: Managing alcohol problems in general practice PETER ANDERSON ..... 1873
- Safe limits of drinking: general practitioners' views PAUL WALLACE, ANNE CREMONA, PETER ANDERSON ..... 1875
- Audit Report ..... 1876

## MEDICAL PRACTICE

- Hospital Topics: The short life of a terminal care support team: experience at Charing Cross Hospital ANDREW HERXHEIMER, RICHARD BEGENT, DORRIE MACLEAN, LYN PHILLIPS, BARBARA SOUTHCOTT, IVAN WALTON ..... 1877
- Contemporary Themes: Unrecognised depression in general practice P FREELING, B M RAO, E S PAYKEL, L I SIRELING, R H BURTON ..... 1880
- My Student Elective: An eyewitness in Bhopal MOIRA SUTCLIFFE ..... 1883
- Occasional Paper: When do epileptic patients need treatment? Starting and stopping medication D CHADWICK, E H REYNOLDS ..... 1885
- Lesson of the Week: Injury to cervical spine after a game of British bulldog J D SPENCER, I W L BINTCLIFFE ..... 1888
- Philosophical Medical Ethics: Rights RAANAN GILLON ..... 1890
- Letter from Chicago: New epidemics GEORGE DUNEA ..... 1892
- Medicolegal: The Savage case: disciplining consultants CLARE DYER ..... 1894
- Materia Non Medica—Contribution from R D MONTGOMERY ..... 1879
- Medicine and Books ..... 1896
- Personal View JOHN M LAST ..... 1900

CORRESPONDENCE—List of Contents ..... 1901

OBITUARY ..... 1911

## NEWS AND NOTES

- Views ..... 1906
- Birthday Honours ..... 1907
- Medical News ..... 1907
- BMA Notices ..... 1909
- One Man's Burden MICHAEL O'DONNELL ..... 1910

## SUPPLEMENT

- The Week ..... 1913
- That ever more elusive green paper WILLIAM RUSSELL ..... 1914
- Senior Hospital Staffs Conference ..... 1915
- From the HJS Conference ..... 1918
- Mr Paige assures juniors of no change in central negotiations 1921
- From the LMC Conference ..... 1922
- Community Medicine Conference: selected decisions ..... 1923
- Lack of consultant expansion: CCHMS responds to Mr Paige's claim ..... 1924

## CORRESPONDENCE

<b>HTLV-III, haemophilia, and blood transfusion</b> A L Bloom, FRCPATH, and others . . . . . 1901	<b>Consultation length: general practitioners' attitudes and practices</b> R Anderson, MSC, and Ann Buxton, MB . . . . . 1903	<b>Philosophical medical ethics</b> G D Ripley, MD; R Gillon, MRCP . . . . . 1904
<b>Exercise and osteoporosis</b> I Hollo, DSCIMED, and I A Gergely, MD . . . . . 1902	<b>Teenage sex</b> J S Bradshaw, MB . . . . . 1903	<b>Severe extravasation injury</b> D A R Burd, MB, and others . . . . . 1904
<b>Male infertility</b> D E Osborn, FRCS; F C W Wu, MRCP, and J H J Bancroft, FRCPsych . . . . . 1902	<b>Occult advanced cervical cancer</b> C A Meanwell, MB, and others . . . . . 1904	<b>Patients who take overdoses</b> G Halasz, MRCPsych, and S Jaworowski, MRANZCP . . . . . 1905
<b>Children not immunised for measles</b> A G MacKenzie, MRCP; E Pugh, MRCP, and E Henson, R A Benson, MB . . . . . 1902	<b>Frozen shoulder</b> N A Watson, FRCS . . . . . 1904	<b>"Missed pill" conception: fact or fiction?</b> P Bye, MB . . . . . 1905
	<b>Comparison of different strategies for treating duodenal ulcer</b> D B Jones, MRCP, and others . . . . . 1904	<b>Does unemployment kill?</b> A Scott-Samuel, MFCM . . . . . 1905

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*Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.*

*Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.*

## HTLV-III, haemophilia, and blood transfusion

SIR,—We are writing on behalf of the directors of the UK haemophilia reference centres to express our concern about the safety of blood and unheated blood products.

The acquired immune deficiency syndrome (AIDS) is now the most important complication of treatment for haemophilia. By the end of April 1985 over 60 American and 20 European haemophiliacs with this disorder had been reported and about half of these had died. In haemophiliacs the prevalence of antibody to the causative agent HTLV-III in the UK has been rising since 1980,<sup>1</sup> mainly due to the use of unheated concentrate of factor VIII imported from America. However, seroconversion is also appearing in patients with haemophilia A treated only with factor VIII concentrates derived from UK plasma (Ludlum CA, Tucker J, Steel CM, *et al*, personal communication) and also in patients with haemophilia B treated only with locally produced factor IX concentrate.<sup>1</sup> Suggestions have already been made for using heat treated dried factor VIII concentrates since HTLV-III is known to be heat sensitive.<sup>2,3</sup> A similar case could also be made for using heat treated factor IX concentrate. However, in some categories of patients cryoprecipitate was considered to be the most appropriate treatment.<sup>3</sup>

To assess the impact of these recommendations on treatment for haemophilia in the UK the directors of the 109 haemophilia centres were circulated in May 1985 with a short questionnaire; 83 replies were received (table). Many centres were using cryoprecipitate and a substantial number were still using unheated UK factor VIII concentrate, but this may have represented clearing of existing stock. Only a few centres were using heat treated factor IX concentrate, presumably because this must be purchased from commercial sources whereas the unheated material is supplied "free" from the UK manufacturers. Heat treated UK factor IX is not yet available.

The figures have some disturbing implications. Without doubt the prevalence of HTLV-III infection in the homosexual population and other potential blood donors is increasing.<sup>4</sup> The safety of

cryoprecipitate and unheated UK blood products with regard to HTLV-III infection can therefore no longer be assumed, especially as these materials may need to be administered in repeated doses. Although there may be regional variations in donor positivity for HTLV-III antibody, we no longer consider that the use of cryoprecipitate or other non-heat treated concentrates is justified. Nor is this problem confined to patients with haemophilia. Although the risk from ordinary blood transfusion is still very small, it is undoubtedly increasing from the previous estimate of one in 100 000.<sup>2</sup> Certain patients, such as those undergoing open heart surgery or those with acute leukaemias or other haematological disorders, may easily receive whole blood, platelet transfusions, cryoprecipitate, or other blood derivatives from 50 or more donors in a short space of time. The risk of HTLV-III infection in such patients could now be as high as one in 20 in certain areas of Britain.

All these considerations underline the need rapidly to introduce screening for HTLV-III antibody for all blood donations. Three commercial test kits have now been approved by the American Food and Drug Administration and, although there may be a small number of false positives, it is unreasonable to delay testing until this possibility is eliminated. Donations which are found to

be positive for HTLV-III antibodies should be discarded. The logistics of retesting, confirmatory testing, and donor counselling can then be dealt with as separate important issues, as discussed in detail in the excellent review of Osterholm *et al*.<sup>5</sup> We believe that donors would readily accept this interim measure because, after all, they are themselves potential recipients. Although such testing will be expensive, we think that it should be implemented as soon as possible to protect recipients and to preserve public confidence in our blood transfusion services. When testing is fully implemented the role of single donor cryoprecipitate in the management of haemophilia can then be reassessed.

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## Factor VIII and IX concentrate use in UK

Concentrate type	Concentrate used		Comment
	Yes	No	
Unheated commercial VIII	1	82	
Children unheated commercial VIII	0	83	
Unheated domestic VIII	33*	48	
Children unheated domestic VIII	15*		
Cryoprecipitate	73	10	
Heated commercial VIII	66	17†	
Heated domestic VIII	46	36	Not yet freely available
Unheated domestic IX	55	12	
Heated commercial IX	14	50	Two centres use both heated and unheated
Neither IX		14	Presumed too few cases of haemophilia B

\* Includes three centres using it only for patients with HTLV-III antibodies.

† Includes five Scottish centres using heated domestic VIII. Others include small centres using unheated domestic VIII or cryoprecipitate.