BRITISH MEDICAL JOURNAL

SATURDAY 30 MAY 1987

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6584 BRITISH MEDICAL JOURNAL 1987 VOLUME 294 1367-1436
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.
WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 294 (6584) 1367-1436 (1987)

CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Abdominal aortic aneurysms

SIR,—Mr Gowland Hopkins (28 March, p 790) and Dr Janet Powell and Professor R M Greenhalgh (2 May, p 1161) are concerned by the cost of ultrasound screening for abdominal aortic aneurysm in all elderly men and propose alternative forms of selective screening.

Mr Gowland Hopkins suggests palpating the abdomen of men over 50 with ultrasonography for doubtful cases. Our screening programme for unselected men aged 65-79 comprises both abdominal palpation and ultrasound examination. Abdominal palpation has so far failed to detect any of the 2·8% of aneurysms yielded by ultrasound examination and has produced 7·1% false positive findings. Robicsek has shown that even in patients with a suspected aneurysm abdominal palpation confirms the diagnosis in less than one third, while in patients with strongly suspicious palpatory findings no aneurysm is present in more than a half.[1]

Dr Powell and Professor Greenhalgh suggest screening the smoking relatives of female and younger patients with aneurysms. There have been only eight women among the 93 patients surviving abdominal aortic aneurysm surgery in Oxford in the past 18 months and only 5·4% of patients were aged under 60. Detailed family histories from our last 28 patients yielded 119 first degree relatives, of whom 84 were already permanently beyond the reach of surgery. Of the 35 surviving siblings our patients would volunteer no addresses for 24, either because all contact had been lost or because they were too old, too frail, or too far away for us to help them. We have obtained the addresses of 11 people, five of whom live in the Oxford region. If we achieve the usual response rate to invitations for examination we can expect to screen one first degree relative for every 15 patients we operate on for an aortic aneurysm.

The screening methods suggested by Mr Gowland Hopkins and Dr Powell would both undoubtedly be cheap but also ineffectual.

JACKIE WALTON
JACK COLLIN

Nuffield Department of Surgery,
John Radcliffe Hospital,
Oxford OX3 9DU

1 Robicsek F. The diagnosis of abdominal aneurysms. *Surgery* 1981;8:275-6.

Laboratory control of oral anticoagulants

SIR,—Dr L Poller (9 May, p 1184) is rightly concerned that after the withdrawal of the Manchester human brain thromboplastin anticoagulant control in this country may suffer. We would disagree, however, that it is necessary to use a reagent with an international sensitivity index of 1·0-1·2.

For the past year we have used Diagnostic Reagents rabbit brain thromboplastin, which has an index of 1·4. Using a large number of patient samples and the Diagnostic Reagents thromboplastin as the reference preparation we have published our results, comparing this reagent with the Manchester human brain thromboplastin and the Manchester rabbit brain thromboplastin. The results gave international sensitivity index values very close to the manufacturers' stated values.[1]

Stimulated by Dr Poller's leading article, we looked at other aspects of our practice. We check our control times daily on fresh plasma pooled from four to eight normal donors. The weekly mean of control times for one year before we changed reagent, using Manchester human brain thromboplastin, was 11·7 (SD 0·352) seconds. The weekly mean of control times using Diagnostic Reagents thromboplastin for a year was 13·6 (0·274) seconds. During the year we have used 12 batches of Diagnostic Reagents thromboplastin and have seen neither a greater variation in control times than when using Manchester thromboplastin nor a change in control times between batches of Diagnostic Reagents thromboplastin.

From batches of frozen control plasma, one from 20 normal donors and another from 20 well controlled patients receiving anticoagulants, the international normalised ratio is calculated daily. The mean value for one entire batch of frozen control samples (two months) using Manchester human brain thromboplastin was 2·3 (0·114) (39 readings). The mean value of a subsequent entire batch of frozen samples using Diagnostic Reagents thromboplastin over two months was 2·0 (0·119). The international normalised ratios are not comparable because they relate to different batches of controls, but the standard deviations are very close.

From our anticoagulant clinic 13 stable patients receiving long term treatment with warfarin, who had not required any change in dose for a year before and a year after the change in reagent, were identified. With Manchester thromboplastin the range of eight results for the international normalised ratio was 2·2 to 2·8 (mean 2·5), with a range of standard deviation of 0·196 to 0·454 (mean 0·299). With Diagnostic Reagents thromboplastin the range of results for the ratio was 2·3 to 3·0 (mean 2·6), with standard deviations ranging from 0·192 to 0·444 (mean 0·34). Again the values are very close. No change in anticoagulant dose was