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SIR,—We thank Dr Arenson and his colleagues for their comments.

We agree that the incidence of 3.2% of patients developing possible post-transfusion hepatitis in our study is lower than the 7-10% incidence quoted from many non-European centres by Dienstag.¹ Our figure does, however, agree well with the 3.9% incidence found by the previous British study carried out by the Medical Research Council.² It is also in accord with the figure of 3.4% found in a similar study from the Netherlands.³

The main thrust of the letter from Dr Arenson and colleagues is that we may well have missed a number of cases of non-A, non-B post-transfusion hepatitis of longer incubation because of the way in which our study was carried out. We were careful to state that this was the case, but we suggest that our main conclusion—namely, that the incidence of appreciable chronic liver disease after blood transfusion was extremely low—is indeed valid. Although we accept that a small number of patients could have developed a transient rise in serum transaminase activity between 30 days and six months after transfusion several studies show that more than half of such patients continue to have abnormal results of liver function tests after six months⁴ and these have chronic liver disease.⁵ The fact that we found only one or at most two such patients is reassuring, as it suggests that only a small number of patients did indeed develop possible non-A non-B post-transfusion hepatitis in this period. If a large number—perhaps up to 10% of the patients as suggested by Arenson—had developed this longer incubation post-transfusion hepatitis we would have expected to see more patients with abnormal liver function values at six months.⁶

We agree that the design of our study was imperfect in that blood samples were not taken from on all patients every two weeks, but we suggest that the absence of raised transaminase concentrations in any of the 44 geographically selected patients who were so tested is also reassuring.

OLIVER JAMES
JONATHAN COLLINS

Department of Medicine,
Freeman Hospital,
Newcastle upon Tyne NE7 7DN

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Withdrawal of fluorescein strips

SIR,—Many ophthalmologists have been in the habit of using small fluorescein-impregnated paper strips, manufactured by the Haag-Streit company, during applanation tonometry. These have now been withdrawn from the market because they are apparently classified as a drug and therefore the instrument manufacturers are not permitted to supply them.

I rather thought that the drug laws were concerned with drugs that were supplied to the public. I am surprised to find that a product which is used exclusively by doctors during the course of their own diagnostic procedures should come under a legal ban. In this particular case, the ban is rendered all the more absurd by the fact that the substitute one might have recourse to is fluorescein drops, which are known to be far more dangerous than impregnated paper strips (due to their habit of harbouring the pyocyanous organism).

Thus bureaucracy is impeding the diagnostic process with no apparent benefit that I can see. Do you think that anything can be done about it?

REDMOND J H SMITH

London W1N 1AA

* *We sent this letter to the Committee on Safety of Medicines.—Ed, *BMJ*.

SIR,—The Medicines Act 1968 is, of course, not confined to drugs that are supplied to the public but covers all products for a medicinal purpose. Medicinal purpose as defined in the Act (section 130(2)(b)) expressly includes diagnosis. Thus we had no alternative to informing the company that imports the Haag-Streit strips that they were required to apply for licences: this they have, in fact, done. There is, however, another fluorescein strip product (Fluorets) on the market produced by another company that has a licence.

J P GRIFFIN

Committee on Safety of Medicines,
Department of Health and Social Security,
London SW8 5NQ

Screening for hypertension in general practice with an automatic machine

SIR,—I would like to take issue with the conclusions drawn by Dr W P Stephens and others (26 November, p 1600) from the results presented in their paper.

From their study they appear to derive a two-fold message. Firstly, that electronic measuring devices are not appropriate for screening patients for hypertension and, secondly, that case finding by routine measurement of blood

pressure on surgery visits is a more efficient means of detecting previously undiagnosed cases.

The figure of 4% of their screened population found to have values considered to be above the normal range at the first manual reading is in line with that reported in my recent paper, where just over 5% of new cases were detected by open access screening,¹ but Dr Stephens and colleagues did not recognise the importance of systolic hypertension.^{2,3} It therefore cannot be said on the basis of their published figures that as a method for detecting possible cases of previously undiagnosed hypertension either electronic instruments or screening programmes are inefficient.

The lack of success they reported is almost entirely related to the nature and results of their follow up programme, and from the published information it is not possible to assess what factors may have produced the lack of response. It may be, for instance, that the use of a doctor from outside the practice had a negative effect or that the times when screening was available tended to exclude those people in employment. The lack of a clear predetermined level of blood pressure above which the patient would be referred may have been another negative factor. I am also startled by the phrase: "The automatic machine conveys an alarming figure to the patient with no reassurance at all." Surely it should be the function of the technician or nurse in charge to make sure that this does not occur.

In conclusion, I suggest that Dr Stephens and his colleagues provide evidence in support of the use of electronic instruments and a formal screening programme for the detection of previously undiagnosed cases of hypertension, but they also valuably draw our attention to the difficulties of following up the patients so detected.

HARVEY GORDON

Mid Surrey Health Authority,
West Park Hospital,
Epsom,
Surrey KT19 8PB

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* *The authors reply below.—Ed, *BMJ*.

SIR,—Dr Gordon's study and our own are two early explorations of the value of automatic devices to screen blood pressure in the detection of unrecognised hypertension. The two studies approach the problem differently and, not surprisingly, have reached different conclusions.

We used Vita-Stat to select patients from a defined population (a health centre) for later manual measurements of blood pressure. The presence of doctors from outside the practice cannot have contributed to the disappointingly low attendance rate of 55% at the automatic screening because WPS and RDGT were not involved at that stage. In fact, once the recalled patients knew they were seeing an "outside doctor" the rate went up to 83%. We acknowledged in our paper that opening hours determine the number of patients seen. Opening hours were dictated by local practicalities, however, and in this respect would differ little from the opportunities