planning. This might be accomplished through a national commission associated with the body responsible for vital and health statistics. Whatever the auspices under which this body operates, the Expert Committee recommends that the national commission should be established at a high level within the Ministry or Department of Health and that it should contain representatives not only from the agencies concerned with health planning and health statistics but also from other agencies and bodies concerned with social, economic, and other data having a bearing on health and health services."¹

We believe that such a group should be established and that it should be chaired by a member from the NHS.

The great advantage of the establishment of such a group is that it should reduce the number of committees considering various aspects of health information in isolation and lead to greater efficiency in the use of personnel, resources, and documentation. Since the improved health information which would emerge from this initiative would be of essential importance for clinical and research purposes, as well as planning and resource allocation, the profession as a whole must take an interest and play a rôle in the development of our health information system.

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- ¹ WHO Expert Committee on Health Statistics, *Statistical Indicators for the Planning and Evaluation of Public Health Programmes*, WHO Technical Report Series No 472, Geneva, WHO, 1971.
- ² *Information on Health and Medical Services*, Report on the 3rd European Conference on Health Statistics, Turin, May 1971. Copenhagen, WHO Regional Office for Europe.
- ³ *Health Information Systems*, Report on Conference in Copenhagen, June 1973. Copenhagen, WHO.
- ⁴ *Health Data Banks*, Report on a Joint IFIP/WHO Working Group, Prague, August 1976. Copenhagen, WHO.
- ⁵ Hicks, D, *Primary Health Care*. London, HMSO, 1976.
- ⁶ *By Guess or by What? Information with Design in the NHS*. London, Oxford University Press for the Nuffield Provincial Hospitals Trust, 1978.
- ⁷ Ashford, J F, et al, in *Framework and Design for Planning: Uses of Information in the NHS*. London, Oxford University Press for the Nuffield Provincial Hospitals Trust, 1977.
- ⁸ Brittain, R D, *Health Information and Planning Systems. A National Health Service View. Health—Part of a Whole*. Cambridge, East Anglian RHA, September 1977.
- ⁹ Rowe, R G, and Brewer, W, *Hospital Activity Analysis*. London, Butterworth, 1972.

Behçet's disease

SIR,—In your recent leading article (22 July, p 234) the statement referring to Chamberlain's work,¹ "Of the 33 patients seen, 32 fulfilled her diagnostic criteria," is misleading in that of those 32 cases, 11 were classified as possible Behçet's syndrome. It should also be mentioned that of the total of six HLA B27-positive cases, four were from the "possible" group. This, of course, casts some doubt on the true prevalence of HLA B27 in Behçet's disease, a point of major importance in trying to lump the disease along with the seronegative spondarthroses.

With reference to Hamza's finding² of an increased prevalence of HLA B5 among patients with uveitis, of the eight patients without uveitis, two were HLA B5-positive, and of the 16 with uveitis, 10 carried HLA B5 ($P > 0.1$ with χ^2). In Turkey, where HLA B5 has a very high prevalence as well,³ no such

association is observed and the number of patients we have thus far tissue typed is 49.

Placing Behçet's disease among the seronegative spondarthroses is also very debatable; in fact, I believe there is enough evidence to exclude it from this group for the following reasons. (1) Vasculitis is a major component of Behçet's disease,⁴ whereas it certainly is not a common feature of the seronegative spondarthroses. (2) It is an HLA B5-positive and, at least in Turkey³ and Israel,⁵ an HLA B27-negative disease and this is also observed in a country where the prototype of the seronegative spondarthroses, ankylosing spondylitis, is an HLA B27-positive disease.⁶ (3) Sacroiliitis is not a feature of Behçet's disease. Of the 30 patients we have radiographed thus far, only two have some evidence of sacroiliac disease. Mason and Barnes⁷ and Chamberlain¹ also failed to find sacroiliitis. On the other hand the evidence for sacroiliitis in Behçet's disease used by Moll *et al*⁸ is not very strong and the authors acknowledge this. I failed to find any patients with Behçet's disease in one of the references⁹ cited by Moll *et al*, and another reference¹⁰ refers to one patient with spondylitis with no mention of sacroiliitis.

Thus I conclude that to remove Behçet's disease from the seronegative spondarthroses is in order.

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- ¹ Chamberlain, M A, *Annals of the Rheumatic Diseases*, 1977, 36, 491.
- ² Hamza, M, *International Symposium on Behçet's Disease*, Istanbul, 1977.
- ³ Yazici, H, et al, *Clinical and Experimental Immunology*, 1977, 30, 259.
- ⁴ Ryan, T J, *Microvascular Injury*. London, Saunders, 1976.
- ⁵ Chajek, T, et al, 14th International Congress of Rheumatology, San Francisco, 1977.
- ⁶ Yazici, H, et al, 14th International Congress of Rheumatology, San Francisco, 1977.
- ⁷ Mason, R M, and Barnes, C G, *Annals of the Rheumatic Diseases*, 1969, 28, 95.
- ⁸ Moll, J M H, et al, *Medicine (Baltimore)*, 1974, 54, 343.
- ⁹ Wright, V, and Watkinson, G, *American Journal of Proctology*, 1966, 17, 107.
- ¹⁰ Perkins, E S, *Proceedings of the Royal Society of Medicine*, 1966, 54, 106.

SIR,—I am writing to challenge the assertion in your leading article (22 July, p 234) that Behçet's disease is associated with an increased frequency of the HLA B27 tissue antigen. In the study on which this proposal is based¹ HLA B27 was present in six of the 23 patients said to have Behçet's syndrome who were tissue typed, but in fact only one of these patients had the classical triad of aphthous oral ulceration, genital ulceration, and uveitis,² with a further patient satisfying the diagnostic criteria of "definite" Behçet's disease proposed by Mason and Barnes.³ Four of the six HLA B27-positive patients were described as having only "possible" Behçet's syndrome and if this group of patients is excluded the incidence of HLA B27 does not differ from that in the general population, a finding in agreement with other tissue-typing studies in Behçet's syndrome.^{4,5}

Two of the patients with "possible" Behçet's disease lacked scrotal or vaginal ulceration, a feature which is useful in differentiating Behçet's from Reiter's disease. The latter syndrome's clinical manifestations also include oral ulceration, uveitis, and arthritis and is undisputedly associated with an increased incidence of HLA B27⁶; indeed, it has been suggested that the presence of HLA B27 in a patient with oral ulceration and arthritis is a useful discriminator in separating

the incomplete form of Reiter's disease from incomplete Behçet's syndrome,⁷ HLA B27 being associated with the former and HLA B5 with the latter.^{5,8}

If conclusions about the incidence of histocompatibility antigens in clinical syndromes are to be drawn from population studies it is important to adopt strict criteria to define the disease entity in the sample surveyed. In patients with definite Behçet's disease the tissue-typing studies published to date do not supply evidence of an increased frequency of the HLA B27 tissue antigen, a finding in accord with the rarity of sacroiliitis in this condition.¹

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- ¹ Chamberlain, M A, *Annals of the Rheumatic Diseases*, 1977, 36, 491.
- ² Curth, H O, *Archives of Dermatology and Syphilology*, 1946, 54, 179.
- ³ Mason, R M, and Barnes, C G, *Annals of the Rheumatic Diseases*, 1969, 28, 95.
- ⁴ O'Duffy, J D, Taswell, H F, and Elveback, L R, *Journal of Rheumatology*, 1976, 3, 1.
- ⁵ Haim, S, Gidoni, O, and Barzilai, A, *Acta Dermatovenereologica*, 1977, 57, 243.
- ⁶ Mahir, A M, et al, *Rheumatology and Rehabilitation*, 1977, 16, 92.
- ⁷ Brewerton, D A, et al, *Lancet*, 1973, 2, 996.
- ⁸ Ohno, S, et al, *Lancet*, 1973, 2, 1383.

* * * Inclusion of Behçet's disease in the group of diseases known as seronegative (for rheumatoid factor) arthropathies or spondarthroses does not imply a common aetiology or for that matter common histocompatibility antigens. The value of inclusion is that Behçet's disease should be considered in the differential diagnosis of uveitis and of seronegative arthritis, which are particularly common presentations. The prevalence of sacroiliitis and of the related HLA B27 is variable in the different diseases in this group, and the reasons for this and the possible effects of gene interaction have been recently discussed.¹ While certain histocompatibility antigens are associated with some diseases, the use of tissue typing as a diagnostic aid or discriminator is misconceived.

In the absence of specific diagnostic features, various criteria for the diagnosis of Behçet's syndrome have been suggested. Curth required the presence of only two features of the triad, and these criteria were fulfilled in three of the four "possible" patients with Behçet's disease and HLA B27. Mason and Barnes devised a different classification with criteria for "definite" and "possible" cases. Most patients with "possible" Behçet's disease fulfil Curth's criteria and the latter form the basis of many published series.—ED, *BMJ*.

- ¹ Brewerton, D A, *Journal of the Royal Society of Medicine*, 1978, 71, 331.

Preventing Rh haemolytic disease

SIR,—Dr P H Renton and Mr R A Riches (26 August, p 634), commenting on our article on Rh haemolytic disease prevention (8 July, p 106), state that if we had ensured that mothers with high fetal red cell "bleeds" had received higher doses of anti-D immunoglobulin our failure rate might have been lower than 0.9%, and they detail the procedure in the Manchester region to ensure that these high-risk mothers receive a larger dose. May we assure them that the procedure in this region is identical with theirs. For the sake of brevity and because details of our procedure in the Leeds region had been published

previously¹ it was not included in this article. Kleihauer tests are performed at the majority of deliveries and any mother with a high fetal count receives a larger dose of anti-D in accordance with the recommendation of the World Health Organisation.

In practice, however, I am not convinced that the matter of dose is a major factor in the incidence of failures of protection. For example, in the 35 cases of failure of protection in 1974-6 only three mothers had fetal counts above the 100 cells/50 low-power field level at which a larger dose of anti-D is recommended. One mother had a count of 672 cells and received a 500- μ g dose, while another had 628 fetal cells and received 400 μ g of anti-D. The third had 375 fetal cells and this patient received a standard 100- μ g dose. Therefore if the fetal cell count/dose regimen had been adhered to one hundred per cent there would have only been one less case. It is my opinion that the major factors in the development of failures of protection are sensitisation prior to the anti-D administration and the (genetically controlled) immunological responsiveness of the mother.

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¹ Tovey, L A D, *Health Trends*, 1976, 8, 25.

Syringe-transmitted hepatitis

SIR,—Professor A J Zuckerman (2 September, p 696) writes that "it is imperative that an adequately sterilised or a disposable syringe and needle should be used for each individual patient" and I strongly support his authoritative statement. It is disappointing, to say the least, that any less careful technique should be contemplated at the present day almost 35 years after the study in military personnel undergoing intravenous treatment for syphilis established the method of infection, epidemiology, and prevention of syringe-transmitted hepatitis. This definitive study was reported in 1945¹ and amplified in the Watson lecture of the Royal Faculty of Physicians and Surgeons of Glasgow in February 1947.² Other reports of serum hepatitis arising in persons having venepunctures in a diabetic clinic, subjected to mass immunisation, receiving blood transfusion, or undergoing tattooing indicated that the risk of acquiring hepatitis B infection was not confined to the syphilis clinic. While I understand the logistic attractions of a multidose-syringe technique, the seriousness of serum hepatitis B infection demands the use of a technique that excludes any risk of serum transmission and fully justifies Professor Zuckerman's unequivocal statement.

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¹ Laird, S M, *British Journal of Venereal Diseases*, 1946, 22, 29.

² Laird, S M, *Glasgow Medical Journal*, 1947, 28, 199.

SIR,—Professor A J Zuckerman (2 September, p 696) advocates the use of a separate disposable syringe and needle for the mass BCG vaccination of schoolchildren and says that the evidence for a change in the current practice is indisputable. Several years of annual reports of the chief medical officer on the state of the public health in England show that some half million schoolchildren are

vaccinated each year with BCG, and this will have been accomplished in the vast majority by using a separate syringe for every 10 injections and a new needle for each child. Statutory notification of infectious jaundice was introduced in 1968, but the literature of this sort of case occurring following BCG vaccination is non-existent.

Professor Zuckerman cites cases of hepatitis occurring in groups such as diabetics after venepuncture and Royal Navy personnel receiving intramuscular injections from a multidose syringe for syphilis and extrapolates the evidence so as to incriminate intradermal injections in school children. This is clearly not good enough, though there may be theoretical grounds to change the present practice so that each child receives vaccine from a separate disposable syringe and needle. The consequence of such a change would be a vastly increased cost for the Health Service in terms of both syringes and doctors' and nurses' time as the procedure would be slowed down. The extra cost would, of course, need to come from the finite pool of Health Service resources and I would like to query whether the increased costs are justifiable.

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Misdiagnosis of amoebiasis

SIR,—It was surely inevitable that the amoebiasis unit should be reorganised following the retirement of its founder last year and we are sorry that this seems to have become the subject of controversy in your columns. Following in your footsteps (leading article, 5 August, p 379) and unassured by our reply (26 August, p 632), Professor Brian Maegaith (9 September, p 769) regrets the "absorption" of the unit into the pathology department of the Hospital for Tropical Diseases. Despite a rather gross disparity of resources, this department was already handling just three times as many routine investigations for amoebiasis as the then separate and well-publicised amoebiasis unit. Since the merger the combined figures have continued to increase. The joint amoebiasis service is separately funded by the Public Health Laboratory Service. We know of no evidence that the reference services are inadequate and, as Dr J E M Whitehead points out (9 September, p 769), there is no reason why anyone should be in ignorance of them; yet Air Vice-Marshal Stamm (9 September, p 769) sees a possible connection between the death of Dr T H Foley's patient (5 August, p 428) and the "loss of independence" of the amoebiasis unit. The death is reported to have occurred about two years ago, at a time when the unit was still under Air Vice-Marshal Stamm's direction.

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Blood cultures for diagnosis of endocarditis

SIR,—Dr Celia Oakley, in her valuable article "Use of antibiotics—endocarditis" (12 August, p 489), states that between four and six blood

cultures should be taken over an hour or two before treatment is given. We believe that this is excessive. It imposes a burden on the laboratory, which will have to spend a disproportionate time on large numbers of negative cultures from patients suspected of, but not suffering from, endocarditis. It is also a burden on the patient.

There is good evidence that three cultures are sufficient.¹ When one is positive all three will be positive in a very high proportion of cases and the need for more than one in endocarditis is to allow for accidental contamination during collection or in the laboratory and to confirm the diagnosis when growth fails to appear in all culture bottles from a single sample. More cultures may be needed from patients who have had previous infection, especially those with prostheses, in whom the diagnosis is less likely to be straightforward, but for primary diagnosis three is sufficient.

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¹ Crowley, N, *Journal of Clinical Pathology*, 1970, 23, 166.

Bell's palsy and herpes simplex

SIR,—Dr John B Wilson's statement (2 September, p 704) that "these results demonstrate a definite relationship between Bell's palsy and herpes simplex infection or reinfection in two of these cases and support the concept that Bell's palsy is a disease of multifactorial aetiology" is highly dubious. No one would dispute that facial nerve palsy can be caused by a variety of insults; herpes zoster is a well-known viral cause. Zoster of the facial nerve is often associated with sensory zoster of branches of the trigeminal or upper cervical nerves.

Unfortunately the information on Dr Wilson's four patients is inadequate. It is a pity that no culture of the vesicle fluid of the "typical herpeticiform rash around the auricle" was attempted; it might have revealed that the second patient had zoster. A varicella-zoster titre of 1/256, not least in a 92-year-old patient, in specimens taken 20 days after the onset of the rash and at about four weeks is consistent with recent zoster. It would have been most helpful to have had the zoster titres in all the patients, not just in case 2. Case 1 might again have been one of facial zoster, and the rise in herpes simplex titre might have been anamnestic. We were given no information about whether these patients had a history of recurrent herpes simplex lesions. I find it impossible to explain the herpes simplex titres in case 2. One assumes the tests were carried out at the same time. Cases 3 and 4 prove nothing, for the herpes simplex titres have not changed significantly.

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SIR,—Dr John Wilson (2 September, p 704) contends that in his four cases the serological results demonstrate a definite relationship between Bell's palsy and herpes simplex infection or reinfection. However, there are serological cross-reactions between herpes simplex and varicella-zoster (V-Z), and rising antibody titres to herpes simplex may be