birth. For most women, probably, even a small excess risk of death would be reason enough to avoid the possibility of being the "extra" one to suffer a perinatal loss. At present, the advice available to women is hampered by the lack of sufficient good quality evidence.

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Making British blood supply safer

EDITOR,—L A Kay states that the blood supply in Britain could be made safer, specifically identifying the absence of routine screening for HTLV antibody and hepatitis B core antibody and the failure to introduce quarantining of frozen components as specific causes for concern.¹

Several factors contribute to the overall safety of the blood supply. The use of appropriate donor exclusion criteria in conjunction with well documented quality assurance programmes is at least as important as the number of screening tests undertaken in determining the overall level of safety.

Kay states that up to 200 components infected by HTLV may be given in transfusions each year. This is likely to be a considerable overestimate. The figure is based on a study in north London,² which found 1 in 19 000 donors were positive for this marker. A similar study in Yorkshire³ identified a prevalence of 1 in 80 000, which if applied across Britain would result in a figure of approximately 50 components, not all of which would be transfused; only a proportion would result in transmission of infection.

Hepatitis B core antibody testing has been proposed as a mechanism to further reduce the risk of transfusion associated hepatitis B. The incidence of hepatitis B surface antigen positivity has fallen significantly in the donor population over the past few years. In the absence of prospective studies any estimate of the current level of transfusion acquired hepatitis B must be treated with some caution and the figure of 50 cases a year quoted by Kay is likely to be an overestimate. Ongoing research may assist in answering this particular question.

Quarantining of frozen components aims to minimise the likelihood of infectious donations entering the blood supply during the window period. It is one of several ways the safety of frozen components might be improved. The low level of positivity for viral markers within the British donor population suggests that the overall benefit of such an approach would be small, and this must be considered in the context of significant cost and the future availability of more specific viral inactivation protocols for these components.

The requirement for extending current measures used to ensure the safety of the blood supply is kept under regular review. Innovative approaches such as "first pass testing," as proposed by Pagliuca and others,⁴ merit consideration, although the operational feasibility of this will require careful assessment. Additional measures will be taken if appropriate to ensure that the current high reputation of British transfusion services in this area is maintained.

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Wrong comparison quoted for breast screening

EDITOR,—Minerva has got it wrong.¹ She quotes figures comparing the rate of detection of breast cancer in women aged over 64 attending for screening for the first time (prevalent round) with rates in women aged 50-64 invited for the second time (incident round).² The first figure should have been compared with the detection rate in the prevalent round in women aged 50-64, which was 10/1000.² The detection rate in women aged over 64 (14.2/1000 in those aged 65-69 and 13.2/1000 in those aged 70-74) is only marginally higher.

There is no point in routinely inviting women aged over 64 for screening until it has been shown that the improvement in mortality in women who have already been offered screening is greater than that in older and younger women. Additionally, not enough staff are available or interested in screening for the service to be extended at the moment.³

In the meantime, the government has funded a large pilot study extending the age for a routine invitation for screening to 69. East Sussex, one of two centres in England taking part in the study, will invite 20 000 women aged 65-69 over the next three years. This study should provide useful information on the attendance rate, practical issues such as whether mammography takes longer in these women, and the incidence and prognostic index (staging, pathological grading, and size) of cancers detected in this group.

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Study of breast feeding and hypertrophic pyloric stenosis does not conflict with others

EDITOR,—Alfredo Pisacane and colleagues found no association between breast feeding and hypertrophic pyloric stenosis in infants.¹ Contrary to their statement, their data are entirely consistent with those of Webb *et al.*, who showed that the rise in infantile pyloric stenosis after 1976 affected predominantly bottle fed babies.² In that paper my colleagues and I speculated that "some other environmental change must therefore be found to explain the increase" in infantile pyloric stenosis that had occurred in south Wales and elsewhere in Britain after 1976, which coincided with the abrupt withdrawal of unmodified cows' milk formulas and their substitution by low solute "humanised" feeds. Although there was a significant excess of breast fed babies with pyloric stenosis in Belfast before 1970,³ this was not apparent after artificial infant feeds were modified.

A careful reading of the papers cited by Pisacane and colleagues^{2,3} will show that there is no conflict between their data and ours.

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Global commissioning by GPs could be detrimental to rehabilitation services

EDITOR,—We read Jonathan Shapiro's editorial on global commissioning by general practitioners with some concern.¹ While we favour increasing the involvement of general practitioners in the commissioning of health services, we are concerned about the possible impact of extending the scope of general practice fundholding on the provision of specialist rehabilitation services for adults and children with complex disabilities.

Some aspects of rehabilitation in common disorders such as stroke are relatively routine, but many people with disabling disorders have a complex and changing pattern of need and require specialist assessment, management, and support. Individual general practitioners are likely to have relatively little experience or knowledge of the management of conditions such as motor neurone disease, major acquired brain damage, or cerebral palsy, yet there may be considerable numbers of people with such conditions in an average sized traditional NHS district.²

We see little evidence that the consequences of fragmenting the purchasing of critical rehabilitation items such as complex orthotics or brain injury services have been adequately thought through. In the NHS internal market, with necessarily limited resources, there is a risk that the provision of more complex and expensive services will suffer through competition with larger volume services that are better understood.

The development of good quality accessible local services would benefit greatly from a collaborative approach from general practice fundholders, perhaps purchasing packages of services but in close liaison with specialists in rehabilitation and in public health and taking account of the views of users of the services. Further fragmentation of the purchasing of rehabilitation services could well discourage the development of good quality local services designed to address the population's needs. It would be all too easy to spend a great deal of money on rehabilitation services to little effect, and this surely is what the NHS reforms seek to prevent.

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