Supporting local ethics committees is a responsibility of purchasers.² Lambeth, Southwark and Lewisham Health Commission is reviewing the organisation of the local committees and will be meeting their chairpersons to discuss how the problems discussed can best be tackled. Given the problems mentioned above and the fact that many hospital ethics committees are already overloaded, the answer may lie in setting up a local ethics committee dedicated to primary care and community research.

CHRIS BONELL

Lambeth, Southwark and Lewisham Health Commission,
London SE1 7RJ

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Local committees overstretched and inexperienced

EDITOR,—Linda M Stanton draws attention to the requirement of the Department of Health that all research involving NHS patients should be reviewed by a local research ethics committee.^{1,2} She goes on to suggest that the standards of independent ethics committees vary and may not reach those of the clinical research ethics committee of the Royal College of General Practitioners. In our experience the standards of overstretched and inexperienced local research ethics committees in the NHS may vary far more than those of independent committees.³ It is characteristic of our system of government that guidelines are issued, and standards set, without the facilities (principally funding) necessary for their attainment being provided. It is therefore hardly surprising that many general practitioners, once satisfied that a clinical study has been adequately reviewed in accordance with the Declaration of Helsinki,⁴ feel constrained not to entangle themselves in the morass of local review, with the likelihood of appreciable delay, further paperwork, and (well intentioned) meddling.

There are many well organised and scientifically aware local research ethics committees working thanklessly in Britain, but until the majority start to achieve the level of efficiency of the best they will continue to pose a considerable threat to clinical research in general practice.

MARK WATLING

JOHN K DEWHURST

TIL Occam,
Surrey Research Park,
Guildford,
Surrey GU2 5YN

1 Stanton LM. Research in general practice. *BMJ* 1994;308:208. (15 January.)

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Human parvovirus B19

Hard to differentiate from infectious mononucleosis

EDITOR,—J R Pattison's editorial prompts us to report recent difficulties that we encountered in differentiating between infectious mononucleosis and parvovirus B19 infection.¹ Fever, pharyngitis, lymphadenitis, and abnormal mononuclear cells in the peripheral blood are the characteristic features of infectious mononucleosis. In most laboratories the diagnosis is now made or reinforced by the finding of heterophil antibodies on latex

agglutination testing. Such testing is based on the agglutination of latex particles coated with the highly purified Paul-Bunnell antigen derived from red cell membranes.² False positive results have rarely been reported, and the test is regarded as highly specific. Confirmation is normally unnecessary,³ but the manufacturers of the kit that we use (Monolatest, Biokit, Kent) state that the results of the assay should be interpreted in the light of the clinical symptoms.

Other conditions, including toxoplasmosis, rubella, and cytomegalovirus and parvovirus B19 infections, may be clinically indistinguishable from infectious mononucleosis and sometimes give rise to false positive reactions, thus reducing the specificity of the latex agglutination test.^{2,4} This was highlighted recently when an unexpectedly large number of serum samples from patients with typical signs and symptoms of infectious mononucleosis sometimes accompanied by a rash or arthritis both contained parvovirus IgM and gave positive results on a latex agglutination test (Monolatest). We consequently carried out serological assays for recent infection with Epstein-Barr virus (table). Unfortunately, these more specific tests are lengthy indirect immunofluorescence procedures, which are often available only in specialist laboratories. Recent infection with Epstein-Barr virus is indicated by the presence of capsid antigen IgM and the absence of nuclear antigen or the appearance of antibodies to nuclear antigen in a patient who was previously positive for capsid antigen IgM and negative for nuclear antigen.

Results of serological investigation of 36 serum samples that yielded positive results in latex agglutination tests during recent outbreak of infection with parvovirus B19

	Positive for parvovirus B19 IgM	Negative for parvovirus B19 IgM	Not tested
No of samples	9*	16	11
Positive for Epstein-Barr virus capsid antigen, negative for nuclear antigen†	0	10	—
Positive for Epstein-Barr virus capsid antigen and nuclear antigen‡	6	6§	—

*Three samples were insufficient for retesting.

†Indicates recent infection.

‡Indicates past infection.

§Three samples were positive for common chlamydial antigen, mycoplasma IgM (enzyme linked immunosorbent assay (ELISA)), and antistreptolysin O.

When the latex agglutination test was performed on 94 serum samples containing parvovirus IgM 36 yielded positive results. Gray *et al* reported that two out of five serum samples containing human parvovirus IgM gave false positive results in latex agglutination tests.² They observed that infectious mononucleosis occurred more commonly in patients in their early 20s and was slightly more common in men whereas parvovirus infection more commonly presented in women in their late 20s and 30s. Previous workers have drawn attention to the limitations of the Paul-Bunnell test. Caution is required to avoid the diagnostic confusion that may result from cross reactivity between latex agglutination test and parvovirus IgM. To resolve the problem it may be necessary to resort to the specific tests for Epstein-Barr virus.

We thank Bristol Public Health Laboratory for performing the tests for Epstein-Barr virus and parvovirus B19.

J WYNNE JONES

JVS PETHER

RWP FROST

Public Health Laboratory,
Taunton TA1 5DB

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Virus transmissible in blood products

EDITOR,—From a haematological perspective, a few points must be added to J R Pattison's editorial overview of human parvovirus B19 infection.¹

Firstly, parvovirus B19 is transmissible in blood components and products.² It is not clear whether chemical or physical treatments, as used for HIV and hepatitis B and C viruses, are successful in inactivating parvovirus B19 from pooled blood products.^{2,3} This is particularly relevant to people with haemolytic states who often require blood and also immunocompromised people, including haemophilic patients infected with HIV, in whom transfusion of blood products contaminated with parvovirus B19 may have severe consequences.³

Secondly, recent evidence suggests that parvovirus B19 infection in adults may present as lymphadenopathy and fever without a rash or arthropathy.⁴ Although this requires further evaluation, it adds to the clinical range of parvovirus B19 infection.

Finally, nosocomial spread has been described from patients with aplastic anaemia induced by parvovirus B19.⁵ Thus such patients should be isolated and respiratory precautions taken; contact with other patients at risk of aplastic anaemia and with pregnant women should be prevented until the anaemia improves.

J A SNOWDEN

W I ALI-WALI

Northern General Hospital,
Sheffield S5 7AU

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Raw eggs in recipes in magazines should go

EDITOR,—In 1988 the chief medical officer advised that "people should avoid eating raw eggs or uncooked foods made from them and that vulnerable people such as the elderly, the sick, babies and pregnant women should only consume eggs which have been cooked until the white and yolk are solid."^{1,2} Despite this advice, raw or inadequately cooked eggs continue to be implicated in outbreaks of illness.³ Magazines and cookery books are a popular source of recipes and can have a role in guiding the public with regard to safe preparation of food. We carried out a survey to see whether these publications encourage compliance with the government's advice.

We looked at 13 of the most widely read magazines available at newsagents during the last two weeks of September 1993 (eight were published weekly and five monthly). We studied each publication for recipes that required raw shell eggs and for warnings about the risks of salmonella infection. Seven of the publications contained recipes that required raw shell egg but did not entail any heating at all. A further three contained recipes in which eggs were only partly cooked and would have been unlikely to reach a safe temperature. Only one suggested an alternative to using raw eggs, although the risk to health was not stated.

We wrote to the cookery editor of each publication asking whether it had a policy on publishing recipes that required raw or lightly cooked eggs; three responded. One admitted that the publication did not publish warnings but intended to introduce them in future for high risk groups. The second claimed that a caption was printed next to high risk recipes. The third said that the publication printed a warning to vulnerable groups alongside recipes containing raw egg; we could find no such warning.

Clearly, many editors still do not appreciate the risk of salmonella infection from eating raw eggs. There seems to be some misapprehension that only high risk groups such as very young or elderly people may be at risk. Many of the people affected in outbreaks in which raw egg has been implicated have been young, previously fit adults.

Cookery writers are well placed to educate the public and to develop alternatives for recipes that require inadequately cooked eggs. Some alternatives, such as dried or pasteurised eggs, are not always easily available in retail outlets. If these products were widely promoted in recipes the increased demand would widen their availability and encourage safe cooking practices.

LORRAINE LIGHTON
LINDSAY GREENWOOD

Tameside and Glossop Health Authority,
Hyde,
Cheshire SK14 1DB

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Health promotion advice in the private sector

EDITOR,—An 86 year old female patient of mine was given a cardiovascular risk assessment as a Christmas present by her family. This was done at a local private hospital and cost £50. The report does not mention her existing angina or osteoporosis as two major health problems. For her £50 she had her total cholesterol concentration measured (7.3 mmol/l, her body mass index calculated (26), and her blood pressure tested (160/90 mm Hg). She was told that she should lose 6.4 kg in weight and given detailed dietary advice on reducing her fat intake. Following this advice would not have lengthened her life but would certainly have made it more miserable. She was greatly relieved when I told her that she could ignore this and eat what she liked.

How can any sensible, coherent, and consistent health promotion advice be given to the general public when messages like this emanate from the private sector?

J JUSTICE

Medical Centre,
South Harrow,
Middlesex HA2 8RS

Study leave difficult to fund

EDITOR,—Like many college tutors I am wrestling with the task of designing an educational scheme for my department's trainees that is compatible with time that they are available and with service demands. The senior house officers and registrars work the equivalent of a 72 hour on call rota. The mathematics of this means that there are occasions when they have complete days free of a service commitment. They may well be recovering from a busy night on call.

Senior house officers and registrars are entitled to up to 30 days' study leave each year. This, however, originated when the normal working week for trainees was frequently over 100 hours. Therefore the time that they could commit to training was considerably less than it is now. The hourly working week now is perhaps two thirds what it used to be. Has the time come to reduce the annual allocation of study leave to senior house officers and registrars to 20 days? I am sure that my department is not alone in finding it impossible to meet the financial demands of 30 days' leave with expenses.

DAVID P COATES

Directorate of Anaesthesia,
Bristol Royal Infirmary,
Bristol BS2 8HW

Failure to thrive

Define it carefully

EDITOR,—Harvey Marcovitch's review of failure to thrive was flawed in its failure to define the term satisfactorily.¹ In the wider sense failure to thrive can be defined as the failure of a child to fulfil his or her potential in terms of physical, social, and emotional growth and development. In the somatic sense, the term failure to thrive is usually applied to infants and preschool children to denote a failure to gain weight at an appropriate rate. In other words, the child is thin; typically, head growth is preserved relative to linear growth, and linear growth is preserved relative to body weight.

By contrast, short stature simply means height below the third centile and makes no assumption about the normality or otherwise of the child. Clearly, a child who is particularly short but proportionate will be below the third centile for weight as well as height without in any sense failing to thrive.

Growth failure can be defined as failure to achieve a height velocity appropriate for age and stage of development. A classic example of this is seen in acquired primary hypothyroidism (for example, Hashimoto's disease), in which initially at least the child will not necessarily be short and certainly will not be thin.

Failure to thrive, short stature, and growth failure may coexist but are separate entities that should not be confused. For example, in box 1 in Marcovitch's review (differential diagnoses in children who may be failing to thrive) a normal child with short stature cannot by definition be failing to thrive.

With regard to mid-parental heights, I agree that parents should be measured whenever possible but disagree that parents "tend to overestimate own height." Though men almost always do this, women usually underestimate it.

MALCOLM DONALDSON

Department of Child Health,
Royal Hospital for Sick Children,
Glasgow G3 8SJ

- 1 Marcovitch H. Failure to thrive. *BMJ* 1994;308:35-8. (1 January.)

Persevere with breast feeding

EDITOR,—We believe that the information on managing failure to thrive in a breast fed baby given in box 6 of Harvey Marcovitch's article warrants further discussion.¹ If other causes have been excluded there is little point in test weighing the baby. This procedure is notoriously inaccurate² and will not assist in the management. It is essential to observe a breast feed.

To feed efficiently the baby needs to make a teat from both the nipple and the breast. If the baby is trying to feed from the nipple alone he or she will fail to compress the lactiferous sinuses underlying

the areola and will obtain most milk via the letdown reflex. The baby will thus fail to obtain the high fat (high energy) milk that comes at the end of an efficient feed.³ The mother's breasts may respond to inefficient use by either increasing or decreasing the volume, but unless the quality of the baby's "mouthful of breast" is improved the feeds will continue to be low in fat.

Discussion with the mother may establish that she is removing the baby from the breast after a set time rather than allowing the baby to terminate the feed by spitting out the nipple when satiated. (Until recently, mothers were told not to allow the baby to feed at one breast for longer than 10 minutes.) Such a practice can also lead to the baby failing to obtain the hind milk.⁴

In both instances the mother will indeed need "practical nursing advice"—that is advice on how to nurse her baby. Marcovitch's instruction to "discuss with the mother how important she regards breast feeding" seems to imply that she should be discouraged from continuing unless she is adamant that she wishes to do so. In view of the overwhelming benefits to the baby of receiving his or her mother's breast milk, surely the emphasis should be on helping the mother to solve her problem. The instruction shows what little confidence health care professionals now have in their ability to help a woman breast feed successfully.

JO ALEXANDER

Midwifery Education Department,
Princess Anne Hospital,
Southampton SO9 4HJ

CHLOE FISHER
SALLY INCH

Breastfeeding Clinic,
Women's Centre,
Churchill John Radcliffe Hospital,
Oxford

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Risk factors for salmonella infection

Loss of gastric acid linked to candidiasis

EDITOR,—Keith R Neal and colleagues report that recent treatment with H₂ antagonists and gastric surgery predispose to salmonella infection, presumably as a result of reduced production of gastric acid.¹ A protective effect of gastric acid against the non-typhoid salmonellosis has been suspected.² Another potential infective complication of reduced secretion of gastric acid is candidiasis.

There have been anecdotal reports of both local and systemic candidal infections after various interventions that produce gastric hypoacidity, including partial gastrectomy, vagotomy, and treatment with H₂ antagonists^{3,4} and proton pump inhibitors.⁵ Because local candidal infections—for example, of the oesophagus—are often asymptomatic the risk of infection after inhibition of secretion of gastric acid is difficult to quantitate by case-control studies. Data from patients with systemic sclerosis suggest, however, that a combination of impaired oesophagogastric motility and reduced production of acid may particularly enhance susceptibility: candida was found in oesophageal brushings in 44% of untreated patients but in 89% of a subgroup of patients treated for oesophagitis with high dose ranitidine (> 300 mg/day) or omeprazole (40 mg/day).⁶ Such observations have prompted the suggestion that