striking and highly significant improvement in the clinical outcome at three months was observed in the nimodipine limb. Among all 554 patients, 235 of whom underwent operation, a bleeding event led to nimodipine being stopped in only one patient. This patient suffered a colonic bleed of moderate severity, which the investigator reported as possibly being associated with nimodipine. The patient required a blood transfusion but recovered uneventfully.

"Bleeding" events were reported as an adverse event in two further patients, both of whom had received nimodipine. The first patient was reported to have a rash and haematoma on the back, which the investigator stated was almost certainly related to the use of ceftazidime. The second patient was reported as having thrombocytopenia and anaemia. This was observed 15 days after the treatment with nimodipine was completed, and the investigator reported that these adverse events were possibly related to atenolol, which the patient was receiving at the time.

Thus the data from the British aneurysm nimodipine trial give little support to the findings reported by Wagenknecht and colleagues, which are possibly artefacts, reflecting the authors' post hoc analyses.

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1 Wagenknecht LE, Furberg CD, Hammon JW, Legault C, Troost BT. Surgical bleeding: unexpected effect of a calcium antagonist. *BMJ* 1995;310:776-7. (25 March.)

2 Pickard JD, Murray GD, Illingworth R, Shaw MDM, Teasdale GM, Foy PM, et al. Effect of oral nimodipine on cerebral infarction and outcome after subarachnoid haemorrhage: British aneurysm nimodipine trial. *BMJ* 1989;298:636-42.

Conflict of interest: Gordon Murray gave statistical advice to the British aneurysm nimodipine trial, which was funded by Bayer, but has no other links with the company.

Authors' reply

EDITOR,—Much of the information provided in the responses to our paper seems to be anecdotal. To settle the question of whether calcium antagonists have a prohaemorrhagic effect a systematic collection of data on blood loss is essential, preferably in a randomised trial. This was a strength of our study. Further support for our observation is the more frequent use of the procoagulant aminocaproic acid (Amicar) in the group treated with nimodipine compared with the placebo group (56% v 36%, $P=0.01$).

Surgical bleeding may possibly be caused by an interaction between calcium antagonists and heparin or thrombolytic drugs, or both. The fact that only 13% of patients receiving nimodipine responded with excessive bleeding perhaps suggests that only some patients were susceptible.

A full report of the study and an extensive literature review are being prepared. Pre-existing blood disorders were found in both study groups, as would be expected in a randomised trial. Removing from the analysis the two patients mentioned in our report is a simplistic approach that breaches the integrity of the original randomisation. We still believe that our unexpected finding requires further exploration.

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Faulty blood bags

Reputation of English blood transfusion service has been unjustly damaged

EDITOR,—I wish to comment on recent reports of faults in some of the blood bags used by the English National Blood Authority.¹ Several of the points made have been misleading and may have given rise to inappropriate public and professional concern.

Firstly, international and published experience confirms that minor defects in plastic blood bags occur infrequently but regularly and that virtually all such defects are screened out during routine quality assurance programmes before blood is issued to hospitals from regional blood transfusion centres. Exceedingly rare (certainly with an incidence of less than one in a million blood transfusions), a defect remains undetected and causes bacterial contamination and consequential septicaemia in the recipient.

Secondly, the English National Blood Authority is to be congratulated for having introduced blood bags from a second supplier into England. This much needed break of the longstanding monopoly on the supply of blood bags must already have saved the NHS in England substantial amounts of money and considerably enhanced the security of quality systems. The competition thereby created must be generating savings approaching £1m a year, much of which will be coming from the original monopoly supplier.

Thirdly, the notion that the authority's second supplier of blood bags (Tuta, Australia) provides products of inferior quality is false. The Scottish National Blood Transfusion Service rejected the proposed monopoly by Baxter in 1966 and for almost 30 years has been purchasing blood bags from both Tuta and Baxter. We have used many millions of both blood bags and have no doubt that Tuta produces a high quality product that, in terms of blood safety, competes equally with the product from Baxter. Both manufacturers have had occasional problems with quality but have always responded expeditiously and in close collaboration with their customers. If doubts have arisen then both manufacturers have had no hesitation in replacing (at no cost to the NHS) any suspect batches of blood bags.

Finally, it is unusual, but not unique, for a product to be recalled from hospital blood banks. Of much greater concern, however, is the perception that this event was deliberately seized on to damage further the public image of the blood transfusion service in England; this is regrettable.

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1 Dyer O. Blood authority investigates faulty blood bags. *BMJ* 1995; 311:145. (15 July.)

Faulty bags were withdrawn from routine use

EDITOR,—Owen Dyer's report on the faulty blood bags withdrawn by the National Blood Authority may have misled readers.¹ He quotes our spokeswoman as saying that "only 5000 of the estimated 7000 Tuta bags had been disposed of immediately because some hospitals had no other kind." When the fault in the Tuta bags was first discovered it was thought that the leaking seals had occurred in only a limited number of batches. Initially 5000 bags were withdrawn. The remaining 2000 bags were withdrawn the next week after the manufacturers informed us that the fault was sporadic and not confined to certain batches. The advice issued to hospitals in the Oxford and Southampton areas, some of which had only Tuta bags in stock, was that when no alternative was available their use

"must be at individual clinical discretion and the blood pack must be carefully inspected before use." This clearly indicated that the bags should not be issued for routine use but should be used only in emergencies.

Dyer also alludes to the costs of the current structure of the National Blood Authority. Before the authority was established the 14 centres in England were the responsibility of the regional health authorities. Each centre had its own management team and senior medical staff. In addition there was a national directorate, based in Manchester, whose role was to coordinate the activities of the centres. If the proposals for reorganisation are approved the new management structure will consist of only three administration centres with senior management teams. The chief executive posts in other centres will disappear, and the result will be a more streamlined management structure, less bureaucracy, and lower administrative costs.

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1 Dyer O. Blood authority investigates faulty blood bags. *BMJ* 1995;311:145. (15 July.)

Screening for melanoma

EDITOR,—When Duncan Keeley states in his commentary to our paper that "feasibility studies . . . that fail to address these issues [workload, earlier diagnosis, and anxiety] should not be undertaken,"¹ he ignores appropriate study design. Ours was a validation study: validity must be proved before money is spent on feasibility studies. Furthermore, such pragmatic outcomes are not appropriate in validation studies because the intensive assessment may well affect patient behaviour.

Keeley suggests that workload would "substantially increase." However, opportunistic screening when patients attend for other reasons would minimise the workload of mole counts—for example, general practitioners could send instructions for self screening or give a leaflet or perform a mole count, or both, when checking blood pressure. Alternatively, community campaigns could advise self screened people at high risk to avoid being sunburnt. The workload would partly depend on the potential to induce anxiety, and here Keeley also automatically assumes "significant adverse consequences." This ignores evidence that reassuring messages, practical advice to minimise risk, and emphasising benefits can allay fears without stopping a change in behaviour (M Johnston, King's Fund Centre conference, London, November 1994). To assume that outcomes will be poor is unjustified for both anxiety and workload.

Targeting populations who have greater need is apparently "unacceptable," despite improving the efficiency of the intervention. Should community or population approaches never be targeted in higher risk areas, where melanoma is common, either?

Keeley's preferred research areas may suffer the limitations of screening. Population approaches could also increase anxiety and workload, and thus not necessarily be any more cost effective, particularly as a fifth of the population (patients with many moles or freckles) account for most cases. Improving doctors' skills will work only if patients attend with moles that are changing—that is, self assessment or screening would need to be encouraged.

The implication is that screening would have a high ratio of cost to benefit. It takes seconds to count moles (the median count for trunk or arm is 2-3), and with reassurance and advice screening could feasibly take 2-3 minutes. If every patient