CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Surgeons and hepatitis B

SIR,—Mr Stuart Kennedy's personal view, in which he describes his "elementary mistake" of submitting to a blood test for hepatitis, raises several issues, not least of which seems to be the management of the incident, which he describes as "the usual shambles that the NHS seems to revel in."[1]

He mentions the various people who had a hand in managing his case: a houseman (took blood); a virologist (told him that he was a hepatitis B virus carrier and should stop operating temporarily); a senior physician (told him that there was no cluster of hepatitis B among his patients); colleagues (told him to have a viral DNA assay); the physician treating him (told him that he could plan his return to work); and his surgical colleagues (told him that he couldn't). No wonder he remains confused and resentful.

This case should have been dealt with from the start by the district's consultant occupational physician following the district's policy on carriage of hepatitis B virus. No single other person is likely to have experience of dealing with these cases, counselling skills, and the independence necessary to apply what is essentially a public health policy sympathetically to someone who may be a colleague. Managed better, this unfortunate case may well have had the same outcome but at least Mr Kennedy would be feeling better about it. There is life after stopping surgery, and in our experience high risk operators who are positive for hepatitis Be antigen have been redeployed happily in other fields of medicine.

Mr Kennedy's "streetwise" surgical colleagues were sharp enough to advise him (after the event) to refuse to be tested but not to advise him (before the event) to be immunised. He says that all the nurses had been immunised. Why hadn't the doctors been?

The Department of Health's guidance on employing health care staff infectious for hepatitis B virus is now well out of date,[2] and in the absence of good occupational health advice the management of these cases will continue to be messy.

Incidentally, hepatitis B acquired occupationally is a prescribed industrial disease and sufferers are entitled to a modicum of no fault compensation.

DAVID SNASHALL
MICHAEL PEEL
IRA MADAN

Department of Occupational Health,
United Medical and Dental Schools of
Guy's and St Thomas's Hospitals,
London SE1 7EH

1 Kennedy S. An elementary mistake? *BMJ* 1991;**302**:1614. (29 June.)
2 Department of Health and Social Security. *Hepatitis B and NHS staff.* London: DHSS, 1981. (CMO (81) 11.)

Hepatitis A immunisation

SIR,—Dr Jane N Zuckermann and colleagues interpret their finding of a lower seroprevalence of hepatitis A IgG antibodies among first year medical students in 1991 than among blood donors and army recruits in 1988 as a dramatic decline in prevalence and attribute this to "improvement in socioeconomic conditions and personal hygiene."[1]

Implicit in this interpretation is the assumption that the important difference between these two samples is the three year period from 1988 to 1991. There are, however, other differences that are more likely to account for the variation in observed prevalence. The first of these is social class: medical students are drawn predominantly from middle class families whereas blood donors are likely to include a broader spectrum and army recruits are predominantly from working class families. Socioeconomic status has been shown to be associated with prevalence of antibodies to hepatitis A.[2]

The second concerns the age distribution of the samples. As IgG antibodies to hepatitis A virus persist for many years after infection, probably for life in most cases,[3] the percentage of the population positive at any age represents the cumulative incidence of infection up to that age. Thus the older the sample tested the higher the expected prevalence. This is apparent in the higher prevalence reported in the whole sample of blood donors (64·4%) compared with that in young donors aged 18 to 30 (57%). The age range of the first year medical students is given as 19 to 31, which seems similar to that of the young blood donors (18 to 30); however, most of the students are almost certainly at the lower limit of the range and the blood donors more evenly distributed with respect to age.

Finally, even a major reduction in the incidence of hepatitis A infection would not have such a dramatic impact on IgG seroprevalence in such a short time as the seroprevalence is a measure of cumulative incidence and so reflects risk of infection over the lifetime of the individuals sampled and not just risk at the time of the sampling.

The interpretation provided by Dr Zuckermann and colleagues is not convincing because the social class and age distribution of their sample—and the dynamics of the infection—are not taken into account.

CLEONE I F ROONEY
LAURA RODRIGUES

Department of Epidemiology and Population Sciences,
London School of Hygiene and Tropical Medicine,
London WC1 7HT

1 Zuckerman JN, Cockcroft A, Griffiths P. Hepatitis A immunisation. *BMJ* 1991;**303**:247. (27 July.)
2 Dienstag JL, Szumness W, Stevens CE, Purcell RH. Hepatitis A virus infection: new insights from seroepidemiologic studies. *J Infect Dis* 1978;**137**:328-40.
3 Hadler SC, Margolis HS. Viral Hepatitis. In: Evans AS, ed. *Viral infections in humans.* London: Plenum Medical, 1989.

Hepatitis A vaccine

SIR,—Dr A J Tilzey and Professor J E Banatvala have outlined some of the current difficulties in controlling hepatitis A and the potential offered by hepatitis A vaccines.[1]

Recent experience in Liverpool emphasises the inadequacies of current means of control. Altogether 313 cases of hepatitis A were notified in 1990 compared with 20 the previous year. This occurred despite efforts to control the disease, including the dissemination of advice on hygiene and appropriate precautions to schools and parents; health education and health promotion activities done through the local media; and a circular sent to all general practitioners concerning controlling hepatitis A by giving human immunoglobulin to close contacts.

An investigation was undertaken in January 1991 to determine the mode of transmission of the infection in the city and to prevent further spread. Forty one cases were notified in that month. The age range of patients was 2 to 57 years, with 29 aged under 14 years and 23 aged 9 years or younger. Twenty one were male and 20 female. Two principal foci of illness were identified in deprived wards in the north and south of the city. Most patients had acquired the infection by person to person contact. Efforts to limit further spread of infection by using immunoglobulin were hampered by delays in notifying the consultant in communicable disease control. The median delay in notification was 10 days (interquartile range 7-20 days).

Long term control of hepatitis A depends on improvements in the knowledge and practice of hygienic principles. Whether passive immunisation is useful in controlling large outbreaks in the community is questionable. Hepatitis A vaccines have the potential to serve as an effective short term intervention, particularly if a group of susceptible subjects can be identified and targeted.

C MARTYN REGAN

Mersey Regional Health Authority,
Liverpool L3 6AL

QUTUB SYED

Public Health Laboratory,
Fazakerley Hospital,
Liverpool L9 7AL

ANN CORKERY

Liverpool Health Authority,
Liverpool L15 2HE

1 Tilzey AJ, Banatvala JE. Hepatitis A. *BMJ* 1991;**302**:1552-3. (29 June.)

Routine testing for HIV at infertility clinics

SIR,—Ms Susan Rice writes that the medical profession should not routinely test infertile