and Sponsorship, of which I am chairman. The committee's role is to examine precisely the sort of issue that Guthrie raises. The committee treats all complaints that it receives about tobacco advertising seriously and investigates them fully. We are keen to look into the concerns raised by Guthrie and have written to him requesting the details of his research. I understand that Guthrie conducted a similar survey in 1994, the results of which we also sought, in April 1994, but have not yet received.

The committee is concerned to ensure compliance with the voluntary agreements, and we have already commissioned an independent national audit of poster sites near schools. The results of this exercise will be included in our ninth report, to be published this year.

CLIVE WHITMORE
Chairman

Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship,
PO Box 3982,
London SK1 8YJ

1 Guthrie B. Tobacco companies violated advertising restriction. *BMJ* 1995;311:1501. (2 December.)

Clinical guidelines may obviate need for thought

EDITOR,—Having read Brian Hurwitz's editorial considering the fate of doctors who deviate from clinical guidelines and how they might fare in court,[1] I thought that the everyday reality of clinical guidelines as seen from the perspective of a senior house officer might be of interest. Clinical guidelines are usually issued by specialist departments as an aid to staff. The number of guidelines gradually proliferates: most hospitals will have protocols for situations varying from the management of neutropenia induced by chemotherapy to the indications for which a full blood count may be requested by the casualty senior house officer. In almost all cases doctors have the greatest input into the formulation of these guidelines. So what is there to fear?

Unfortunately, in everyday practice it is not doctors but junior radiographers, biochemists who are medical laboratory scientific officers, or pharmacists who use the guidelines, absolutely confident in their knowledge of their department's policy and unhesitating in their refusal of deviant requests. If a request does not comply with the guideline, explanation rarely makes any difference and inevitably results in lengthy and exasperating discussions with their seniors. The black and white simplicity of, for example, an *x* ray department's policy on requests for ultrasonography may run the risk of obviating the need for thought and the consideration of factors not included in hospital protocols. Even a consultant's decision that deviates from department policy will often be regarded not as evidence of clinical acumen but as proof that even senior doctors are unable to understand the guideline.

The senior doctor may have the last word now, but for how long can the medical profession survive the undermining criticism that clinical guidelines so often serve to legitimise? Doctors must be cautious when being party to the development of hospital protocols. Though I am glad that I have memorised the European and UK Resuscitation Councils' guidelines, I hate the fact that the the ward pharmacist thinks that I am a good doctor because I know my hospital's laxative policy by heart.

DOMINIC HEANEY
General medical senior house officer I

Western Infirmary,
Glasgow G11 6NT

1 Hurwitz B. Clinical guidelines and the law. *BMJ* 1995;311: 1517-8. (9 December.)

HTLV-I screening in Britain

Blood supply in Britain should be made safer

EDITOR,—A Pagliuca and colleagues' editorial on the developments needed to improve Britain's blood transfusion service after the recent reforms is welcome.[1] The blood supply in Britain is manifestly not as safe as it can reasonably be made. We do not screen blood for human T cell leukaemia/lymphoma virus type I (HTLV-I) despite the seroprevalence of the virus being 1 in 20 000. This results in an estimated 200 recipients being infected annually. France, Sweden, and the Netherlands, which have similar prevalences of HTLV-I, do screen for it.[1] We do not screen blood for hepatitis B core antibody, allowing an estimated maximum of 50 cases of transmission a year (R Tedder, personal communication). France and Germany and many other countries do screen for this antibody. We do not "quarantine" pooled fresh frozen plasma or cryoprecipitate and retest donors at three months before its release, as is done in the Netherlands.

Even within Britain standards differ among regions, making uniform access to the best care impossible. Some regions advocate prophylactic antenatal anti-D for first pregnancies in rhesus negative women while others do not despite ample evidence of its efficacy in reducing haemolytic disease of the newborn.[2,3] Some regions state the full rhesus and Kell antigen types in addition to ABO and RhD types for all red cells. This encourages, for example, the selection of blood that is negative for Kell antigen for all female subjects before the menopause, enabling the prevention of the rare but severe anaemia related to Kell antigens in newborn infants.[4]

It is ironic that in Britain, where blood supplies are arguably among the less stringently tested in Europe,[1] autologous blood transfusion is rarely provided. Needless to say, our European neighbours have readily accessible, well publicised, and well used autologous services.[5]

I hope that the £10m saved by the National Blood Authority is deployed to help correct these deficiencies.

L A KAY
Consultant haematologist

46 Clarence Terrace,
London NW1 4RD

1 Pagliuca A, Pawson R, Mufti JG. HTLV-1 screening in Britain. *BMJ* 1995;311:1313-4. (18 November.)
2 Tovey LAD, Townley A, Stevenson BJ. The Yorkshire antenatal anti-D immunoglobulin trial in primagravidae. *Lancet* 1983;ii: 244-6.
3 Letsky EA, Da Silva M. Preventing Rh immunisation: much scope for improvement. *BMJ* 1994;309:213-4.
4 Warwick R. Erythropoietin suppression in fetal anemia. *Am J Obstet* 1994;171:247-52.
5 International Society of Blood Transfusion. *Practical methods to avoid blood transfusion. Proceedings of a satellite symposium of the ISBT, Lugano, May 1989.* Manchester: ADIS Press International, 1989.

Antenatal screening is important

EDITOR,—In their editorial A Pagliuca and colleagues revive the debate on whether British blood donors should be screened for human T cell leukaemia/lymphoma virus type I (HTLV-I).[1] Five European Union countries with rates of HTLV infection among blood donors similar to that in Britain now screen blood donors routinely, and Portugal will start to do so this year, so we agree that Britain will need to follow suit.

Antenatal screening may, however, be an even more urgent issue than screening of blood donations. In the four studies to date the seroprevalence of antibodies to HTLV-I and HTLV-II in pregnant women in Britain has been between 10 and 50 times higher than that in blood donors.[2,3] Most cases of adult T cell leukaemia/lymphoma occur after infection in childhood,[4] which may be due to blood transfusion in some cases. More important is vertical transmission: 25% of babies born to infected mothers become infected if they are breast fed, but this figure is reduced to 5% by bottle feeding.[5] Although HTLV-I antibodies can be detected from dried blood spots obtained by heel prick, we recommend antenatal diagnosis, which allows time for counselling and for the mother to make an informed decision about breast feeding.

The HTLV European Research Network addressed the problems of cost and diagnosis at a workshop of virologists, epidemiologists, and representatives of the blood transfusion services in 1994. We recommend screening first with an inexpensive, sensitive assay (such as a particle agglutination assay) followed by a more specific enzyme linked immunosorbent assay (ELISA), which reduces the number of expensive confirmation assays required. If a western blot that includes recombinant envelope peptides is used the following interpretations are recommended: HTLV-I/II negative if no bands are detected; HTLV-I positive if antibodies to p19, p24, rgp21, and rgp46-I are present; and HTLV-II positive if antibodies to p24, rgp21, and rgp46-II are present. Band patterns that do not fulfil these criteria should be described as indeterminate; these are rarely positive for HTLV-I/II proviral DNA by the polymerase chain reaction.

We agree that blood infected with HTLV-I or HTLV-II should not be transfused, especially to those most at risk of developing disease (children) or transmitting the infection (expectant mothers and sexually active people). Additionally, we believe that mothers should be given the opportunity not to transmit their infection to their children.

J N WEBER
Professor of communicable diseases
G P TAYLOR
Scientific secretary, HTLV European Research Network

St Mary's Hospital Medical School,
London W2 1NY

1 Pagliuca A, Pawson R, Mufti GJ. HTLV-I screening in Britain. *BMJ* 1995;311:1313-4. (18 November.)
2 Tosswill JHC, Ades AK, Peckham C, Mortimer P, Weber JN. Infection with human T-cell leukaemia/lymphoma virus type I in patients attending an antenatal clinic in London. *BMJ* 1990;301:95-6.
3 Parker SP, Taylor MB, Ades AE, Cubitt WD, Peckham C. Use of dried blood spots for the detection and confirmation of HTLV-I specific antibodies for epidemiological purposes. *J Clin Pathol* 1995;48:904-7.
4 Murphy EL, Hanchard B, Figueroa JP, Gibbs WN, Lofters WS, Campbell M, *et al.* Modelling the risk of adult T-cell leukaemia/lymphoma in persons infected with human T-lymphotropic virus type I. *Int J Cancer* 1989;43:250-3.
5 Oki T, Yoshinaga M, Otsuka H, Miyata K, Sonoda S, Nagata Y. A sero-epidemiological study on mother-to-child transmission of HTLV-I in southern Kyushu, Japan. *Asia Oceania J Obstet Gynaecol* 1992;18:371-7.

Failure to screen may be a false economy

EDITOR,—We have recently seen a case of acute adult T cell leukaemia/lymphoma that leads us to support A Pagliuca and colleagues' call for a reappraisal of screening of blood donors for human T cell leukaemia/lymphoma virus type I (HTLV-I).[1]

A 47 year old white man presented with hypercalcaemia, a rash, dyspnoea, and lung infiltrates on chest radiography. Skin biopsy and serological testing confirmed the diagnosis of acute adult T cell leukaemia/lymphoma associated with HTLV-I, and, despite combination chemotherapy, his condition deteriorated rapidly and he died. He had no obvious risk factors for HTLV-I infection: no history of blood transfusion, injecting drug use, or travel to areas in which HTLV-I is endemic. The man had donated blood on 24 occasions from 1981 to 1990, and an extensive look back programme was started to trace all the recipients of cellular blood components derived from his