The risk and consequences of salmonella infection in sickle cell disease are well established, though patients' susceptibility to this micro-organism remains unexplained. Simple preventive measures, however, may limit exposure to the micro-organism. We recommend that all patients with sickle cell disease who develop diarrhoea are investigated for infection with *Salmonella* spp and given antibiotics. If Gram negative bacteraemia is found to be present an antibiotic that is effective in salmonella infection should be started. Other measures to reduce the risk of salmonellosis—for example, the provision of education about scrupulous food hygiene and information on food sources of salmonella—should also be taken.

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1 Working Party of the British Committee for Standards in Haematology Clinical Haematology Task Force. Guidelines for the prevention and treatment of infection in patients with an absent or dysfunctional spleen. *BMJ* 1996;**312**:430-4. (17 February.)
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Under half of doctors know that antibiotic prophylaxis should be life long

EDITOR,—Despite several articles in the medical press over the past two years, including communications to all doctors from the chief medical officer, we were dismayed to note that several elderly patients admitted to our wards who had had splenectomies years previously had not been given advice on prophylaxis against infection or relevant immunisation. Deodhar *et al* found that in 184 patients who had had a splenectomy during a 12 year period 58% had not received advice or prophylaxis against infection and only 36% had received pneumococcal vaccination.[1]

We recently assessed doctors' knowledge of prophylaxis after splenectomy by means of a questionnaire survey An anonymous questionnaire was sent to 160 hospital doctors of all grades and 200 general practitioners. A total of 118 questionnaires was returned for analysis (69 (43%) by the hospital doctors and 49 (25%) by the general practitioners). Most of the doctors (116/118) knew that patients who had had a splenectomy were at risk of pneumococcal infection. However, only half (34) of the hospital doctors and a third (16) of the general practitioners knew that patients were at risk of meningococcal infection and malaria. Most of the respondents (50 (72%) of the hospital doctors and 27 (55%) of the general practitioners) knew about the risk of *Haemophilus influenzae* infection. Although there was general awareness about antibiotic prophylaxis, only seven (14%) of the general practitioners and 34 (49%) of the hospital doctors knew that this prophylaxis should be life long.

Six of the general practitioners had a computerised splenectomy register, and 20 said that they would like more advice and information on managing patients who had had a splenectomy. The general practitioners had (to their knowledge) a total of 107 patients who had had a splenectomy registered with their practices; the commonest reasons for the operation were trauma, idiopathic thrombocytopenic purpura, and lymphoma.

Awareness and implementation of guidelines for preventing and treating infection in patients with reduced or absent splenic function is essential.[2] This could be helped by the setting up of computer databases on patients. The guidelines in our district are accessible on the pathfinder system, which is a computerised information system available in our hospital and to a number of general practitioners. Hopefully, this system will become available to all general practitioners; the guidelines and other information would then be easily accessible.

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1 Deodhar HA, Marshall U, Barnes JN. Increased risk of sepsis after splenectomy. *BMJ* 1993;**307**:1408-9.
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Patients expect splenectomy in rural Zaire

EDITOR,—The working party of the British Committee for Standards in Haematology's Clinical Task Force has produced comprehensive guidelines on preventing and treating infection in patients with an absent or dysfunctional spleen.[1] Massive splenomegaly is common in north east Zaire, mainly owing to the occurrence of the tropical splenomegaly syndrome in a region holoendemic for falciparum malaria. Patients with this syndrome present in the outpatient department with pain and a large mass extending from the lower left costal margin. They expect the hospital to perform a splenectomy to relieve their discomfort.

Splenectomy is dangerous here because facilities for blood transfusion are limited. The seroprevalence of HIV in our region is roughly 7%,[2] so the procedure carries an appreciable risk for the surgeon. The risks of overwhelming infection after splenectomy are high as vaccination against *Streptococcus pneumoniae* and *Haemophilus influenzae* infections is not possible. Lifelong prophylaxis with oral phenoxymethylpenicillin and chloroquine is difficult to assure as the population is mobile and patients may live beyond the reach of even basic medical facilities.

In view of these difficulties splenectomy should be performed only if the patient's life is in danger—that is, for splenic trauma with uncontrolled haemorrhage or hypersplenism with severe anaemia (haemoglobin concentration less than 50 g/l with symptoms of anaemia). Splenic tissue should be conserved when possible and the patient informed of the need to take lifelong antibiotic and malarial prophylaxis.

The main role of doctors in this region with regard to splenectomy is to educate patients and dissuade them from having the operation except in life threatening situations. Instead of operating we should be providing simple analgesia for the pain and treating the tropical splenomegaly syndrome with long term antimalarial drugs.

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1 Working Party of the British Committee for Standards in Haematology Clinical Haematology Task Force. Guidelines for the prevention and treatment of infection in patients with an absent or dysfunctional spleen. *BMJ* 1996; **312**:430-4. (17 February.)
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Data linkage is useful in setting up a register

EDITOR,—We wish that the guidelines on preventing and treating infection in patients with an absent or dysfunctional spleen[1] had included advice on ways of ensuring that all patients at risk are contacted and reminded about the need to carry a splenectomy card and other precautionary measures. One way of doing this is by means of a register.

Grampian Health Board has established a register of patients who have had a splenectomy since 1984. This was coordinated by the department of public health medicine as part of its monitoring of and advice on immunisation. Patients were identified from both routine hospital discharge data and pathology records because of concern about the completeness of these sources of data.[2 3] Many patients die shortly after splenectomy because of underlying disease. To minimise the work in establishing the register, linkage of hospital discharge data and death certificates[4] by the information and statistics division of the Common Services Agency, Edinburgh, was used to exclude patients who had died. This excluded 98 of the 315 patients initially identified.

For efficient identification of patients at risk we recommend using discharge data, pathology records, and data linkage supplemented by additional information from general practitioners and hospital clinicians. Local data linkage with the community health index can then be used to help keep such a register up to date.

We thank S Kendrick for supplying the data linked information.

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Uncertainty exists over frequency of blood tests to test antipneumococcal immunity

EDITOR,—I wonder whether the British Committee for Standards in Haematology would comment on the level of antibody to pneumococcus that indicates protection against infection in patients who have had a splenectomy and have received pneumococcal vaccine.[1] General practitioners need further guidance on the frequency of blood tests to assess immunity to pneumococcal infection in these patients. Should we first test six weeks after vaccination, then three years later, and thereafter every year?

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1 Working Party of the British Committee for Standards in Haematology Clinical Haematology Task Force. Guidelines for the prevention and treatment of infection in patients with an absent or dysfunctional spleen. *BMJ* 1996;**312**:430-4. (17 February.)

Is there evidence to show that daily antibiotic treatment is best?

EDITOR,—The recent guidelines on preventing and managing infection in patients with an absent or dysfunctional spleen recommend lifelong prophylaxis with oral antibiotics for all