

surveillance began in 1982. Among these infants, only one has been reported to have had acute clinical hepatitis B in early infancy.

Although the exclusion of infants of anti-HBe positive mothers from the immunisation programme has resulted in so little ill effect, the ability to identify a subgroup of anti-HBe positive women and to offer immunisation for their infants would make it possible to prevent the rare clinical hepatitis B infection without too large an increase in numbers. However, the use of hepatitis B virus DNA hybridisation tests in place of e antigen/antibody tests for antenatal patients must depend on assessments of cost and feasibility.

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Prevalence of hepatitis B markers among district general hospital staff

SIR,—We have read with interest Professor A J Zuckerman's review (16 February, p 492) of the prospects for new hepatitis B vaccines and the letter of Drs E M Vandervelde and P P Mortimer (9 March, p 787). We fully agree with the latter authors that exposure to hepatitis B virus in Britain is uncommon in hospital practice. During May and June 1983 we screened for hepatitis B markers blood specimens from 507 employees, representing 42.5% of the total staff, working at Rotherham District General Hospital. The study included 29 doctors, 267 nurses, 29 medical laboratory scientific officers, 13 phlebotomists, and 169 others. All sera were tested for anti-HBs by an enzyme linked immunosorbent assay using Ausab EIA diagnostic kit (Abbott Laboratories Ltd). The sera were also examined anonymously for HBsAg by an enzyme linked immunosorbent assay using Auzyme II diagnostic kit (Abbott Laboratories Ltd).

All staff were negative for HBsAg. Serological evidence of previous hepatitis infection (positive anti-HBs) was found in 15 employees (3%). These were 10 doctors, four nurses, and one porter. The rate among doctors (34%) was significantly higher than that among nurses (1.5%) ($p < 0.01$). Although staff of Oriental origin (12 doctors, four nurses) represented only 3% of the study population, their rate (56%) was significantly higher than

that for staff of Western origin (1.2%) ($n = 491$), ($p < 0.01$). All the seropositive Oriental staff were doctors. The prevalence of anti-HBs in doctors of Oriental origin (75%, 9/2) was significantly higher than that among those of Western origin (6%, $p < 0.01$). Seropositive Western staff included one out of 17 doctors, four out of 263 nurses, and one porter.

The number of seropositive subjects varied between departments and was highest in the departments of orthopaedic surgery, orthodontic surgery, accident and emergency, mental subnormality, and general surgery.

The infection rate did not increase uniformly during years of employment in the specialty. No difference was noticed below 20 years of employment. The infection rates were 2.6% for up to 5 years, 3.3% for 6-10 years, 2.3% for 11-15 years, and zero for 16-20 years. However, the infection rate rose to 16.6% for 21-25 years and 6.2% for 26-30 years' employment.

A questionnaire was given to the 15 seropositive staff and also to 15 staff matched for age, sex, and occupation who were used as controls. The questionnaire included the country of origin; duration of stay in country of origin since birth; overseas visits and their duration; history of hepatitis or jaundice; reception of blood or blood products; previous surgery, dental surgery, bleeding disorder, tattooing, dialysis for renal failure, immunosuppression, or prophylactic or therapeutic injections; contact with cases or carriers of hepatitis; and history of any other important disease.

All of the nine seropositive staff of Oriental origin had stayed more than 30 years from birth in India (6), Pakistan (2), or Burma (1). Only one had a history of hepatitis. The remaining six staff were of Western origin, of whom two had had hepatitis and two were contacts of patients with hepatitis B. Four of the Westerners had been abroad (to Africa (1), Singapore (1), or elsewhere) for periods ranging from four months to four years. In the control group four had been abroad for brief periods: one to the USA, one to Malta and France, one to Malaya and Eritrea, and one to Gibraltar. One had suffered from hepatitis and one had had poliomyelitis. The numbers included in the questionnaire were too small to draw sound conclusions.

This work supports the findings of Drs Vandervelde and Mortimer, who showed that exposure to hepatitis B in Britain is infrequent. It is, indeed, a small fraction of that observed in the United States.¹

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Chronic hepatitis in the 1980s

SIR,—We were interested in the excellent leading article by Dr John Hegarty and Dr Roger Williams (23 March, p 877) and would like to refer to a few of the issues they raised. We fully support their view that it can at times be extremely difficult to distinguish between chronic persistent and chronic active hepatitis. It is our policy to repeat the liver biopsy in such patients after an interval of six months even in the absence of clinical or biochemical change.

We believe it is still premature to attribute histological change to viruses known or assumed to be present. Thus in parenteral drug abusers with known hepatitis B virus infection our findings suggest that non A, non B viruses represent the initial viral insult to the liver in over two thirds of the patients and probably contribute to the histological findings in no less than 90% of patients.¹ In addition

we believe that hepatitis D virus (δ agent) may have a major contributory role in chronic active hepatitis associated with hepatitis B virus.²

Finally, it is our experience that chronic active hepatitis associated with hepatitis B has a better prognosis than chronic active hepatitis not associated with the B virus.³

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Informed consent from the mentally ill

SIR,—I produced the *Horizon* film on Friern Hospital. Until recently psychiatric hospitals have been reluctant to let television crews on the premises to film patients, for the kind of reasons discussed by Dr R L Palmer (23 March, p 931). If some hospitals have now changed their minds it is perhaps because the public image of hospital psychiatry has become so unfavourable that the closure of hospitals is planned by the government.

Friern Hospital provided me with a consent protocol. We filmed only those patients who had provided a written consent, asked for once. The written consents of their consultants and their next of kin (when they could be contacted) were also required. The chairman of the hospital ethical committee and the administrator of the hospital viewed the film before transmission, with powers to protect the rights of patients from abuse.

Nevertheless, Dr Palmer has a very good point. Were the patients shown in the film really the best judges of their own interests, despite the views of their consultants and relations? It is a very difficult question to answer. I have only to look at television to realise what extraordinary revelations mentally well people and "reasonable men" are prepared to make about themselves. That this happens would seem to indicate that well people have ideas of their own self interest which may at times be surprising and that the examples cited by Dr Palmer are not that unusual. I am pleased to report that all the patients who appeared in my film and who I spoke to afterwards said that they had enjoyed the experience.

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Metoclopramide versus chlorpromazine in controlling nausea and vomiting induced by cytotoxic drugs

SIR,—We would like to comment on the conclusions drawn by Dr David Cunningham and others from their study comparing the anti-emetic efficacy of high dose metoclopramide versus intramuscular chlorpromazine for cytotoxic induced vomiting (23 February, p 604). They infer from their data that whereas high dose metoclopramide is better in