Reported management of threatened miscarriage by general practitioners in Wessex

SIR,—Dr C C Entwistle and colleagues from the regional blood transfusion centres at Oxford and Leeds are dismayed (17 October, p 998) that a recent report (5 September, p 583) showed that 29% of Wessex general practitioners never gave anti-D to Rh(D) negative women after a complete abortion and 77% failed to do so for a threatened abortion. This appears to be in contrast with the guidance given by the Department of Health and Social Security[1] and may be partly responsible for some women being Rh sensitised.

The implication is that general practitioners are failing to provide a necessary service. The matter, however, is not so simple. I have been in correspondence with my regional blood transfusion service (Trent) since 1982 about this problem, and Trent's advice, and possibly that of other regional blood transfusion services, has been that it is unnecessary to give anti-D prophylaxis to women whose threatened abortion is not severe or prolonged enough to warrant hospital admission. This advice overlooks the fact that there is no generally accepted treatment for early abortion (apart from Shrodker suture), so some women are not sent to hospital, particularly in a country area, unless complications ensue. It also overlooks the threatened abortion at home that becomes complete quite quickly and the woman who regards abortion as "natural" and wishes to stay at home.

Further to the regional blood transfusion service's advice, I have also been informed that the guidance contained in the DHSS recommendations in 1981 came as a surprise to a number of members of the committee that supposedly drew it up. Clearly, even in 1987 there is still no unanimity of opinion among workers in this subject. In 1982 I was also told that if every general practice held stocks of immunoglobulin (which would be necessary to provide an effective domiciliary service, particularly at weekends and bank holidays) the nation's supply might be depleted within the first month or two. This may not now be the case.

Dr Entwistle and colleagues are in a position to put their dismay to constructive use. The blood transfusion service needs to settle on agreed nationwide policy and to ensure that there are sufficient stocks of immunoglobulin for that policy to be effective.

J DEANE COLLINGE

Sleaford Medical Group,
Northgate, Sleaford, Lincs

1 Department of Health and Social Security, Scottish Home and Health Department, Welsh Office. *Haemolytic disease of the unborn*. London: HMSO, 1976. (Addendum 1981.)

Detecting pneumococcal antigen in community acquired pneumonia

SIR,—The recent leading article on community acquired pneumonia (31 October, p 1083) and the survey by the Research Committee of the British Thoracic Society and the Public Health Laboratory Service[1] noted the value of sputum and urine examination for pneumococcal antigen in cases of community acquired pneumonia. The microbiological method for antigen detection in sputum used in this survey was counterimmunoelectrophoresis and this was found to be 86% sensitive for pneumococcal infection.

The advantage of early diagnosis of pneumococcal infection is obvious, but there are disadvantages in the use of counterimmunoelectrophoresis. It is labour intensive, suited particularly to batching tests, and therefore not ideal for emergency specimens. It also requires a limited amount of specialised equipment and certain technical skill.

Commercial antigen detection tests (Wellcogen and Phadebact) have been available for some time and are of value in detecting antigen in cerebrospinal fluid and urine.[2] To date the manufacturers do not recommend their use in sputum analysis. In 1985 Whitby and others[3] compared counterimmunoelectrophoresis, the Wellcogen latex agglutination, and Phadebact coagglutination for pneumococci directly on specimens of sputum. They found all three tests to be at least as sensitive—67%, 71%, and 74% respectively—and all were 98-99% specific; however, the sputum samples examined were not all from patients with community acquired pneumonia. Other workers showed counterimmunoelectrophoresis to be at least as sensitive as coagglutination.[4,5] It seems commercial antigen detection may be a more convenient (and equally sensitive) means of detecting pneumococci in patients with pneumonia.

E G SMYTH

Department of Medical Microbiology,
St George's Hospital Medical School,
London SW17 0RE

L POMEROY

Department of Microbiology,
Royal Free Hospital,
London NW3 2QG

1 Research Committee of the British Thoracic Society and the Public Health Laboratory Service. Community acquired pneumonia in British hospitals: a survey of aetiology, mortality, prognostic factors and outcome. *Q J Med* 1987;62: 195-220.
2 Ingram DL, Pearson AW, Occhiuti AR. Detection of bacterial antigens in body fluids with the Wellcogen Haemophilus influenza b, Streptococcus pneumoniae and Neisseria meningitidis (ACY W135) latex agglutination tests. *J Clin Microbiol* 1983; 18:1119-21.
3 Whitby M, Kristinson KG, Brown M. Assessment of rapid methods of pneumococcal antigen detection in routine sputum bacteriology. *J Clin Pathol* 1985;38:341-4.
4 Kalin M, Lindberg AA, Olausson EH. Diagnosis of pneumococcal pneumonia by coagglutination and counter immunoelectrophoresis of sputum samples. *Eur J Clin Microbiol* 1982;1:91-6.
5 Edwards EA, Coonrod JD. Coagglutination and counter immunoelectrophoresis for detection of pneumococcal antigen in the sputum of pneumonia patients. *J Clin Microbiol* 1980;11: 488-91.

Variations in admission rates

SIR,—Mr G Bevan and Professor R Ingram are correct in pointing out that both the treatment intensity and the referral process must be considered when allocating resources (24 October, p 1039). Treatment intensity is considered to be a characteristic of the district of treatment and applies independently of the patient's district of residence. Similarly, the referral rate is considered to be a characteristic of the district of residence—for instance, availability of primary care—and independent of the district providing the treatment.

If a third assumption is made it becomes possible to calculate both the treatment intensity and the referral rate from hospital activity analysis data. The assumption is that the relative rate of admission of female compared with male patients is constant irrespective of the district of residence or of treatment.

The table shows a two district model in which district 2 represents the remainder of England. The data yield a unique (positive) solution: catchment populations of 661 700 and 47 058 300, a treatment intensity that is 20% greater in district 2, a referral rate that is 10% greater in district 1, and a female admission rate that is 80% of the male rate.

J J JONES

Department of Community Medicine,
Leicester LE1 6TP

Catchment population calculation: patients admitted

Health district of residence	Sex	Health district of treatment 1	Health district of treatment 2	Resident population
1	Male	30 000	3 600	330 000
1	Female	28 000	3 840	390 000
2	Male	450	2 376 000	22 000 000
2	Female	504	2 160 000	25 000 000

Greeks bearing gifts

SIR,—Most of the arguments for and against general practice computerisation have been well and fairly represented in your columns, but the two most recent letters (7 November, p 1208) deserve further comment, since one typifies progress and one shows a lack of awareness.

Dr Rupert Fawdry highlights one scheme to bring together those health workers concerned with the follow up of a pregnant patient. Shared obstetric care is just one of the extended applications possible with general practice computerisation.

Dr John Robson, however, shows a total lack of awareness of modern computer software and, referring to the "Micros for GPs" scheme, seems to suggest that the modern automobile should be avoided simply because Henry Ford had a few problems with his Model T. The AAH Meditel software in fact contains extensive report creating facilities which cannot be described as "crude." If he has any doubts I would be more than pleased to arrange to demonstrate these for him. Quite rightly he asks what his patients will gain: quite simply, care from a practice with more time to treat them as a community of people rather than ill patients; care based on a practice able to identify and even prevent health problems from arising; a better audit of the prescription medicines they receive; more certain follow up of immunisation and other preventive procedures, etc.

Finally, I would remind Dr Robson that the practice owns its own data and it is simply not true to say that software design means that the data are inaccessible to the team. Our software and training are designed specifically to facilitate data access.

IAN BLACK

AAH Meditel Ltd,
Bromsgrove,
Worcestershire B60 2EW

Aluminium bone disease

SIR,—Dr D Maharaj and colleagues (19 September, p 693) draw attention to the risk of aluminium related osteodystrophy in patients with impaired renal function receiving high doses of albumin replacement solution contaminated with aluminium, and other studies have dealt with aluminium toxicity.[1,2] We measured the aluminium content of 10 consecutive batches of our 20% albumin as well as one to four batches of the same preparation from 19 suppliers.