

BLOOD-DONORS WITH HISTORY OF JAUNDICE

SIR,—Both the Department of Health and Social Security (1975) and the World Health Organisation (1977) now advise that, provided sera are tested for HB_sAg, there is no need to turn away blood-donors who have a history of jaundice. Renton et al.¹ explored the likely effect of this policy change and examined the relation between jaundice history and hepatitis B surface antigen (HB_sAg) carriage among blood-donors. The history was recorded at the time of donation.

447 HB_sAg-positive donors have been found in the West of Scotland since testing was introduced in 1970. 13 (2.9%) of these donors admitted to a history of jaundice. This proportion is very similar to the proportion (2.8%) of those with a history of jaundice among 228 631 donors in our active donor file and to the proportion (2.6%) found in a sample of 7460 new donors who first gave blood in 1978–79. If a jaundice history was an important determinant of HB_sAg carriage it should have been present in a higher proportion of these HB_sAg positive donors.

Our active donor file records all donors who have given blood since January, 1975, and the prevalence of HB_sAg among jaundice-history donors is as follows:

History	Total	Hb _s Ag positive
No jaundice	222 249	193 (0.087%)
Jaundice	6 382	9 (0.141%)

$\chi^2=1.495$; 1 d.f.; $0.25 > p > 0.20$.

The record includes new and previously screened donors but the comparison seems to be valid. If there is a real difference it is likely to be small. The Manchester workers¹ found more new donors with a history of jaundice (6.3%) than we did (2.6%) and the prevalence of HB_sAg in their new donors was lower (0.078% compared with 0.129%). Methods of testing have varied but almost all our donors have been tested by sensitive radioimmunoassay methods. Wallace² suggested that radioimmunoassay methods might give a different pattern of results from those of Renton et al.

In studies to be reported separately we have tested the sera of donors with a history of jaundice for other markers of prior exposure to both hepatitis B and hepatitis A viruses by radioimmunoassay methods. Two markers for hepatitis B were used—antibody to hepatitis B surface (anti-HB_s) and to hepatitis B core (anti-HB_c). As with HB_sAg there was no evidence that the prevalence of these markers in donors with a jaundice history was different from that in the random population. On the other hand the marker for hepatitis A virus, antibody to hepatitis A (anti-HAV) was significantly more common in the jaundice group than in the controls. Carriage of HB_sAg tends to follow subclinical infection and most of our HB_sAg donors have never had clinical hepatitis. Of those HB_sAg carriers who have had jaundice most will have antibody to HAV. We have tested 8 and found anti-HAV in 6.

We conclude from these results that a history of jaundice does not materially increase the prevalence of HB_sAg among blood-donors and is likely to imply previous infection with HAV rather than with HBV.

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BOTTLE-FEEDING AND THE LAW IN PAPUA NEW GUINEA

SIR,—Bottle-feeding of babies is spreading in the urban areas of many developing countries where, because of ignorance and poor living conditions, it often leads to infection and malnutrition.¹ Babies' bottles used to be widely available in shops in Port Moresby, Papua New Guinea, and a survey of children in five typical settlements in December, 1975, and January, 1976, showed that of 127 children under two years of age, 45 (35%) were artificially fed.² 52 of the children were below 80% of the Harvard 50th centile of weight for age, and of the underweight children a significantly greater proportion were artificially fed.

The Baby Food Supplies (Control) Act, restricting the sale of baby bottles and teats to registered pharmacists, was passed in 1977. Each sale now has to be authorised by a health worker, who must ensure that the mother is fully taught about bottle-feeding. We repeated the survey in four of the five original areas in March, 1979, to evaluate the effect of this Act.

In the three larger settlements a 1-in-3 sample of houses was obtained using random-number tables, and in the smallest settlement all houses were visited. The survey was done during the day, and the selected households were visited and asked if there were any children under two years of age. Mothers were interviewed using a standard questionnaire, and the child was weighed on a pretested Salter scale. The ages of nearly all children were known accurately to within one month.

5 children were excluded from the 1979 survey results in table I because they were no longer receiving breast or arti-

TABLE I—FEEDING METHODS 1975/76 AND 1979

Date	Breast-fed	Artificially fed	Total
1975/76	82 (65%)	45 (35%)	127
1979	127 (88%)	17 (12%)	144

Chi square with Yates' correction 20.02, $p < 0.0005$.

TABLE II—WEIGHT FOR AGE IN RELATION TO HARVARD MEDIAN

Date	80% or more	79–60%	59% or less	Total
1975/76	75	38	14	127
1979	103	40	6	149

Chi square 5.94, not significant.

cial milk. Of the 17 children who were artificially fed, 11 used feeding-bottles, and 10 of these bottles had been obtained on prescription the other being obtained illegally. 6 babies were fed by cup and spoon. We found no evidence of bottles other than baby bottles being used for baby feeding.

Although there was a trend for higher weight-for-age in the 1979 survey this trend did not quite reach statistical significance (table II).

We believe that the introduction of a law to make bottle-feeding a little more difficult for those with no medical reason to bottle-feed has resulted in a reversal of a dangerous drift towards bottle-feeding among urban mothers. The contribution of health education by the Health Department and by lay groups must be acknowledged.

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