

Hepatitis B Antigen in V.D. Clinic Patients

SIR,—Mr. T. H. Bloomfield (30 June, p. 779) challenges the validity of using blood donors in comparative studies of the incidence of hepatitis b antigenaemia. The objection is that the exclusion of potential donors with a history of jaundice or of recent contact with a case of jaundice may reduce the proportion of subjects positive for hepatitis B antigen (HBAG) among those accepted for donation below the level in the general population. This contention is not necessarily correct.

Many of the rejected donors will have been exposed to the infective agent of viral hepatitis type A. In general, acute viral hepatitis type B is not followed by the persistence of HBAG in the serum, and there have been reports of almost identical carrier rates in adults with and without a past history of hepatitis.¹ Studies² of hepatitis B infection among volunteers and those naturally infected with the virus suggest that a greater proportion of individuals who have had a mild or inapparent infection than of those who have had a more severe illness become chronic carriers of HBAG.

A series of 5,640 volunteers with a history of either jaundice or of contact in the past six months with a case of jaundice have been tested for HBAG and hepatitis B antibody (HBAb). Four were HBAG positive and three HBAb positive, giving respective incidences of 1 in 1,410 for HBAG and 1 in 1,880 for HBAb. Using the same immunoelectro-osmophoretic technique to test for the first time 123,102 acceptable donors, 145 (1 in 849) were HBAG positive and 121 (1 in 1,017) were HBAb positive.

These findings by current methods of testing indicate that within the donor population of this region volunteers with a history of jaundice or of recent contact with a case of jaundice do not have a higher incidence of positivity for HBAG and HBAb than donors lacking this history. More sensitive methods of testing such as haemagglutination and radioimmunoassay might reveal a different picture.

However, Mr. Bloomfield draws attention to an important point. Blood donors are unrepresentative of the community as a whole, particularly in respect of age and sex. Even within a donor population there are subgroups with different incidences of HBAG positivity. For example, men prisoners have a higher incidence of HBAG positivity than non-institutionalized men, who in turn have a higher incidence of antigen than women³.—I am, etc.,

JOHN WALLACE

Glasgow and West of Scotland
Blood Transfusion Service,
Law Hospital,
Carlisle, Lanarkshire

¹ Cossart, Y. E., *British Medical Bulletin*, 1972, 28, 156.

² World Health Organization. *Viral Hepatitis*. Technical Report Series, No. 512. London, H.M.S.O., 1973.

³ Wallace, J., Milne, G. R., and Barr, A., *British Medical Journal*, 1972, 1, 663.

Confidentiality

SIR,—The recent tape-recorded discussion on confidentiality and access to large amounts of data of a highly personal character (23 June, p. 700) and the sub-

sequent correspondence have focused particularly on one issue—danger of recorded data being divulged—but left out almost entirely another aspect that seems to me no less important. The computer specialist, Mr. Barry Barber, who took part in your discussion came close to stating it when he said: "The key questions remain: (a) who may see what part of what record? (b) who may add to the record? (c) who may alter the record?"

What is recorded in medical data banks is not necessarily all, or even part, of what the subject of the record wished to be recorded. It is professional interpretation of that and of other assessments made by members of a profession—one of the oldest professions, it is true, but none the less interpretation of facts or believed facts.

With the rapid extension of nation-wide or even more comprehensive data banks facts are recorded also about credit-worthiness, alleged crimes, reliability, and all manner of personal information, by members of professions or quasi-professions who put down data they consider relevant, leaving out others, and often adding to them personal evaluations. Such information may then remain on the record for as long as the subject is alive, or even longer.

My point is that the general uneasiness about computer-aided information processing has given rise to a demand that the subject himself should have access to all that is recorded about him, question what he dislikes, and, if he so desires, have it removed from the record.

I am not at all convinced that what applies to, say, fiscal, criminal, or insurance records—where all medical doctors would no doubt agree—should not apply also to medical records. The possibility of dual loyalties, even among employed medical practitioners, is in fact alluded to in your discussion. It might be argued that a client, a tax payer, or an alleged criminal offender can assess a record but that a patient can not. It might be argued also that submarginal illiterate subjects would not understand the records or that seeing records might, in exceptional circumstances, aggravate the subject's condition.

It seems to me (as one concerned with studies bordering medicine and biology) that statutory or constitutional safeguards need to be provided, giving the individual person the right of access to all information stored about himself in data banks, and to have records altered. If this seems far-fetched in regard to medicine, look perhaps at the literally vital implications of psychosomatic "health" or "normality" under some Orwellian systems of government. We like to assume that data are recorded and seen only by reasonable individuals exclusively concerned with the subject's wellbeing and fair treatment. That may be so in some countries today. Can you guarantee that it will be so next year?—I am, etc.,

H. A. RHEE

Geneva

Hazards of Laparoscopy

SIR,—I would like to comment on the excellent letters from Drs. M. McD. Usherwood and A. D. R. Ogborn (30 June, p.

773) and draw attention to certain relevant points.

It is wise to teach that all laparoscopic instruments require careful maintenance. They are not "nurse-proof," and every working part of each instrument should be checked at the beginning of each laparoscopy by the operator. I am surprised that Dr. Usherwood was unable to remove the detached part of his diathermy forceps, as foreign bodies in the pelvis and abdomen are usually removed readily at laparoscopy. I would recommend direct insertion of a long pair of artery forceps if there is difficulty in catching and holding a foreign body with either Palmer's forceps or Steptoe's grasping forceps.¹

As regards the safety of introduction of the pneumoperitoneum needle to which Dr. Ogborn draws attention, it is well known that there are various sites which can be selected according to the obesity of the patient and the presence of abdominal scars.¹ However, the most important factor in safety is the actual technique of introduction of the needle. This should include two definite steps: (1) the insertion of the Verres or Palmer needle through the skin into the subdermal adipose layer of the abdominal wall only, using two hands on the needle, one at the cuff and one near the point; (2) the lifting up of the abdominal wall below the umbilicus, so that the needle can be advanced from the fatty layer through the fascia and peritoneum in a nearly horizontal direction. Adoption of this technique avoids altogether the hazard of damaging any retroperitoneal structure. The thinner the patient, the more horizontal should be the final thrust. Under no circumstances should the pneumoperitoneum needle be introduced with the gas source already attached and flowing, as I have seen some laparoscopists doing. The risk of puncturing a vessel of the abdominal wall, no matter which site is selected, is ever present, so that gas embolism could be caused.

The success of all techniques of laparoscopy depends not only on the skill of the operator, but also on good anaesthesia with relaxation of the abdominal wall, good instrumentation including maintenance, and constant attention to many minute details on the part of the laparoscopist. Gynaecological endoscopy is crying out for the establishment of special teaching centres so that the techniques of these most valuable procedures can be properly taught. Only in this way can fatalities be avoided.—I am, etc.,

PATRICK STEPTOE

Oldham and District General Hospital,
Oldham, Lancs.

¹ Steptoe, P. C., *Journal of Reproductive Medicine*, 1973, 10, 221.

Toxicity of Benorylate

SIR,—The letter from Professor V. Wright and Dr. I. Haslock (26 May, p. 487) succinctly explains that the apparent increase in the overall incidence of tinnitus in patients receiving benorylate is most probably an indication that such patients are achieving therapeutic plasma salicylate levels for the first time. However, this logical explanation does not adequately explain the unexpectedly high concentrations of plasma salicylate in nine patients re-