When the curious silence of the Royal College of General Practitioners is broken, then I feel sure the incidence in those over 75, who now form a large part of most practices, can be measured more accurately. The trouble is that dementia exists on a continuum between apparent normality and gross disturbance, and incidence figures relate to where the cut-off is set.

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SALMONELLOSIS PRESENTING AS CROUP

Sr.,—Salmonella food poisoning may present with any of a variety of clinical features but no association with croup has been reported. We describe the following case.

A previously healthy 75-year-old English boy was admitted with a 24-h history of a barking cough and fever. Onset was acute, with vomiting and diarrhea 2 days earlier. Within 2 weeks he had had a mild cough associated with fever, coryza, and "noisy breathing." During the first week of the illness, he had also had loose watery motions, occasionally vomiting, and often screamed as if in pain. The diarrhoea resolved after a week, but the respiratory symptoms persisted. On examination, the patient looked ill and had a barking cough with inspiratory stridor at rest. Temperature was 37.8°C, pulse rate 160, and respiratory rate 80. The throat appeared normal. Apart from intercostal retraction, there were no other physical signs. White-blood-cell count and chest X-ray were normal. Respiratory secretions were not cultured because of the risk of precipitating laryngospasm. Blood cultures grew Salmonella enterica, sensitive to ampicillin, chloramphenicol, and trimethoprim. The organism was recovered from his stools but not isolated from the parents’ stool.

Urine culture showed no growth after 48 h incubation. A clinical diagnosis of croup, secondary to acute laryngotracheitis, was made. He was placed in humidified oxygen and, in view of his state, was given ampicillin 250 mg intravenously 6 hourly and paracetamol elixir. Within 24 h the patient was apyrexial and his stridor had improved considerably.

The ninth day, it had resolved completely. Treatment was discontinued after a further 4 days without relapse. His stools were negative 10 days later.

His father was a butcher. The patients had not travelled abroad recently and both remained well during the child’s illness.

Bacterial croup in childhood is generally considered to be caused by either capillary strains of Haemophilus influenzae or toxicogenic strains of Corynebacterium diphtheriae. Other bacteria have been associated with staphylococcal croup. In a review of 71 cases of laryngotracheitis, described under the titles “bacterial tracheitis”, “membranous laryngotracheobronchitis”, and “pseudomembranous croup”, Staphylococcus aureus was associated with 65% of cases. Other bacteria were haemolytic group A streptococci, pneumococci, and H influenzae.1 Chloramphenicol trachomatis and S aureus have been isolated simultaneously from subglottic secretions in one case.2 We suggest that Salmonella be added to the list of bacteria implicated in croup.

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HTLV-III ANTIBODY SCREENING OF BLOOD BANK DONORS

Sr.,—Administration of blood or blood products accounts for about 2% of the cases of acquired immunodeficiency syndrome (AIDS).3 Considerable effort is therefore being directed at the
RESULTS OF ELISA SCREENING FOR ANTIBODIES TO HTLV-III IN 1014 HEALTHY BLOOD DONORS FROM NORTHERN CALIFORNIA

<table>
<thead>
<tr>
<th>ELISA PRN ratio*</th>
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<tr>
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<td>75</td>
<td>12</td>
<td>12</td>
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*Median PRN ratio = 0.5, a range 0.2-5.0

We screened 1014 consecutive anonymous blood donor sera by ELISA and retested all specimens with PRN ratios of 2 or more by IFA and western blot (table). Our regional blood centre serves a population of 1.5 million and draws 77,000 units a year from about 50,000 individuals in twelve counties of northern California, excluding San Francisco county. A large percentage of the blood is drawn in Sacramento County where 13 cases of AIDS have been reported since 1982. Two additional cases have been reported in the other counties. The general donor population thus appears to be at low risk of AIDS.

93 specimens (9.2%) had PRN ratios of 2 or more by ELISA. These were re-examined by IFA and western blot and 1 serum was found (PRN ratio 2.7) with contained antibodies to HTLV-III. Virus specificity was confirmed in the western blot by reactivity with HTLV-III polypeptides (p21, p55, p41, p24). The remaining 92 sera were negative by IFA and western blot. This included 18 specimens with an ELISA PRN ratio of 4 or more. None of 48 selected samples with PRN ratios below 2 contained HTLV-III antibodies as identified by IFA or western blot.

Blood banks want to be able to identify all true-positive results without jeopardizing the blood supply by unnecessarily deferring blood donors or alarming donors by mentioning a "positive" test that does not represent true infection. In a recent study of a blood donor population, a PRN ratio of 5-9 was established as the cutoff for true positives. However, none of the specimens with a PRN ratio of 4-9 were examined by confirmatory methods. Therefore, according to our findings true positives may have been missed in that study. Our results indicate that use of the more sensitive PRN ratio of 2 or more without confirmatory testing would have resulted in 3-4% of blood units being discarded. However, only a single unit would have been discarded if ELISA screening had been used in combination with a confirmatory test.

We conclude that it is necessary to use the most sensitive ELISA PRN value possible to detect all antibody-positive sera in the healthy blood donor population. When used in combination with a confirmatory test, either IFA or western blot, this strategy will not result in a major disruption in the procurement of blood or in the significant loss of future blood donors. Further, we recommend that only individuals who are positive by both ELISA and confirmatory tests be placed on a deferred donor list and inform them about their AIDS serology results.

A few symptomless virus-positive individuals without antibody will be missed by even the most sensitive HTLV-III antibody screening methods. The resolution of this problem depends on HTLV-III antigen detection tests yet to be developed.

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HTLV-III ANTIBODY IN SEQUENTIAL PLASMA SAMPLES: FROM HAEMOPHILICS 1974-84

Sr.-In an earlier report1 we showed that seroconversion for antibody to human T-lymphotropic virus type III (HTLV-III) among Scottish and Danish haemophiliacs was related to the use of factor concentrates made from United States donor material. We here present the HTLV-III antibody results of