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psychiatric distress. The Mental Health Act Commission concerns itself with more than just the application of the Mental Health Act [illegible]. It often comments on issues such as standards of practice and whether informal patients' consent to procedures is truly informed. Perhaps the Commission might wish to consider issuing information sheets to those attending for psychoanalysis, pointing out that psychoanalysis has no proven benefit.

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SIR,—Critics of psychotherapy include those who seek to have it exterminated as a medical discipline, others who wish it to be relegated to a subsidiary therapeutic role, and those who feel it is probably a valuable treatment whose place in the spectrum of psychiatric management is still not determined. I suspect that most [illegible]ists who are not psychotherapists belong to the third group. Unfortunately Dr Steiner, despite an honest account of the difficulties facing psychotherapy, chooses to ignore most of its critics on the grounds that the motives behind such criticism are [illegible] mercenary or malign, so that nothing can be gained by responding to them. This attitude, if widely held, will only reinforce the numbers wanting to dispose of psychotherapy. At a time when cost effectiveness is becoming more of a necessity than a sideline in the evaluation of treatment, all forms of management have to be subjected to its scrutiny. Despite Steiner's protestations, psychotherapy cannot be regarded as an exception, and there is increasing awareness, particularly in the United States, that comparison with other treatments is important as much for the health of the discipline as in making advances in knowledge. Open minds can open new doors and it would be a pity if the ones marked psychotherapy were permanently shut.

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SIR,—Dr Steiner's motives for attacks on psychotherapy include rivalry and envy, but he omitted the dogmatic nature of psychoanalytic concepts, the unreliability and lack of validity of psychoanalytic terminology and nosology, the lack of scientific evidence that psychotherapy works, and the smug, self-righteous attitude of psychotherapists who attribute the attacks to the [illegible]hic deficits of the critics rather than to fundamental flaws [illegible] analytic thought and practice.

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MYTHS ABOUT THE CARE OF THE ELDERLY

SIR,—I was glad to read Dr Freers excellent review on myths in the care of the elderly (Feb 2, p 268), and for one particular reason. For a long time now I have been advocating[1,2] the replacement of higher capitation fees for elderly groups by item-of-service payments. Freer's figures accord with mine in showing that higher capitation fees are increasingly unwarranted. For the past 5 years in my practice the workload from the 65–74 age group has been no heavier than that from younger age groups. What is needed is an incentive to provide intelligently structured care instead of symptom-oriented demands and crisis intervention which make this form of care unpopular.

Whilst I agree that families do still look after their own, despite the popular myth to the contrary, there is a trend in my area now towards warden-controlled homes and good-neighbour schemes with well-spaced family visits. The rising divorce rate and frequency of cohabitation with successive partners is certain to weaken the sense of kinship and family obligation to support in the future.[3]

I think that Freer should be careful about relying on the Kahnberg figures for dementia and its low incidence. Dementia is a silent condition, detectable only by challenge. As he points out, it is frequently confused with depression, with which it often coexists. 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, might 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 sited.

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SALMONELLOSIS PRESENTING AS CROUP

SIR,—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 7½ month old English boy was admitted with a 24 h history of a barking cough and severe breathlessness. For 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 vomited, 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 39·5°C, pulse rate 160, and respiratory rate 80. The throat appeared normal. Apart from intercostal recession, there were no other physical signs. White-blood-cell count and chest X-ray were normal. Respiratory secretions were not obtained because of the risk of precipitating laryngospasm. Blood cultures grew *Salmonella virchow*, sensitive to ampicillin, chloramphenicol, and trimethoprim. The organism was recovered from his stools but not isolated from the parents' stools. 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. By the sixth 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 parents 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 capsular strains of *Haemophilus influenzae* or toxigenic strains of *Corynebacterium diphtheriae*. Other bacteria have been associated with atypical 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] *Chlamydia trachomatis* and *S aureus* have been simultaneously isolated 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

SIR,—Administration of blood or blood products accounts for about 2% of the cases of acquired immunodeficiency syndrome (AIDS).[1] 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

ELISA P/N ratio*					
<2	2–3·9	4–5·9	6–7·9	8–9·9	>10
921	75†	12	4	2	0

*Median P/N ratio = 0·7, mean±SD = 0·95±0·99.
†Single true positive serum (P/N ratio 2·7).

development of a screening test to detect antibodies to AIDS-related retroviruses. The US Public Health Service has recommended excluding blood donors known to be at high risk of AIDS. With the introduction of an enzyme-linked immunosorbent assay (ELISA) for antibody to human T-lymphotropic virus type III (HTLV-III) regulations will soon require the screening of all blood donors. As with any screening test, the problem lies with false positives which will have a significant impact both on blood supplies and on blood donors since seropositive blood will be discarded and donors will be notified of their test result. The definition of "positivity" is thus an important issue. The positive detection limit is best established by comparison of the ELISA P/N ratio with reference methods: the ELISA P/N ratio is calculated as the optical density of a test specimen divided by that of the background or a negative sample. To establish performance standards we compared results by ELISA with those obtained by immunofluorescent assay (IFA) and western blot procedure. The target antigen was gradient purified, disrupted HTLV-III for ELISA and western blot and productively infected cells for IFA. The HTLV-III infected cell line was provided by Dr R. C. Gallo.

We screened 1014 consecutive anonymous blood donor sera by ELISA and retested all specimens with P/N 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. 2 additional cases have been reported in the other eleven counties. The general donor population thus appears to be at low risk of AIDS.

93 specimens (9·2%) had P/N ratios of 2 or more by ELISA. These were re-examined by IFA and western blot and 1 serum was found (P/N ratio 2·7) which contained antibodies to HTLV-III. Virus specificity was confirmed in the western blot by reactivity with HTLV-III polypeptides (p61, p54, p41, p24).[2] The remaining 92 sera were negative by IFA and western blot. This included 18 specimens with an ELISA P/N ratio of 4·0 or more. None of 48 selected samples with P/N 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 jeopardising 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 P/N ratio of 5·0 was established as the cut-off for true positives.[3] However, none of the specimens with a P/N ratio ⩽4·0 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 P/N ratio of 2 as a cut-off point without confirmatory testing would have resulted in 9·2% 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 P/N 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 a confirmatory test be placed on a deferred donor list and informed 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.[4] The resolution of this problem depends on HTLV-III antigen detection tests yet to be developed.

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SIR,—We believe that current commercial kits for HTLV-III antibody tests are likely to give a high rate of false-positive results. We would therefore recommend that careful consideration be given before they are introduced for the screening of all voluntary blood donors; for the amount and degree of unnecessary stress and hardship that a fair number of our donors and their families would thus have to undergo is unacceptable. This in turn could lead to a sizeable drop in the supply of blood and blood products. Of no less importance, for the safety of transfused patients, is the need to ensure that the first priority for the introduction of any HTLV-III antibody tests into a community is given to patients attending special (venereal disease) clinics and other members of the general public who wish to have access to these tests. If this is not done, many high-risk people, from a blood-transfusion point of view, may present themselves at blood-donation sessions simply to find out their HTLV-III antibody status.

We do support, strongly, the screening of all blood donors for HTLV-III antibody testing, but we would advise that this is delayed until test systems have been appropriately evaluated and efforts have been made to give all members of the public access to HTLV-III antibody testing.

National Blood Transfusion Service; Birmingham, Newcastle upon Tyne, Edgware, Oxford, Bristol, Brentwood, Lancaster, Cardiff, Southampton, Leeds, and Sheffield; Scottish National Blood Transfusion, Dundee, Edinburgh, Glasgow, Aberdeen, and Edinburgh; and Protein Fractionation Centre, Edinburgh

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

SIR,—In an earlier report[1] we showed that seropositivity for antibody to human T-lymphotropic virus type III (HTLV-III) among Scottish and Danish haemophiliacs was related to their use of factor concentrate products made from United States donor material. We here present the HTLV-III antibody results on