having the same API 20NE profile as the original blood culture isolates. We therefore feel confident that the organism isolated from the blood cultures was introduced at the time of venepuncture from the contaminated antiseptic.

Although care is needed to ensure scrupulous asepsis in the collection of blood for culture this incident emphasises that the agent used for achieving cleansing of the venepuncture site should not only be appropriate but also that any recommendations made should be monitored to ensure that they are being followed.

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HEAT INACTIVATION OF SERUM MAY INTERFERE WITH HTLV-III/LAV SEROLOGY

SIR,—Commercial kits have lately been introduced for the detection of antibodies to human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) in serum. Not all kits licensed for the screening of blood donors can be used for routine diagnostic purposes in other circumstances. The US Centers for Disease Control recommends that sera from individuals suspected or known to be at high risk of HTLV-III/LAV infection be heated at 56°C for 30 min before testing by enzyme immunoassay.[1] Martin et al[2] state that sera can be heated without loss of antibody activity. However, we have found that this procedure may interfere with subsequent serological testing.

We have tested 15 sera from 15 healthy laboratory workers by the Organon Teknika 'Vironostika' anti-HTLV-III micro-ELISA and by the Abbott HTLV-III enzyme immunoassay before and after heat treatment. Both kits have been licensed by the US Food and Drug Administration for blood donor screening. All 15 unheated sera were negative in both tests (median ratio of extinction value to cut-off: Organon 0·4, range 0·2–0·7; Abbott 0·4, range 0·2–0·5). After heating at 56°C for 30 min all sera were still negative in the Organon test (median 0·4, range 0·2–0·5) but had become positive in the Abbott test (median 2·1, range 1·2–3·4).

Although the Abbott kit is recommended by the manufacturer for blood donor testing only, for which purpose sera are not routinely heated, this test is also used for diagnostic work with heated sera. The directions enclosed in this kit do not warn against heat treatment.

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TRANSMISSION OF AIDS VIRUS AT RENAL TRANSPLANTATION

SIR,—In May, 1985, a 42-year-old man with chronic renal failure was admitted to our hospital with a 6-month history of generalised rash, fever, and malaise. In February, 1984, he had received at another hospital a cadaver kidney graft from a haemophiliac donor who had died of cerebral haemorrhage. Because of irreversible loss of renal function immunosuppressive drugs had been discontinued one month before his May, 1985 admission. He was acutely ill, febrile, and had a widespread vesiculopapular rash with ulcers. His total lymphocyte count was 1000/μl (OKT4:OKT8 ratio 0·9) and his serum was strongly positive for HTLV-III antibodies (Abbott ELISA). Skin biopsy revealed vasculitis with no evidence of Kaposi sarcoma. 2 months after discontinuation of immunosuppression his lymphocyte count was 1200/μl (OKT4:OKT8 ratio 0·97).

The recipient of the other kidney had miliary tuberculosis. Immunosuppressive drugs had been discontinued in December, 1984, but graft function remained normal. This patient was a 52-year-old heterosexual man with no history of drug abuse. In June, 1985, he was HTLV-III antibody positive (Abbott ELISA) with a total lymphocyte count of 1110/μl (OKT4:OKT8 ratio 0·2).

Serum from both transplant recipients obtained immediately before transplantation for cross-matching, was available in the tissue typing laboratory. Assay for HTLV-III antibodies was negative in both. One of the patients did not receive blood transfusion, during or after the transplant surgery.

We conclude that both patients were infected by HTLV-III probably transferred in the kidney grafts from the donor. We recommend that potential cadaver donors, especially homosexuals or haemophiliacs, should be screened for HTLV-III infection.

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FAMILY ANTHROPOMETRY: A NEW STRATEGY FOR DETERMINING COMMUNITY NUTRITION

SIR,—Anthropometric measurements are generally socially acceptable, have good levels of test/retest and inter-observer reliability, and can be done readily in the field. Indices derived by comparing the measurements with reference data are widely used to show the type and timing of nutritional disorders in children.[1,2] In developing countries, the indices in the children are often used as indirect indicators of the nutritional status of the whole community.[3] In Western countries, anthropometry is increasingly used in adults to measure nutritional status and so help estimate the risk of cardiac and other diseases.[4,5] Much more information can be gained by studying the anthropometric patterns of nutrition and malnutrition within and between families rather than in individuals.

Weight-for-height is the best anthropometric indicator of present nutritional status and it can be used at all ages. In children the WHO reference set[6] has been recommended for international use. Weight-for-height can be determined easily.[7] A cut-off point of 90% standard has been widely accepted as the lower limit of normal.[2] In adults, body mass index (BMI, weight/height^2) is generally used.[8] BMI is commonly used to determine the upper limit of normality, so the lower acceptable limit is not well defined.[9,10] A value of 19 or 20 is generally accepted as a reasonable lower limit, but data from Thailand (unpublished) suggests that 18 might be a better cut-off level for developing countries.

The results of weight-for-height indices can be tabulated on a family-by-family basis (see table). This table has been simplified by entering "+" for individuals above the cut-off point, "0" for those below this level, and "–" for no family member.

The patterns of malnutrition shown in the table are not exhaustive, but show the main family distributions that can be expected:

SOME PATTERNS OF UNDERNUTRITION IN FAMILIES

	Present nutritional status of							
				Preschool child		School child		
Pattern	Father	Mother	Infant	1	2	1	2	3
A	+	+	+	+	–	+	+	–
B	+	+	+	0	0	+	+	–
C	+	+	0	0	–	+	–	–
D	+	0	0	0	–	+	+	–
E	0	0	0	0	0	0	–	–
F	+	+	+	+	–	+	0	+

+ means weight-for-height satisfactory, 0 means weight-for-height below critical level, – means no family member.