This would suggest a score of two out of two against universities as upholders of intellectual standards of honesty. It leaves the victim of such theft very much in the cold.

Broom Lodge,
58 High Street,
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J. M. WALSHE


Storage of information by medical journals

SIR,—Like you in your Nov 17 editorial “Brevity in The Lancet” we decided to “store, rather than print, the fine detail” of certain articles which we call, in their published form, Technical Briefs. We have published 5–10 in each monthly issue since 1986.

We have been surprised at the rarity of requests for these stored details: among several hundred Technical Briefs published so far, we have received only one such request. Of course, we do not know the frequency with which authors are contacted directly by interested readers.

Clinical Chemistry,
University of Virginia,
Charlottesville, VA 22908, USA
DAVID E. BRUNS, Editor

Placental localisation in early pregnancy

SIR,—I disagree with the statement in your Feb 2 editorial that “placental localisation at the initial scan cannot be recommended, and when a low placenta is noted incidentally, it is not necessary routinely to order a third-trimester scan”.

Having been in practice as an obstetrician gynaecologist, and specialising solely in prenatal diagnosis for the past 10 years, it is my experience that the advent of new equipment certainly results in better visualisation for sonograms done in the first and early second trimester, especially with respect to the high incidence of diagnosis of low-lying placenta. I believe that the term placenta praevia is inappropriate before 12 weeks’ gestation, unless placental tissue can be clearly seen to cover the internal os region. It is regarded as routine to always visualise the internal os and the whole endocervical canal with an empty bladder to prevent any anatomical distortions. Central placenta praevia can be diagnosed in early pregnancy, especially when the relation of the placental tissue to the os and the endocervical canal is noted. In my experience with these cases, usually without any further abnormal bleeding, repeat sonography between 16 and 18 weeks’ or as late as 20 weeks’ gestation, allows further confirmation of persistent praevia.

Prenatal diagnosis is routinely recommended for all women aged 35, when the incidence of chromosome abnormalities is 1%. Surely central placenta praevia with a population frequency of less than 1% or a delivery frequency of placenta praevia, which you cite as anything from 2.5% to 16–9%, warrants a routine repeat sonogram when in early pregnancy the placenta is seen to be overlying the os?

Koala Labs,
San Jose, CA 95128, USA
JOHN D. STEPHENS

Different hantavirus serotypes in western Europe

SIR,—So far, human infections with hantavirus, causing haemorrhagic fever with renal syndrome (HFRS), other than those transmitted by laboratory animals, have in western Europe been associated with serotype III.1,2 The main reservoir host is the red bank vole Clethrionomys glareolus. In the Netherlands we have published 5–10 in each monthly issue since 1986.

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Antibody titres of human sera in ELISA, measured against hantavirus serotype I, serotype III, and strain Dobrava.

(A) 11 sera from laboratory-associated cases and (B) 16 sera from non-laboratory-associated cases in Netherlands and Belgium; and (C) 32 sera from non-laboratory-associated cases in Yugoslavia. With the same ELISA system we have tested 32 immunofluorescent antibody positive sera, collected from people with a non-laboratory-associated infection in Yugoslavia, against serotype I (strain HV 76–118) which strongly cross-reacts with serotype II (SR-11),4 serotype III (Hallnas), and a recent isolate from Yugoslavia (strain Dobrava).6 The Dobrava strain was isolated from the yellow-necked field mouse (Apodemus flavicollis) during a recent period of high incidence of HFRS in Yugoslavia;4 it reacted more strongly with sera specific for serotypes I and II than with sera specific for serotype III. In addition 16 positive sera from non-laboratory-associated infections and 11 positive sera from laboratory-associated infections in the Netherlands and Belgium were tested in the ELISA against these three viruses. All sera from the laboratory-associated infections showed higher titres against serotype I and strain Dobrava than against serotype III (figure, A). The titres of these sera against serotype I were slightly higher than those against strain Dobrava. All but 2 of the 16 sera from non-laboratory-associated infections in the Netherlands and Belgium showed the highest titres against hantavirus serotype III (figure, B). 14 of the 32 sera from Yugoslavia showed the highest titres against serotype I and strain Dobrava, whereas the other 18 reacted more strongly against serotype III (figure, C). This confirms the results of an earlier serological study with an IFA,
which indicated that two different hantavirus serotypes caused HFRS in Yugoslavia.  

I serum from the Netherlands and I from Belgium reacted more strongly with serotype I and strain Dobrava than with serotype III. Furthermore, both sera neutralised serotype I (strain HV 76-118) strongly with serotype I and strain Dobrava than with serotype III. Both individuals had recently been infected and had not recently been abroad. In a report by Pilaski and co-workers, 1 out of 21 sera from HFRS patients in Germany proved to react more strongly with serotype I. These data suggest that in western Europe as in Yugoslavia non-laboratory-associated hantavirus infections may be caused by more than one serotype.

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J. G. M. JORDANS

Increasing incidence of resistance among shigellae to trimethoprim

Sir,—Shigella organisms resistant to trimethoprim (TMP) and other antimicrobial agents have been reported,
 and this had led to re-evaluation of the treatment regimen for shigellosis. The first report of TMP-resistant shigellae in Ontario, Canada, appeared in 1980.  


