

infection in an HIV-seronegative thalassaemic patient in the same area,⁵ might suggest the need for further serological and molecular investigations of HTLV-I infection in this region.

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Influenza types and patient population

SIR—The National Influenza Centre of the Netherlands and the Netherlands Institute of Primary Health Care participate in the world-wide influenza surveillance of the World Health Organization¹ by collecting and characterising virus isolates from individuals with influenza and by collecting epidemiological data on the incidence of influenza-like illness via sentinel general practitioners (GPs). Since 1970 the thus generated data have proven to be a valuable tool in monitoring the influenza virus activity in our country. Influenza virus isolates have routinely been collected via a network of diagnostic virological laboratories of municipal health services and hospitals. During the past 3 years, however, we have also collected influenza virus isolates by requesting the sentinel GPs to submit nose and throat swabs from patients with influenza-like illness for virus isolation. In the most recent episode of increased influenza activity in March and April of this year, we have compared the influenza virus isolates originating from these two sources.

Of the total number of 213 influenza virus isolates, 85 originated from diagnostic laboratories and 128 from sentinel and other GPs. As shown in the figure, there proved to be a significant ($p < 0.001$) difference in the types of the influenza viruses from these two sources: the ratio between influenza A/H3N2 versus influenza B virus isolates from the diagnostic laboratories was 55/29 (64% influenza A/H3N2) and from the sentinel GPs 34/93 (26% A/H3N2). From each of the groups one influenza A/H1N1 was isolated in this period.

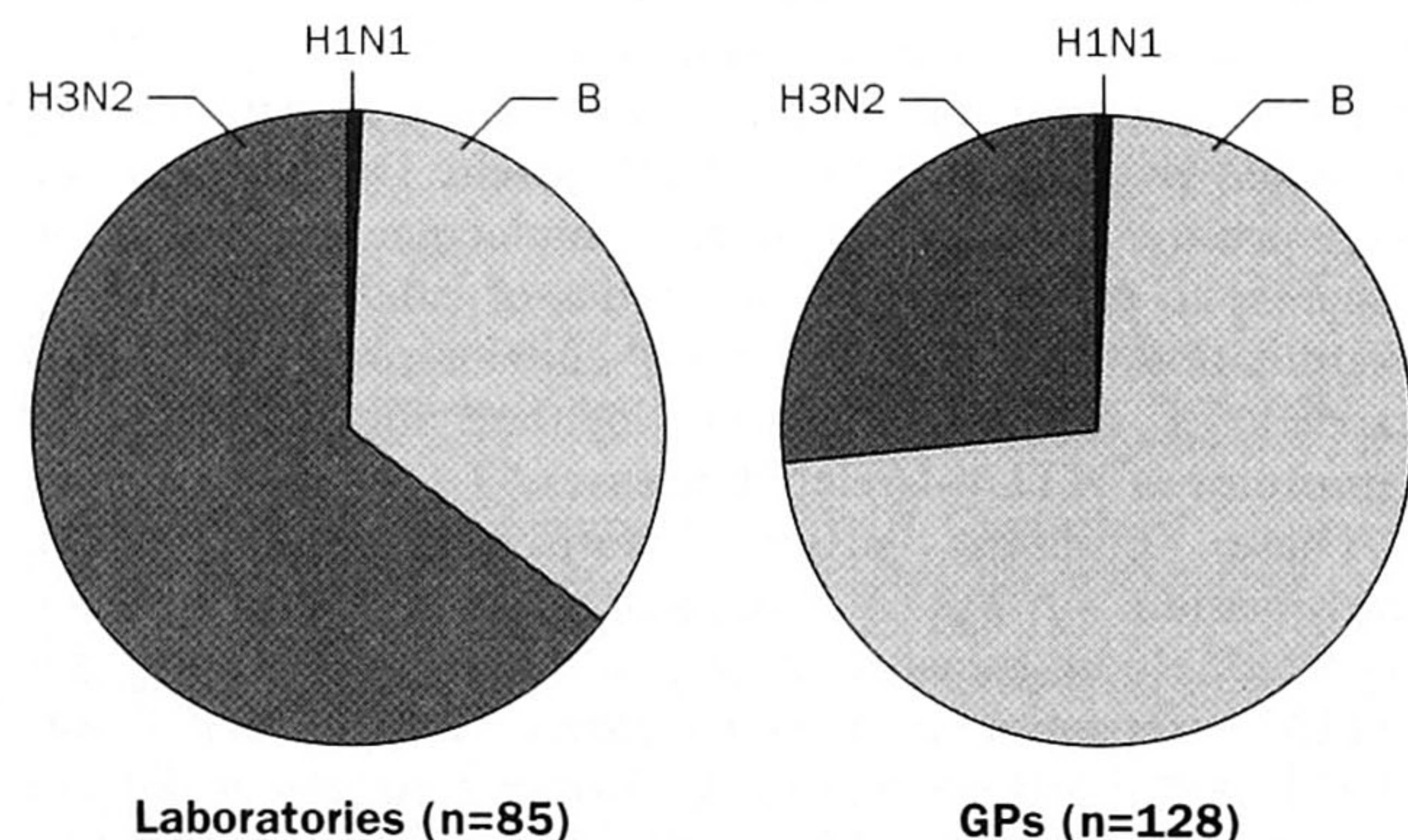


Figure: Influenza virus isolations in Netherlands in 1994-95

These differences are in agreement with the generally more severe clinical outcome of infections of influenza A viruses in comparison with those of influenza B:²⁻⁴ virus isolates from diagnostic laboratories originated from hospitalised patients with more severe clinical symptoms than those treated by GPs. It is likely that isolates obtained via GPs are a better reflection of the type of viruses circulating in the population at large. Therefore, the selection of individuals sampled to monitor the epidemiology of influenza may have a major impact on the outcome of the surveillance with respect to the (sub)types of the circulating influenza viruses.

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Beta blockers to prevent clenbuterol poisoning

SIR—Poisoning due to consumption of meat containing clenbuterol residues has been reported.^{1,2} Between Feb 9 and March 6, 1995, in Malo, Vicenza, Italy three families (16 persons) developed tachycardia, tremors, and nervousness after consumption of fillet and rump steaks purchased from the same butcher. The symptoms started 3 h after the meal and lasted 10 h. A physician on treatment with oral atenolol 50 mg daily did not show any symptoms.

A sample of cooked meat still stored in the freezer of one family revealed a clenbuterol content over 0.5 parts per million by GC-MS analysis. The contaminated meat was from a hind quarter of a heifer, target animals for illicit beta agonist treatment. Investigations are in progress to ascertain all the contaminated food chain. This dose, equivalent to an ingested drug dose of about 100 µg for 200 g of meat, is well above the clenbuterol therapeutic dose, which is about 0.8 µg per kg body weight daily.

This case suggests that beta blockers could prevent clenbuterol poisoning.

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