expense for 2 year olds who wet themselves? No doubt opinions will vary. If not for 2 year olds, why for 3 year olds? Where should the cutoff point in supply be? Should the policy be applied to all children, including those who are severely handicapped and who may in some cases be in receipt of an attendance allowance?

I think that when a mother consults a health visitor concerning her child's wetting management of the problem has to be dealt with on an individual basis, taking all relevant factors into account. If the health visitor takes a professional decision to issue nappies in an individual case she will probably be guided far more by clinical and social factors than by the precise age of the child concerned. I cannot think it wise to impose a general control of this kind, depending solely on the child's age.

Should administrators be taking over-riding decisions of this sort anyway? Might I as a general practitioner be faced one day with a directive that I can sanction pads for a healthy patient of 70 who has the occasional lapse but not for a constantly wet paraplegic of 60? At what point should managers be permitted to over-ride professional judgments on economic grounds? Would not this government be wise, even at this late hour, to reconsider its electoral image and soften its budgetary pressure on local administrative bodies to make savings, whatever the cost? More and more, erstwhile supporters of the present administration are beginning to ask themselves if the NHS is really safe with Mrs Thatcher.

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Continuous ambulatory peritoneal dialysis fluid: another fluid positive for HIV antibody?

SIR,—Antibodies to the human immunodeficiency virus (HIV) have been detected in a wide variety of body fluids, although infectivity is thought to be confined to blood. Screening for such antibodies is becoming widespread in European dialysis units (19 July, p 161; 30 August, p 565), although it may be more relevant in other parts of the world. There have been few reports of dialysis patients positive for HIV antibody, and it is debatable whether a patient with the acquired immune deficiency syndrome (AIDS) or AIDS related complex should be offered long term dialysis. However, heavily transfused dialysis patients may have been inadvertently exposed to the virus before the introduction of screening of donated blood in areas of the world with a high prevalence of the disease.

A 45 year old black woman was started on haemodialysis in Bermuda in 1981 because of end stage renal failure due to lupus nephritis. Forty two months later she started continuous ambulatory peritoneal dialysis because of problems with vascular access. After she had been on continuous ambulatory peritoneal dialysis for 14 months she was antibody positive in both blood and dialysis fluid. Her lymphocyte subsets were low (T4, 271 × 10^6/l (normal >400 × 10^6/l); T8, 152 × 10^6/l (normal 250-750 × 10^6/l)) but the helper: suppressor ratio was 1·78 (normal 1·0-2·2). She had neither symptoms nor signs of AIDS or AIDS related complex and presumably acquired her antibody positive state from blood transfusion(s) received while on haemodialysis, as there were no other known risk factors.

Drained continuous ambulatory peritoneal dialysis fluid contains small quantities of albumin and immunoglobulins (usually under 1 g of total protein/l in the absence of peritonitis); hence in patients positive for HIV antibody who are receiving continuous ambulatory peritoneal dialysis strict precautions should be taken in the disposal of such fluids. Continuous ambulatory peritoneal dialysis would seem, however, to be the treatment of choice for such patients with renal failure as it reduces the risk of exposure of hospital staff to blood positive for HIV antibody.

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Incidence of rhesus immunisation after genetic amniocentesis

SIR,—Dr Ann Tabor and her colleagues (30 August, p 533) claim that anti-D immunoglobulin injections after genetic amniocentesis are unjustified, and I would not disagree with this for third and subsequent pregnancies. I would be much more cautious, however, in mothers having amniocentesis in first or second pregnancies. There is a small group of rhesus negative mothers who are "hyper-responders" in that they may well develop rhesus antibodies after one stimulating episode even if the volume of rhesus positive cells is very small, and if unprotected they have a substantial risk of becoming sensitised.[1] TThe 12 mothers who already had demonstrable antibodies before amniocentesis in the Danish study almost certainly included some hyper-responders and were excluded from the survey.

I would recommend, therefore, that rhesus negative mothers in their first and second pregnancies should continue to receive a 50 μg (250 IU) injection of anti-D. It is mainly because of the hyper-reponders that we continue to encounter new cases of rhesus immunisation, although rhesus prophylaxis has been with us for more than a decade.

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1 Tovey LAD, Taverner JM. A case for the antenatal administration of immunoglobulin to primigravidae. *Lancet* 1981;i: 878-81.

New method for typing Staphylococcus aureus resistant to methicillin

SIR,—I would like to take up two issues arising from the paper by Dr J R Stephenson and colleagues (6 September, p 581). Firstly, they selected for epidemic methicillin resistant *Staphylococcus aureus* (EMRSA)[1] by incorporating gentamicin into nutrient agar. This could result in some EMRSA escaping detection, as gentamicin resistance in EMRSA is commonly borne on an 18 megadalton plasmid and may be encoded by a 5·2 kilobase pair transposon, Tn 3851.[2] This is an unstable characteristic and may be readily lost from cells. This selection for resistance to gentamicin may explain why new cases arose after screening of patients and staff yielded negative results, although another possibility may be that the EMRSA was being harboured in the environment. During ward outbreaks at The London Hospital EMRSA has frequently been cultured on air sampling (unpublished findings).

Secondly, experience at The London Hospital suggests that chlorhexidine based antiseptics are not particularly effective against this strain. In an outbreak on the neurosurgical ward in November 1982 chlorhexidine was used to try to ablate carriage in six members of staff. It was used in daily washing and shampooing and as a cream (1%) for nasal carriage (table). Despite these measures it took from three to 20 days to clear the organism from these members of staff, who were meanwhile removed from their duties. Later on, in 1984, chlorhexidine cream was used in five members of staff and 10 patients with nasal carriage of EMRSA.[3] After 10 days' treatment all still carried the organism. They were all cleared within two days when treatment with nasal mupirocin was started and were still clear up to 14 days after the five day course of mupirocin.

Details of staff on neurosurgical ward receiving chlorhexidine washes and nasal cream for carriage of EMRSA, November 1982

Case No	Site of first isolate	Other positive sites	Interval to clear (days)
1	Paronychia	Perineum, fingers, nose	7
2	Nose, cut hand	Fingers	16
3	Nose		16
4	Nose, eczema		12
5	Nose	Bite	20
6	Nose		3

Treatment of more widespread colonisation poses greater difficulties as mupirocin is not available in a formulation for ready application over large areas. Some units have found Triclosan to be useful.[4] Hexachlorophane is effective against Gram positive organisms, but reports of toxicity have limited its use over large areas of the body and on abnormal skin.[5 6]

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2 Townsend DE, Ashdown N, Greed LC, Grubb WB. Transposition of gentamicin resistance to staphylococcal plasmids encoding resistance to cationic agents. *J Antimicrob Chemother* 1984;14:115-24.
3 Casewell MW, Hill RLR, Duckworth GJ. The effect of mupirocin on the nasal carriage of Staphylococcus aureus. In: *Mupirocin—a novel topical antibiotic*. London: Royal Society of Medicine, 1984. (Royal Society of Medicine International Congress and Symposium Series No 80.)
4 Bartzokas CA, Paton JH, Gibson MF, Graham R, McLoughlin GA, Croton RS. Control and eradication of methicillin-resistant Staphylococcus aureus on a surgical unit. *N Engl J Med* 1984;311:1422-5.
5 Martin-Bouyer G, Lebreton R, Toga M, Stolley PD, Lockhart J. Outbreak of accidental hexachlorophene poisoning in France. *Lancet* 1982;i:91-5.
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Medical housing "lines"

SIR,—I agree with Drs J A Reid and E J Hunt (6 September, p 628) that "priority can be allocated only relative to the needs of the population," but I disagree with the assertion that "it is unrealistic to expect caseworkers to allocate priority fairly" because these caseworkers would be assessing only social priority (and may be in a better position to decide this than general practitioners or community physicians). They would not be involved in assessing the other elements of determining housing priority.

I think Drs Reid and Hunt miss my point when I suggested that communication between general practitioners and housing departments should be improved (9 August, p 370). As community physicians are involved in allocating medical priority they become part of the housing department's system, so that feedback to general practitioners