editorial, is the need for Ortho and/or Chiron to deposit the sequence of the viral genome in the GenBank database. These matters are so important that they should be taken up by Government health departments. In view of the impending European legislation on blood transfusion, European governments are especially well placed to coordinate such actions.

JOHN D. CASH
D. B. L. MCCLELLAND
S. J. URBANIAK
E. BROOKES

Scottish National Blood Transfusion Service, HQ Unit, Edinburgh EH17 7QT

Virology Laboratory, Ruchill Hospital, Glasgow

E. A. C. FOLLETT

SCREENING FOR HEPATITIS C VIRUS ANTIBODY

SIR,—The flurry of publications on hepatitis C virus (HCV) in *The Lancet* of Aug 5, including an excellent editorial, comes as no surprise.

We agree that the Ortho ELISA for anti-HCV is specific for the major agent causing post-transfusion non-A, non-B hepatitis (NANBH): it is clearly superior to all previous attempts at an assay for NANB virus and provides a welcome advance over surrogate markers for infection with this virus. However, in the context of donor screening, precipitate action should be avoided. As in any other assay, the predictive value of a positive result hinges on the prevalence of the marker in a given population. While the test scores well in panels of well-characterised NANB hepatitis sera and in samples from patients with a diagnosis of NANB hepatitis, we do not know the predictive value of the test in low prevalence populations, such as UK blood donors. We must have confirmatory assays to eliminate, for example, cross-reactivity with yeast antigens before sensible policies for generalised screening of blood donations can be implemented.

We have evaluated the Ortho ELISA for anti-HCV on behalf of the National Blood Transfusion Service. 0·5–1% of blood donations have been found to be repeatedly reactive. Excluding such blood donors might not seem to be a problem. However, the UK has an annual 2·5 million blood donations, and contacting and counselling 12 500–25 000 donors would be an enormous and costly undertaking, especially when the significance of a positive test in a healthy person is as yet unknown.

The test takes at least 3 h; its introduction in routine donor screening would be logistically difficult. The release of components such as platelet concentrates, especially those collected by apheresis, would be considerably delayed. Testing time and the need for a confirmatory assay should be considered when evaluating the cost-effectiveness of routine donor screening.

North London Blood Transfusion Centre, London NW9 5BG

MARCELA CONTRERAS
JOHN A. J. BARBARA

SIR,—Whilst we share the views of your Aug 5 editorial on the importance of the new detection systems for HCV antibodies, especially in the context of screening blood donations, we take issue with the last point made by Professor Kühnl and colleagues in the correspondence section (p 324) of the same issue.

The apparent absence of a confirmatory test will cause serious problems for blood transfusion services, which are likely to bear the brunt of sensitive donor counselling. A repeatably reactive ELISA test is suggestive but not definitive evidence for antibody. We accept that the existing difficulty (use of the same antigen) is scientifically less than satisfactory, but it is better than nothing. Ortho Diagnostic Systems should make available, as a matter of urgency, appropriate reagents and/or tests so that even when an identical antigen is used, assay systems that are fundamentally different from the marketed ELISA screening tests can be used for confirmation testing. Of no less importance for blood donors, as you have indicated in your