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larger professional contribution in posts appropriate to their capabilities, and have a chance to influence departmental and hospital policies. At a time when specialist training is becoming more prolonged we see the increase in posts of senior house officer grade as giving us registrars by another name, and pushing the bottle-neck further down the career ladder.

If both foreign and British graduates are to be doing the same rotations, and if the posts are to be of equal quality, then the contracts must all be held at regional headquarters so that acceptable rotations can be organised. As a majority of registrars will eventually obtain consultant appointments in district general hospitals, we believe that it should be obligatory for all registrars to have at least two years' experience in such hospitals. Opportunities for overseas graduates to work in teaching hospitals should also be available.

Despite much time and thought having been given to the problem of hospital staffing in 1980-81, little progress had been made by 1985. What has happened since then that could not have been foreseen? We now have imposed on us an ill thought out, hasty, and short sighted solution in a struggling hospital service, which remains unsympathetic to the requirements of flexibility that are now needed for 50% of medical school graduates, so that their full potential may be realised.

H P McDOWELL and J GREGG
Royal Liverpool Children's Hospital,
Alder Hey, Liverpool L12 2AP

Concern over safety of SAGM blood

Sir,

We read with interest the letter from Drs Robertson and Chiswick. We recently carried out an exchange transfusion in a neonate using 500 ml of partially packed SAGM blood. She was born at 38 weeks' gestation, weighed 3000 g at birth, and required an exchange transfusion for ABO group incompatibility when 19 hours old.

Before the transfusion the infant's total serum protein concentration was 58 g/l, and the serum albumin concentration was 36 g/l. These fell to 43 g/l and 28 g/l, respectively, immediately after the transfusion. By the following day the patient's total serum protein concentration was 52 g/l with a serum albumin concentration of 32 g/l. A coagulation screen immediately after the transfusion showed a prothrombin ratio of 1:3, a kaolin cephalin coagulation time of 39 seconds [control 38 seconds], and a prothrombin time of 22 seconds [control 19 seconds].

This infant tolerated a SAGM exchange transfusion with a temporary fall in plasma protein concentration and no disturbance of coagulation. Partially packed SAGM contains protein concentrations that are one third to one half of those of normal plasma. Though SAGM donor blood may be safe for use in exchange transfusions in the well term infant, further assessment is required in the ill low birthweight baby.

Reference

- Robertson NRC, Chiswick ML. Concern over safety of SAGM blood. *Arch Dis Child* 1987;62:638.

S W RYAN
Clarendon Wing,
Leeds General Infirmary,
Leeds

B BHADURI
York District Hospital,
York

M J HARRAN
York District Hospital,
York

Peptic ulceration: long term outcome

Sir,

Murphy *et al* reviewed 110 children with duodenal ulcers.¹ We are carrying out a long term follow up study of 36 children with peptic ulcers. The clinical features are similar but the long term outcome is different. The aim of our study, begun in 1982, was to determine endoscopically the healing rate after eight weeks of treatment with ranitidine, and the rate of relapse after stopping the drug. Endoscopy was repeated every six months or when symptoms recurred. For ethical reasons no placebo group was included.

The average number diagnosed annually was seven, the mean age at diagnosis was 9 years 7 months (range 18 months to 19 years), the male:female ratio was 1.8:1 and the mean duration of symptoms before diagnosis two years four months. There was a family history of peptic ulcer in 47%. The commonest symptoms were abdominal pain (91%), vomiting (47%), and bleeding (11%). The maximal acid output after pentagastrin stimulation was two standard deviations above normal in 66%. Of six patients with antral and prepyloric ulcers the maximal acid output was raised in five and normal in one, suggesting an identical pathogenetic factor.²

The table shows the sites of the ulcers, the rate of healing in 34 patients, and the rate of relapse in the 30 who were followed for more than a year. Though our series is smaller than that reported by Murphy *et al*, some of these preliminary data can be compared with his.

The main difference is in the rate of relapse (36% compared with 70%) and the length of time before relapse

Table Features of peptic ulcers in 36 patients

Features of ulcers	No of boys (n=23)	No of girls (n=13)	Total No (n=36)
Site:			
Duodenum	18	10	28
Antrum or prepyloric zone	5	3	8
No healed after eight weeks	22/23	10/11	32/34
No relapsed	9/21	2/9	11/30