spondyloarthropathies, they are separate entities. Both are distinct from rheumatoid arthritis.

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References

1. Lindsay JA. Chronic sequelae of foodborne disease. Emerg Infect Dis 1997;3:443-52.
2. Veys EM, Mielants H. Enteropathic arthropathies. In: Klippel JH, Dieppe PA, editors. Rheumatology. St. Louis: 1994; 3.35.
3. Khan MA. Seronegative spondyloarthropathies. In: Schumache HR, editor. Primer on rheumatic diseases. Atlanta (GA): Arthritis Foundation; 1993.
4. Hammer RE, Maika SD, Richardson JA, Tang J-P, Taurog JD. Spontaneous inflammatory disease in transgenic rats expressing HLA-B27 and human a2m: an animal model of HLA-B27-associated human disorders. Cell 1990;63:1099-112.
5. El-Khoury GY, Kathol MH, Brandser EA. Seronegative spondyloarthropathies. Radiol Clin North Am 1996;34:343-57.
6. Toivanen A. Reactive arthritis. In: Klippel JH, Dieppe PA, editors. Rheumatology. St. Louis: 1994: 4.9.

Reply to Drs. Blumberg and Sloan

To the Editor: I concur with your comments. After reviewing the literature related to foodborne disease, it appears that the original classification of reactive arthritides has been in error for some time. I certainly appreciate the correction.

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Cost of Blood Screening

To the Editor: In reference to G.A. Schmunis' article on the risk for transfusion-transmitted infections in Central and South America (1), I would like to comment on the cost of blood screening. In a screening program, the objective is to have safe blood units, not to assess the prevalence of different infections among potential or actual donors. Thus, while acknowledging all infections present in a given donor or potential donor is not required, detecting at least one of the infections that would make a donor noneligible is. If samples from every potential donor are subjected (by default) to all the tests, information on every infection present is provided, and the cost of screening this donor is the sum of the cost of every test applied; in this case, both the information and the cost are greater than necessary.

Information on the prevalence of bloodborne infections among the general population or, preferably, among potential donors (particularly where professional donors are frequent) along with information on the costs of the tests to be used can form the basis of a stepwise screening scheme. Tests for infections with the highest prevalence would be applied first. For example, in many areas of Peru, using the Venereal Disease Research Laboratory (VDRL) test (for screening *Treponema pallidum* infection) first would reduce the number of samples to be subjected to other more expensive and often less available tests (e.g., HIV enzyme-linked immunosorbent assay [ELISA] or hepatitis C virus [HCV] ELISA); in others areas, a test for hepatitis B virus antigen (HB_sAg) should be used before HIV ELISA. The reduction in cost provided by stepwise screening will depend on the prevalences of the more frequent infections and the frequency of concurrent infections.

The questionnaires applied to candidate donors should be validated, and the benefit of using them should be assessed. In most settings, candidate donors are either ignorant of their status as carriers of bloodborne infection or ready to deny it; therefore, the questionnaire is of little use. In some cases candidate donors are turned down because of "hepatitis history" when in fact they have not had bloodborne hepatitis.

Finally, screening tests seem to be quite more expensive than reported in Table 4 of the Schmunis article. In Lima, at a ministry of health facility, some prices are as follows: HIV ELISA US$12.50, VDRL US$6.40, HB_sAg US$13.90.

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Reference

1. Schmunis GA, Zicker F, Pinheiro F, Brandling-Bennett D. Risk for transfusion-transmitted infectious diseases in Central and South America. Emerg Infect Dis 1998;1:5-11.