thought that embarrassment or fear of a judgmental attitude by health professionals might act as a deterrent. Health professionals must acknowledge this fact. Postcoital contraception should become an integral part of the contraceptive repertoire. Manufacturers need to investigate other methods of postcoital contraception which will make women feel more confident about controlling their fertility —ie, products that are safe, effective, easily accessible, and least likely to cause side-effects. With such an agent women can concentrate on protecting themselves from sexually transmitted disease, including HIV infection. An agent to do both? That would be an agenda item for the Conference on the Status of Women, to be held in Beijing in September.

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SIR—Your editorial notes that a recent consensus statement had stressed that "emergency contraception is not abortion". You claim that it is ignorance of this premise that has impeded more widespread acceptance of this method of birth (or pregnancy) control. The six methods of emergency "contraception" you refer to are all interceptive, not contraceptive. They primarily interfere with the implantation of a fertilised ovum and thus represent the very-early-abortion approach. Embryology textbooks imply that conception begins at fertilisation and US Supreme Court (Webster *vs* Reproductive Services, July 3, 1989) let stand a lower court's definition of conception as occurring at the time of fertilisation. The term "emergency contraception" as used in your editorial and by the expert consensus group referred to is a misnomer. The correct term for the six methods is "emergency interception" or "emergency pregnancy termination". The word "contraceptive" should be restricted to drugs or procedures that interfere with fertilisation or gametogenesis.

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Vitamin A and measles vaccination

SIR—In his commentary accompanying Semba and colleagues' report (May 27, p 1330) showing that simultaneous administration of 100 000 IU vitamin A with standard titre Schwarz measles vaccine at 6 months of age reduced the likelihood of seroconversion, Ross concluded, "... the wisdom of giving vitamin A supplements with measles vaccine in programmes that vaccinate from six months is questionable".

Although the study certainly suggests the potential advisability of administering large-dose vitamin A before or after, rather than simultaneously with, measles vaccination, alternative opportunities for delivering high-dose vitamin A to infants are limited. A simple calculation suggests that when measles vaccination is done at 6 months, and this is one of the few opportunities available for giving large-dose vitamin A, the potential benefits still outweigh the disadvantages.

In the Semba study, simultaneous administration of vitamin A resulted in a 10% excess failure of seroconversion (13% fewer seroconversions in children with baseline maternal blocking antibody titres of 8 or greater). If measles accounts for as much as 20% of all childhood deaths in this age group, the largest potential reduction in overall mortality would range from 18% to 20%. By contrast, several studies have shown that improved vitamin A status alone reduces overall preschool child mortality by 23–34%.[1-3] The added benefit of combined measles vaccination should reduce mortality even more. Simultaneous administration of large-dose vitamin A and measles vaccination at 6 months of age, although not ideal, should nonetheless prove more effective (at least over the ensuing 6 months) than immunisation alone.

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Is it possible to catch leukaemia from a cat?

SIR—The commentary of Donaldson and colleagues[1] lists several of the unanswered questions concerning the potential oncogenicity of feline leukaemia virus (FeLV) and feline immunodeficiency virus (FIV) in human beings. As a contribution to this debate, we report a study in patients with haematological neoplasms, carried out with immunological and molecular techniques.

We examined serum samples of 150 patients with various types of leukaemias for the presence of the group-reactive FeLV p27 antigen (which is common to all three FeLV subgroups A, B, and C) and FIV antibodies by ELISA (IDEXX Snap™, Combo FeLV Ag/FIV Ab test). To achieve the highest possible distribution, we included in our study samples of adult leukaemias (patients of the Division of Haematology and Haemostaseology, University of Vienna, Austria) and childhood leukaemias (samples collected at the Department of Paediatrics, Haematology and Oncology, University of Giessen, Germany), with a preference being given to acute leukaemias. To gain additional information, and to detect possible non-viraemic cases, peripheral blood mononuclear cells (PB-MNCs) or bone marrow cells of 79 patients were investigated for the presence of a, amongst all the FeLV subgroups, highly conserved 341 basepair sequence within the U3 region of the FeLV LTR by DNA-PCR.[2] Following Southern blotting, hybridisation with a ^{32}P-labelled FeLV specific oligonucleotide probe was done.

Samples from 213 individuals were investigated (from 16 patients both serum and cells were tested). The leukaemias of those patients had been classified as acute lymphoblastic leukaemia (ALL; 105 cases—87 children and 18 adults—including precursor and mature forms of B-ALL and T-ALL), acute non-lymphoblastic leukaemia (ANLL; 81 cases—70 adults and 11 children—including the morphological subtypes M0 to M7), myelodysplastic syndromes (7 cases), chronic myelogenous leukaemia (9 cases), chronic myelomonocytic leukaemia (3 cases), chronic lymphocytic leukaemia (5 cases), hairy cell leukaemia (2 cases), and large granular lymphocyte leukaemia (1 case).

FeLV antigen was not detected in any of the samples; all but one were negative for FIV antibodies with ELISA. The one ELISA-reactive sample (an adult ANLL case) proved clearly negative in western blot, and therefore apparently represents a false-positive ELISA result. Similarly, no FeLV sequence was found in the PB-MNCs and bone marrow cells. To conclude, we have not found any evidence of infection with either FeLV or FIV in patients with different haematological neoplasms.

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Mycophenolate mofetil for prevention of acute rejection

SIR—The European Mycophenolate Mofetil Cooperative Study Group (May 27, p 1321) reports the encouraging results of adding mycophenolate mofetil (mycophenolic acid) to prophylactic immunosuppression with cyclosporin and prednisolone for renal transplant recipients. The importance of these results for clinical practice, however, should be viewed with caution since the control immunosuppression regimen produces suboptimum results in terms of graft survival[1] compared with the more standard induction regimen, such as triple therapy with cyclosporin, azathioprine, and steroids, as used in over 80% of renal transplant cases in Europe. Furthermore, the cyclosporin formulation used was the conventional form (Sandimmun), which has been superseded by a more readily absorbed formulation (Neoral). The two formulations cannot be regarded as interchangeable, especially since a recent trial has suggested that the rate of acute rejection seen with the Neoral formulation is lower than with the Sandimmun form.[2] It would therefore be interesting to examine the adjunctive use of mycophenolate mofetil with a Neoral-based immunosuppressive regimen.

A recent case at Cardiff Royal Infirmary shows the clinical difference between the two formulations of cyclosporin. A 44-year-old man received a one haplotype-matched kidney from his mother and was given prophylactic immunosuppression with cyclosporin (Sandimmun), prednisolone, and azathioprine. At day 7 post transplant he had an episode of acute biopsy-proven rejection (figure). Treatment was initiated with methylprednisolone, but because of clinical severity and histological features indicating a vascular component, he was started on OKT3 (muromonab-CD3). After a period of dialysis dependence, his renal function improved, but then plateaued, and biopsy confirmed continuing grade II cellular rejection. Further pulses of methylprednisolone led to a transient response, but biopsy-confirmed rejection continued and anti-thymocyte globulin (ATG) was begun. During this period cyclosporin blood concentrations fluctuated widely. Thus, a cyclosporin pharmacokinetic profile after a single dose of 300 mg

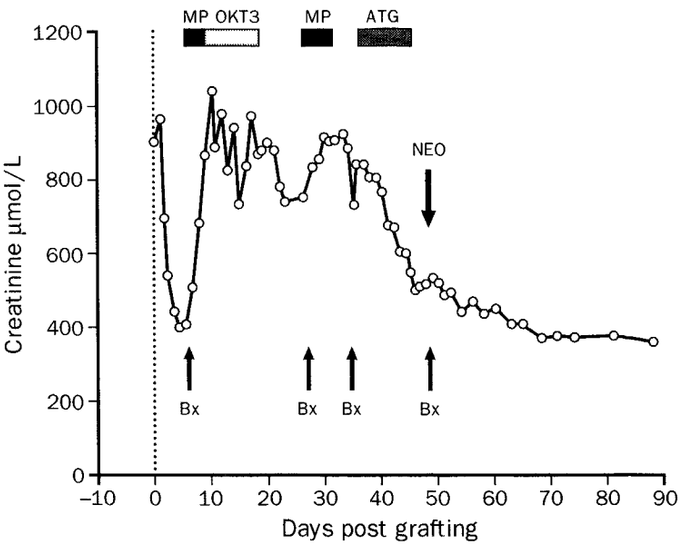

Figure: **Clinical course of transplant showing time of biopsies (Bx) and treatment with methylprednisolone (MP), OKT3, and ATG and time of transfer to cyclosporin Neoral (NEO)**

Sandimmun was done. The time to maximum absorption (T_{max}) was 5 h, with a maximum whole blood concentration (C_{max}) of 1200 ng/mL. Graft function improved after ATG, but plateaued at an unacceptable level. Another biopsy showed no evidence of acute cellular rejection, but in view of the history of severe recurrent rejection and the slow absorption, which may have explained the patient's complicated clinical course, he was transferred to Neoral. No further rejection took place, creatinine concentration fell, and cyclosporin blood concentrations stabilised. A repeat pharmacokinetic profile was performed on Neoral. After a single dose of 200 mg (33% reduction), the T_{max} decreased to less than 2 h and the C_{max} to 1600 ng/mL.

Mycophenolate mofetil is undoubtedly a promising new drug and alongside tacrolimus and Neoral offers new hope for transplant recipients to prevent acute rejection and promote long-term graft survival. However, before widespread clinical use is advocated we need more data on its use as adjunctive therapy to the optimum immunosuppressive protocols; this is especially true in view of the probable extra cost that would be associated with the addition of mycophenolate mofetil and tacrolimus to life-long post-transplant immunosuppression. In this context, cost-effectiveness analysis focuses on outcomes and, in particular, graft survival rather than acute rejection. From a provider perspective it is disappointing, therefore, that it may be some time before compelling clinical data are available to satisfy health commissioners that the use of these powerful new agents is of proven clinical and economic effectiveness.

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SIR—The European Mycophenolate Mofetil Cooperative Study Group quite appropriately draws only modest conclusions from the study of mycophenolate mofetil on the prevention of acute renal allograft rejection. The combination of cyclosporin, corticosteroids, and mycophenolate mofetil (three immunosuppressive agents) was more effective than cyclosporin, corticosteroids, and placebo (two immunosuppressive agents). So what? The important question is, does this triple therapy combination