Letters

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Breast feeding: the baby friendly initiative

Unicef's baby friendly initiative is making great progress in UK

EDITOR—We share Malik and Cutting's enthusiasm for Unicef's baby friendly initiative in the United Kingdom but were disappointed that they did not acknowledge the great progress made over the past year.[1] It is pessimistic to state that hospitals have been slow to work with the initiative. In fact, almost all units are working towards baby friendly accreditation; 11 British maternity units have achieved the required standard and another 40 have a certificate of commitment. Although Malik and Cutting suggest that hospitals might be demoralised by unachievable targets (such as the 75% breastfeeding rate required for the global baby friendly award), we removed this requirement for the United Kingdom's standard award in order to focus on the support and encouragement of best clinical practice.

It is also unfair to suggest that the baby friendly initiative is confined to hospitals. On 15 May we launched best practice standards for community healthcare settings, with the support of the minister for public health. This is the first step in introducing the initiative into the community and provides a framework around which clinical accreditation will be developed. The United Kingdom will probably be unique in having a primary care baby friendly award. As with the existing awards, particular emphasis is placed on support for mothers to make informed decisions about feeding their babies.

Malik and Cutting call for better coordination with existing groups that support mothers; in fact, all four national groups are fully involved with the baby friendly initiative. We were also puzzled by the statement that "government and NHS managers should recognise and encourage [the baby friendly initiative's] development." The Department of Health has worked in partnership with the initiative since its inception in the United Kingdom,[2 3] while an increasing proportion of NHS managers see the initiative as a cost effective quality framework to achieve a high standard of care, which can be independently accredited.

We agree that much more could be done to support mothers in their choice to breast feed. Nevertheless, the healthcare system has a crucial role; it was particularly pleasing to note that the 1995 infant feeding statistics[4] documented progress on relevant hospital practices.[5] We are optimistic that the progress of Unicef's baby friendly initiative in the United Kingdom can strengthen this trend.

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1 Malik ANJ, Cutting WAM. Breast feeding: the baby friendly initiative. *BMJ* 1998;316:1548-9. (23 May.)
2 Department of Health/Unicef UK Baby Friendly Initiative. *Memorandum of understanding between the National Breastfeeding Working Group and the Unicef UK Baby Friendly Initiative.* London: Department of Health/Unicef UK Baby Friendly Initiative, 1993.
3 National Breastfeeding Working Group. *Breastfeeding: good practice guidance to the NHS.* London: Department of Health, 1995.
4 Foster K, Lader D, Cheesbrough S. *Infant feeding 1995.* London: Stationery Office, 1997.
5 Williams A. Infant nutrition in Britain: where are we and where should we be going? *BNF Nutr Bull* 1998; 23(suppl 1):5-11.

Support must continue beyond hospital

EDITOR—Part of the problem experienced by mothers who want to breast feed their babies, which Malik and Cutting do not mention,[1] is the lack of experience of breast feeding among nursing and medical staff—it is one thing to be told how to do it and quite another to manage it. In the past, older women in the family or community would have provided this advice from their personal experience.

Support must continue beyond the maternity hospital. Once outside the confines of the hospital, nursing mothers—especially those who need to return to work—find the outside world a hostile place. Despite assurances by the National Childbirth Trust and other interested organisations, it is difficult to combine work and breast feeding. A big step forward would be for maternity leave to extend to six months after the birth and not three or four, as generally happens at present. Not every woman would want to take so much leave, but that would be her choice. For a breast feeding woman, leaving her baby at the age of 3-4 months is fairly traumatic; the baby would probably not be naturally fully weaned until much later. Workplaces are supposed to provide somewhere for mothers to express and store milk in hygienic conditions, but do they provide the time to do this?

Generally, in modern society women who breast feed are seen as "earth mothers" with time to "waste" on such things. Until our culture changes and the mother and baby are protected as a unit from social and work pressures that threaten their time together during the first year, many women will give up. They don't want to be seen as inefficient, unproductive, and time wasting.

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The arts and the media can help

EDITOR—Malik and Cutting's editorial drew attention to the potential in the imaginative use of the media in promoting breast feeding, especially among mothers in their teens and 20s.[1] In Walsall we are working towards achieving the 10 steps to successful breast feeding[2] and developing a card informing mothers where they can feed their babies while shopping locally.

We also have a multiagency working group promoting breast feeding within the hospital and in the community. This group, in collaboration with the health authority, wrote to five producers of the leading soap operas based in the United Kingdom and shown during prime viewing time, asking them to help us in our efforts to promote breast feeding. We received only three responses, varying from a total lack of interest in our campaign to one of great enthusi-

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asm. The BBC production *EastEnders* has not only commissioned research on breast feeding but also made positive references to breast feeding in its story line.

Increasingly, the arts and media are being recognised as effective means of providing health education messages to people and obtaining feedback from service users. Walsall Health Authority has commissioned a theatre company to research women's choices for childbirth, and the company has delivered workshops for health professionals on the issues of informed choice and breast feeding.[3]

All these initiatives are likely to have a cumulative effect on women in Walsall, and we expect that the number of mothers who take up breast feeding will increase.

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2 Vallenas C, Savage-King F. *Evidence for the ten steps to successful breast feeding.* Geneva: WHO Child Health and Development Unit, 1997.
3 Norton J, Connolly J, Belbin A, Patel B. *Changing childbirth: what choices for Walsall women? A research project.* Walsall: Walsall Health Authority, 1997.

In Sri Lanka only quarter of babies under 4 months are exclusively breast fed

Editor—Promotion of breast feeding in Sri Lanka is not confined to the hospitals of the baby friendly initiative[1] but is carried out island wide, through the mass media and posters in hospitals and maternal and child health clinics. In Sri Lanka, advertising and promoting formula milk as a substitute for breast feeding is prohibited. Tins of artificial milk must carry the slogan "Breast milk is best for your baby." To promote breast feeding, obstetricians, paediatricians, and family doctors must be competent to advise mothers. A national survey showed, however, that most obstetricians and paediatricians were dissatisfied with the training they received on breast feeding. Furthermore, there was no consensus regarding certain baby friendly initiative practices that are being promoted (D P Gunasekera et al, paper presented at the annual scientific congress of the Sri Lanka College of Paediatricians, 16-20 July 1997, Colombo, Sri Lanka). A consensus on current breast feeding policies is imperative so that mothers are not confused by contradictory advice.

In Sri Lanka mothers receive full pay maternity leave for three months. Hence early supplementation is started so that they can return to work. Although legislation exists that allows mothers to take time off to breast feed once they return to work, many are unaware of their rights.

Traditional herbal supplements and water are often recommended by elderly relatives, and this advice is often accepted by the new mother. Only 24% of babies aged under 4 months are exclusively breast fed, while 41% of babies aged under 2 months are given supplementation with water.[2] Promotion of breast feeding should be continued in the community once the mother returns home, but only seven tenths of women receive postnatal care by the public health midwife at least once within the first 10 days of delivery.[3]

The importance of updating those who give maternity and infant health care about breast feeding, both in hospitals and in the community, must be emphasised. Promotion of breast feeding in the mass media, legislative control of promotion of artificial feeds, and the leave entitlements and working hours of mothers who breast feed would also help promote the baby friendly initiative.

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1 Malik ANJ, Cutting WAM. Breast feeding: the baby friendly initiative. *BMJ* 1998;316:1548-9. (23 May.)
2 Department of Census and Statistics, Ministry of Finance, Planning, Ethnic Affairs and National Integration in collaboration with Ministry of Health, Highways and Social Services. *Feeding patterns and nutritional status of children. Sri Lanka demographic and health survey 1993.* Colombo: DCS, 1995:133.
3 Evaluation Unit, Family Health Bureau. *Annual report on family health—Sri Lanka 1995.* Colombo: Colombo, 1997.

Fentanyl is not best anaesthetic induction agent in rapid sequence intubation

Editor—One of Minerva's paragraphs notes a recent study of rapid sequence intubation in the emergency department.[1 2] This Canadian study found fentanyl, a potent opioid analgesic, to be a superior induction agent to thiopentone or midazolam as assessed by time to intubation and haemodynamic responses.

Rapid sequence intubation is the well established method of airway management in patients at risk of aspiration of stomach contents at induction of anaesthesia. After three minutes of preoxygenation a predetermined dose of induction agent is given to achieve unconsciousness, followed by a short acting muscle relaxant; the application of cricoid pressure and tracheal intubation protect the airway from soiling.

Use of an intravenous anaesthetic agent such as thiopentone alone or in combination with a benzodiazepine or opioid will greatly reduce the risk of awareness during the intense stimulation of intubation. Haemodynamic monitoring is always mandatory for the early recognition and treatment of any resultant instability. Fentanyl, even in high doses, has only ever been shown to consistently produce unconsciousness in critically ill patients.[3] Its use as the sole anaesthetic induction agent in rapid sequence intubation in the emergency department should be discouraged.

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1 Minerva. *BMJ* 1998;316:1398. (2 May.)
2 Sivilotti LAM, Ducharme J. Randomised, double-blind study on sedatives and hemodynamics during rapid-sequence intubation in the emergency department; the SHRED study. *Ann Emerg Med* 1998;31:313-24.
3 Hug CC. Does opioid 'anesthesia' exist? *Anesthesiology* 1990;73:1-4.

Relative's consent to treatment of patient is not needed

Editor—Morris described the problems he faced when an anaesthetised woman's partner refused consent for an emergency laparotomy after a caesarean section and primary haemorrhage.[1] He was making life more difficult for himself than he need. The Medical Defence Union's booklet *Consent to Treatment* states: "There is at present no mechanism in English and Welsh law for any other person, or indeed a court, to authorise or consent to treatment on behalf of an adult, whether that adult is competent or not."[2] It goes on to suggest that it is advisable to obtain a second, senior opinion and to inform the next of kin or other relatives. A note should be made in the clinical record to explain the absence of formal consent, but lifesaving treatment should not be withheld in these circumstances for apparent lack of consent.

This is an important and subtly different approach from that when dealing with a conscious, competent adult who refuses consent. In that case, recent legal judgment makes it clear that the patient's wishes should be respected.

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1 Morris E. Consent may be hard to obtain for incompetent patients when relatives object. *BMJ* 1998;316:1608. (23 May.)
2 Medical Defence Union. *Consent to treatment.* London: MDU, 1997.

Evidence based case reports

Undergraduates in Cork have to submit them during their course

Editor—Over the past two academic years colleagues and I have used the concept of an evidence based case report, similar to that presented by Glasziou,[1] in teaching evidence based medicine in the penultimate year of our undergraduate course in epidemiology and public health.

Students are asked to submit a case report based on the management of a single patient encountered during their clinical work. They are advised to identify one key intervention in the management of the case and to summarise any evidence that supports this intervention. The submission should not exceed 1000 words, of which not more than 300 should describe the clinical details of the case. Students are advised to use no more than five references and to take care to select key papers; they must describe the Medline search strategy that they used.

The case report contributes towards the students' mark in epidemiology and public health at the end of the year. The exercise is designed to help the students relate the theory of evidence based medicine to the reality of everyday clinical practice. Marking the case reports provides good feedback on the effectiveness of our teaching in evidence based medicine. A high proportion of students display evidence of critical reading of the key references. Students tend, however, to focus on the evidence for pharmacological interventions rather than on other forms of treatment or diagnostic strategies. They are reluctant to reflect critically on the management of the case and have difficulty with formulating good questions for evidence based medicine. These observations have prompted a review of methods and content in our teaching, and we hope that the *BMJ*'s evidence based case reports will become a valuable teaching resource.

In this medical school, as elsewhere, we are reviewing the undergraduate curriculum. We aim to promote reflective, self critical practice combined with an understanding of the scientific method. The standard of evidence based case reports submitted by our students may emerge as a useful outcome measure for this aspect of the curriculum.

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1 Glasziou P. Twenty year cough in a non-smoker. *BMJ* 1998;316:1660-1. (30 May.)

Results of search strategy should be given for readers

Editor—In Glasziou's evidence based case report I found the description of the literature search too tidy for belief.[1] My own experience as a librarian over 13 years is considerably closer to that of Naidoo—"many of the citations retrieved in a Medline search are irrelevant."[2] Using Medline back to 1966, I reproduced the literature search given by Glasziou and found some interesting variations on what was described in the report (table). The five year limit would obviously have excluded two of the four references that Glasziou cited as being found by the search strategy given (those published in 1989 and 1981). When I used the five year strategy I found considerably more than four references, the bulk of which Glasziou obviously considered irrelevant. If the search had gone back to 1981 (which would have retrieved the four references cited) Glasziou would have had around 100 titles to wade through in order to identify the four pertinent articles.

Number of references found with various search strategies

Step	Terms used	No of references found
1	"chronic *near* cough"	1 827
2	"investigat* *or* diagnos* *or* cause*"	2 206 605
3	consecutive *or* (follow *adj* up)	341 126
4	1 *and* 2 *and* 3	114
5	*. . . limit year greater than 1980*	107
6	*. . . limit year greater than 1991*	55
7	*. . . limit year greater than 1992*	49

I realise that brevity is needed in the *BMJ*, but brevity can end up by being misleading. Searches are rarely as simple as that described by Glasziou, there is almost always unwanted material, and narrowing down the parameters of the search is not as easy as Glasziou suggested. As Glasziou went into so much detail regarding the search strategy, surely it would not have taken up too much extra space to for him to say "the search retrieved X references, four of which were considered relevant." This would have introduced a note of realism into the search process—something that is extremely important when people are using unfamiliar technology and systems for the first time to look for the answer to their problems. As Naidoo has already found, answers do not always exist and are certainly not always easy to find.

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1 Glasziou P. Twenty year cough in a non-smoker. *BMJ* 1998;316:1660-1. (30 May.)
2 Naidoo N. Information "Nuggets" are not easy to find quickly. *BMJ* 1998;316:1676. (30 May.)

Evidence based medicine is not magic

Editor—Glasziou has written an evidence based case report about a case in which he did a selective search on Medline to inform his decisions on treatment.[1] We are worried that this article may convey a misleading message about evidence based medicine.[1] All diagnostic efforts focused on cough (his patient's problem), which subsided with empirical treatment for oesophageal reflux; nevertheless, no further evaluation for possible severe complications of gastro-oesophageal reflux is mentioned.

Adenocarcinoma of the oesophagus is among the types of cancer whose incidence in Western countries is rising fastest.[2] Barrett's oesophagus is found in 15% of patients with chronic gastro-oesophageal reflux and has been associated in prospective studies with up to a 125-fold excess risk of adenocarcinoma; gastro-oesophageal reflux has been associated with an increased probability of adenocarcinoma (odds ratio 2.7 (95% confidence interval 1.5 to 4.9)) after adjustment for potential confounders.[3] Antireflux treatment controls symptoms and oesophagitis, but Barrett's oesophagus generally persists. Evidence indicates that endoscopy should be performed in patients with long term symptoms (>5 years)[4]; on the other hand, endoscopy significantly influences doctors' decisions about medical management of gastro-oesophageal reflux disease.[5] We obtained this information from a search on Medline, 1996-8, using "gastro-oesophageal reflux," "management," and "endoscopy" as research terms (which yielded 29 articles and four close matches).

Evidence based medicine should not be regarded as a form of magic whereby solutions become evident after patients' complaints are entered in detail on a computer; rather, it is a valuable tool that has to be used wisely by skilled clinicians.

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2 Hansen S, Wiig JN, Giercksky KE, Tretli S. Esophageal and gastric carcinoma in Norway 1958-1992: incidence the trend variability according to morphological subtypes and organ subsites. *Int J Cancer* 1997;71:340-4.
3 Chow W, Finkle WD, McLaughlin JK, Frankl H, Ziel HK, Fraumeni JF. The relation of gastroesophageal reflux disease and its treatment to adenocarcinomas of the esophagus and gastric cardia. *JAMA* 1995;274:474-7.
4 Kahrilas PJ. Gastroesophageal reflux disease. *JAMA* 1996;276:983-8.
5 Ellis KK, Oelke M, Helfand M, Lieberman D. Management of symptoms of gastroesophageal reflux disease: does endoscopy influence medical management? *Am J Gastroenterol* 1997;92:1472-4.

Author's reply

Editor—Searching for "nuggets" is not easy: it requires both skills in clinical epidemiology and in literature searching and clinical skill to assess the relevance of what is found. The exercise that Perry describes for medical students is no longer a peripheral luxury but will be central to the information-overloaded but evidence-starved practitioner of the future. Fortunately, others are easing the work of tracking down the evidence. For example, if I did the search for evidence on chronic cough today I would try the "clinical queries" section of the National Library of Medicine's PubMed (www.ncbi.nlm.nih.gov/PubMed/clinical.html). Typing in "chronic cough" and choosing "diagnosis" (which pre-filters diagnostic articles) gives 21 "hits," including three of the four articles I previously identified. Finding articles on differential diagnosis and on diagnosis, however, is difficult compared with finding controlled trials of treatment—now gathered in the Cochrane Controlled Trials Registry.

When I must use Medline I generally start with the last five years; only later do I expand the search to all years—as in the search about chronic cough. My results were similar to those of Bates, but many articles could be discarded after scrutiny of the titles and most after scrutiny of the abstracts. If space is limited, how much detail should be provided on the methods and results of the literature search compared with on the patient and the question, the assessment of the validity of the identified articles, and their applicability to the patient?

Finally, I agree with Zuccalcalà et al that the practice of evidence based medicine still requires clinical knowledge and wisdom in addition to information skills. Part of what is needed is the translation of epidemiological information into terms relevant for individual decision making. For example, the

incidence of oesophageal adenocarcinoma is around 2/100 000 a year.[1] If oesophageal reflux increases this by an odds ratio of 2.7 then the incidence becomes 5.4/100 000 a year. Does that warrant an endoscopy? Of course, Barrett's oesophagus may also be detected—in 1% of older people and 3-5% of those with gastro-oesophageal reflux.[2] Should they all be identified (including the 10-25% with asymptomatic reflux[3])? There is no evidence that antireflux treatment reduces the risk of adenocarcinoma (though there are no controlled studies of this), and hence long term monitoring by repeat endoscopy is the only current intervention. When I next see my patient I will ask her opinion about this absolute risk and the management options.

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2 Cameron AJ. Epidemiology of columnar-lined esophagus and adenocarcinoma. *Gastroenterol Clin North Am* 1997;26: 487-94.
3 Ter RB, Castell DO. Gastroesophageal reflux disease in patients with columnar-lined esophagus. *Gastroenterol Clin North Am* 1997;26:549-63.

Statistics on misuse of drugs have been misused

EDITOR—The government's anti-drugs strategy places great emphasis on reducing drug related crime.[1] Part of its concern is based on evidence of high drug use among offenders and the assumption that crime is driven by the need to finance drug use and may be prevented if problem drug users are diverted into treatment. The white paper reports that "latest indications from a random sample of suspected offenders arrested by the police suggest that over 60% of arrestees have traces of illegal drugs in their urine." It also emphasises the importance of evidence and information in developing the strategy.[2] The notion that 60% of all arrested people give urine samples that are positive for drugs has entered policy debate as "evidence." But this evidence is based on shaky ground if we examine the report from which it is derived.[3]

Urine testing was conducted in five police areas for different periods over two years. Sites were chosen for convenience: Cambridge because the police quickly participated, Hammersmith and Manchester because they were considered to be areas of high drug use, and Nottingham and Sunderland because they were thought to differ from other sites. In the first three surveys samples were non-random, with arrested people being selected at the interviewer's discretion (mostly during the daytime). In the last two surveys all eligible candidates were approached whatever the time of day. The first three surveys have no data on those not sampled. In the other two, 803 of 1416 arrested people were deemed eligible, 557 were approached, 480 interviewed, and 342 had a urine test.

The time for which drugs remain testable in urine varies (amphetamine, two days; opiates, cocaine, and benzodiazepines, three days; and cannabis, up to a month with chronic use). Figures should be adjusted for differences in half life; there were high rates of cannabis use and it was responsible for over four tenths of the "60% of arrestees" found positive for drugs. The above factors suggest that the samples are not representative of those obtained from people who have been arrested and that the results are not generalisable.

These and other problems were acknowledged by the report's author. The research was designed to refine methodology because such a study had not been done before in the United Kingdom. Though the author is cautious in the interpretation of the data, the white paper is not. If the government is committed to evidence based policymaking, greater caution should be exercised in the selection and use of drug statistics.

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1 President of the Council. *Tackling drugs to build a better Britain: the government's 10 year strategy for tackling drug misuse.* London: HMSO, 1998.
2 Farrell M, Strang J. Britain's new strategy for tackling drugs misuse. *BMJ* 1998;316:1399-400. (9 May.)
3 Bennett T. *Drugs and crime: the results of research on drug testing and interviewing arrestees.* London: Home Office, 1998. (Home Office research study 183.)

Screening for hydroxychloroquine retinopathy

Screening should be selective

EDITOR—The editorial on screening for hydroxychloroquine retinopathy covered none of the recent publications on the subject and failed to distinguish those cases in which screening is necessary.[1]

Levy et al's review of 1505 patients found no cases of proved retinopathy in patients taking <6.5 mg/kg/day of hydroxychloroquine but one case in a patient taking a higher dose.[2] Silman and Shipley point out that "bull's eye retinopathy" can occur in patients not taking hydroxychloroquine.[3] Indeed, Scherbel et al reported that the incidence of maculopathy in patients with rheumatoid arthritis was greater in untreated patients than in those receiving hydroxychloroquine or chloroquine.[4] Mavrikakis and colleagues' study of 360 patients identified two cases of retinopathy with daily doses <6.5 mg/kg.[5] In both of these cases the cumulative dose exceeded 700 g.

Research confirms that hydroxychloroquine is safer than chloroquine and that at a daily dose of hydroxychloroquine <6.5mg/kg the risk of retinopathy is negligible if patients are younger than 60 years with normal renal and liver function.[2] In these circumstances regular screening is unnecessary, although we suggest recording visual acuity before starting treatment.

We recommend ophthalmic screening in the following patients, for whom evidence suggests an increased risk of hydroxychloroquine retinopathy: patients with known retinal disease or visual impairment; with renal or liver impairment; over 60 years old; receiving a daily dose greater than 6.5mg/kg; or who have received an accumulated dose above 500 g.

Screening should take the form of an initial ophthalmic assessment and annual ophthalmic review for the duration of treatment. The best form of ophthalmic assessment is unclear and currently depends on the preferences of the screening ophthalmologist. We recommend visual acuity, automated perimetry, and funduscopy, ideally with initial fundal photographs. Fluorescein angiography should be used in elderly people to differentiate between age related macula degeneration and hydroxychloroquine toxicity when continuing treatment with hydroxychloroquine is deemed essential.

The decision to stop treatment will depend on the opinion of both the ophthalmologist and the treating physician, taking into account the likelihood that retinal and visual changes are due to hydroxychloroquine, the extent of retinal damage, and the risk of increased disease activity after stopping treatment. It should be noted that effects of stopping treatment are uncertain as both progression and reversibility have been reported.

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1 Blyth C, Lane C. Hydroxychloroquine retinopathy: Is screening necessary? *BMJ* 1998;316:717-8. (7 March.)
2 Levy GD, Munz J, Paschal J, Cohen HB, Pince KJ, Peterson T, et al. Incidence of hydroxychloroquine retinopathy in 1207 patients in a large multicenter outpatient practice. *Arth Rheum* 1997;40:1482-6.
3 Silman A, Shipley M. Ophthalmological monitoring for hydroxychloroquine toxicity: a scientific review of available data. *Br J Rheumatol* 1997;36:599-601.
4 Scherbel AL, Mackenzie AH, Nousek JE, Atdjain M. Ocular lesions in rheumatoid arthritis and related disorders with particular reference to retinopathy. *N Engl J Med* 1963; 273:360-6.
5 Mavrikakis M, Papazoglou S, Sfikakis PP, Vaiopoulos G, Rougas K. Retinal toxicity in long term hydroxychloroquine treatment. *Ann Rheumatic Dis* 1996;55:187-9.

Authors' reply

EDITOR—The articles cited by May et al confirm that the incidence of hydroxychloroquine retinopathy resulting in permanent or progressive visual loss is extremely low. If the drug was introduced today it would be difficult to justify the initiation of a screening programme.[1]

We maintain that with few exceptions routine ophthalmological screening is unnecessary. Baseline assessment, including measurement of visual acuity, could be done

by the prescribing physician.[2] Patients with pre-existing macular disease or poor vision should be seen by an ophthalmologist before starting the drug. Screening may not detect reversible toxicity because there is no reliable test to identify this before ophthalmoscopic changes develop.[2] The prevalence of pigmentary macular changes in the elderly British population is high and increases with age, reaching 72.8% in those aged over 80.[3] These changes can be indistinguishable from chloroquine retinopathy on funduscopy and fluorescein angiography.[4]

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2 Royal College of Ophthalmologists. *Ocular toxicity and hydroxychloroquine: guidelines for screening*. London: RCO, 1998.
3 Dickinson AJ, Sparrow JM, Duke AM, Thompson JR, Gibson JM, Rosenthal AR, et al. Prevalence of age-related maculopathy at two points in time in an elderly British population. *Eye* 1997;11:301-14.
4 Weise EE, Yanuzzi LA. Ring maculopathies mimicking chloroquine retinopathy. *Am J Ophthalmol* 1974;78:204-10.

Routine episiotomy should be abandoned

EDITOR—In their editorial Maduma-Butshe et al discussed the need to abandon the routine use of episiotomy in developing countries.[1]

The use of episiotomy is a paradigmatic example of the many interventions that are introduced into clinical practice without scientific evidence and found after well performed research to be not only unjustified but also possibly harmful.[2] In addition, once an intervention has been established in clinical practice it is not easily abandoned, even when strong scientific evidence shows its uselessness and harmfulness.

We have presented the results of our study on episiotomy[3] and the reviews about it[2 4] many times, but clinicians have often remained sceptical and expressed little desire for change.

The table shows the trend in the use of episiotomy in one of the hospitals where the Argentine episiotomy trial was performed (Maternidad Martin, Rosario, Argentina).[3] Overall rates of episiotomy changed from 47.9% before the trial to 28.4% four years after completion of the trial. However, the decrease in the rate of episiotomy was observed predominately in multiparous women, with little change in nulliparous women. During the trial nulliparous women had an episiotomy rate of 39.5%, but rates in daily practice increased to 82%; four years after the end of the study and an intense dissemination of the results, rates were nearly double those obtained during the trial.

There is no obvious way to change a practice that has strong evidence against it once the practice has been implemented. The challenge is now to look for and test strategies to obtain such a change for routine episiotomy.

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1 Maduma-Butshe A, Dyall A, Garner P. Routine episiotomy in developing countries. *BMJ* 1998;316:1179-80. (18 April.)
2 Lede R, Belizán JM, Carroli G. Is routine use of episiotomy justified? *Am J Obstet Gynecol* 1996;174:1399-402
3 Argentine Episiotomy Trial Collaborative Group. Routine vs selective episiotomy: a randomised controlled trial. *Lancet* 1993;342:1517-8.
4 Carroli G, Belizán JM, Stamp G. Episiotomy policies in vaginal births. In: Pregnancy and childbirth module of the Cochrane database of systematic reviews. Cochrane Library. Oxford: Update Software, 1997.

Episiotomy rates in one hospital in Rosario, Argentina, before, during, and after episiotomy trial.[3] Values are percentages (proportions)

		Trial, 1991-2					
Parity	1990	Intervention*	Control	1993	1994	1995	1996
0	92.2 (273/296)	39.5 (307/777)	90.7 (706/778)	82.4 (210/255)	67.6 (226/334)	71.3 (751/1053)	65.3 (760/1164)
⩾1	28.9 (199/689)	16.3 (87/531)	70.4 (366/520)	21.0 (88/418)	14.8 (142/960)	15.6 (442/2841)	13.4 (389/2896)
All	47.9 (472/985)	30.1 (394/1308)	82.6 (1072/1298)	44.3 (298/673)	29.1 (368/1264)	30.6 (1193/3894)	28.5 (1149/4033)

*Selective use of episiotomy.

Elimination of elder abuse would be fitting way to mark millennium

EDITOR—Badrinath and Ramaiah,[1] in criticising the *BMJ* for failing to discuss elder abuse in an issue devoted to healthy ageing (25 October 1997), highlight something that should be a basic right for us all: to live a life free from the threat of violence. The importance of elder abuse to those who are abused and to the clinicians who care for them was indicated by the statement about elder abuse that was included in the Adelaide Declaration on Ageing issued at the world congress of gerontology (Adelaide, Australia, August 1997).[2] At that conference the International Network for the Prevention of Elder Abuse was established and regional representatives were selected to coordinate membership, distribute newsletters, and disseminate research findings.*

Research into the prevalence and identification of elder abuse and into the assessment of intervention strategies is occurring around the world.[3] In 1992 elder abuse was identified as a serious and not uncommon problem in Britain.[4] Recent research into the knowledge and experience of elder abuse among general practitioners has identified some educational and training needs.[5] In the United Kingdom, Action on Elder Abuse (a national charity) launched a helpline in November 1997 (0800 731 4141). Since its launch it has received over 1000 calls about elder abuse. This prevalence of elder abuse is truly shocking for a society that is generally viewed as a caring one.

The limited awareness of the issue among the public, clinicians, and politicians prevents those who have been abused and their abusers from receiving the attention and help they deserve. The end of the 20th century is in part noted for the large number of people living longer. This will be a pyrrhic victory if it is associated with the taint of mistreatment. An initiative for the millennium that centred on the health and social care of elderly people and helped them to remain free of abuse and neglect would be a major advance towards truly healthy ageing.

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1 Badrinath P, Ramaiah S. Elder abuse should have been discussed in issue on ageing. *BMJ* 1998;316:1384-5. (2 May.)
2 Andrews GR. 1997 World congress of gerontology. *Australian J Ageing* 1998;17(suppl 1):3-4.
3 Bennett G, Kingston P, Penhale B. International research in elder abuse. In: *Dimensions of elder abuse*. London: Macmillan, 1997.
4 Ogg J, Bennett G. Elder abuse in Britain. *BMJ* 1992:305: 998-9.
5 McCreadie C, Bennett G, Tinker A. General practitioners' knowledge and experience of the abuse of older people in the community: a report of an exploratory research study in the inner London borough of Tower Hamlets. *Br J Gen Pract* (in press).

Fever from the tropics

ACDP guidelines are impractical

EDITOR—Klein and Millman describe 31 children with fever who had recently visited the tropics and presented to their department.[1] Many of these children, including the 11 who had visited sub-Saharan Africa, would be likely to fall into the moderate risk category as defined by guidelines published in a document by the Advisory Committee on Dangerous Pathogens.[2] This category includes febrile patients who have been in an endemic area during the 21 days before onset of illness. It would be interesting to know if the possibility of viral haemorrhagic fever was considered in any of these children, and if the guidelines were followed.

There are serious implications for the clinical management of patients falling into the moderate risk category. These people

can be admitted only to isolation facilities, which have stringent specifications and are not available in most district hospitals. Urgent laboratory investigations are severely limited. If, for example, viral haemorrhagic fever cannot be excluded with certainty only a thin blood film for malaria may be examined outside a high security laboratory for infectious diseases. Only two of these are listed in the guidelines for investigations of these patients—in Coppetts Wood Hospital, London, and Newcastle General Hospital, Newcastle upon Tyne.

With the addition of Congo Crimean haemorrhagic fever to the list of viral haemorrhagic fevers of concern to the United Kingdom, the areas where the disease is potentially endemic have been substantially increased. They now cover countries such as Greece and Turkey, which are popular destinations for British residents.

Insufficient information is given in the document on the distribution of viral haemorrhagic fever and which parts of endemic areas pose a considerable risk for travellers.[2] Importation of viral haemorrhagic fever into the United Kingdom is extremely rare, whereas other life threatening infections are more common.[1 3] More specific guidance should be available on areas where diseases are endemic—for example, in the form of a regularly updated website or a telephone hotline. This way, most of the visitors to areas currently identified in the document who present with a fever in the United Kingdom could possibly be excluded. Otherwise patients may unnecessarily be transferred over long distances and put at risk by investigation being restricted.

If guidelines are impracticable and unrealistic they may be ignored. The true risk of viral haemorrhagic fever in returning travellers is extremely small. Risk assessment as detailed in the guidelines can be improved, and made more accessible to the general practitioners and hospital doctors who see these patients.

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1 Klein JL, Millman GC. Prospective, hospital based study of fever in children in the United Kingdom who had recently spent time in the tropics. *BMJ* 1998;316:1425-6. (9 May.)
2 Advisory Committee on Dangerous Pathogens. *Management and control of viral haemorrhagic fevers.* London: Stationery Office, 1997.
3 Doherty JF, Grant AD, Bryceson ADM. Fever as the presenting complaint of travellers returning from the tropics. *Q J Med* 1985;88:277-81.

Children should be investigated for malaria

Editor—Klein and Millman are right to highlight imported infections in children,[1] which can account for 2% of paediatric admissions in the United Kingdom.[2]

Causes of fever in 45 children who travelled to the tropics in the past 12 months, admitted to Birmingham Heartlands Hospital, March-September 1996. Ten children had more than one cause. Median age (range) 8 (0.8-15) years

Diagnosis	No of admissions
Malaria	13
vivax	10
falciparum	3
Lower respiratory infection	7
Traveller diarrhoea	6
Upper respiratory infection	6
Hepatitis	6
Campylobacter	3
Gastritis	2
Rotavirus	2
Cellulitis	2
Measles	1
Urinary tract infection	1
Typhoid	1
Giardia	1
Cryptosporidia	1
Systemic lupus erythematosus	1
No cause found	3

Altogether 42% of patients present more than four weeks after returning[2] and would have been missed by Klein and Millman's study. The common imported infections seen by British paediatricians are malaria, diarrhoeal disease, and hepatitis.[2 3] Since malaria can present up to 12 months after patients have visited the tropics, children with fever who have travelled to a malarious area in the previous year should be investigated for malaria.[4]

The table shows the causes of fever in all children who had visited the tropics in the previous 12 months and were admitted to Birmingham Heartlands Hospital between March and September 1996. Forty one children had visited South Asia and four had visited Africa. All except two children were of South Asian or African origin. Ten children had two or more infections, some having both "tropical" and "cosmopolitan" infections.

Despite the potential for exotic infections in this group, standard investigation of febrile children combined with blood films for malaria will identify most treatable conditions. A high index of suspicion for malaria in children who have visited the tropics in the preceding 12 months and an awareness that other infections may occur together with malaria are needed. This is particularly important for those who work with children from ethnic minorities.

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1 Klein JL, Millman GC. Prospective, hospital based study of fever in children in the United Kingdom who had recently spent time in the tropics. *BMJ* 1998;316:1425-6. (9 May.)
2 Riordan FAI, Tarlow MJ. Imported infections in East Birmingham children. *Postgrad Med J* 1998;74:36-7
3 Paget-Stanfield J, Reid D. Imported infections in children. *J R Coll Physicians Lond* 1980;14:232-7.
4 Brabin BJ, Ganley Y. Imported malaria in children in the UK. *Arch Dis Child* 1997;77:76-81.

Single parents need home visits by health visitors

Editor—Fleming and Charlton have shown that children of single parents receive fewer immunisations and have more accidents than children in other households.[1] Both of these areas are regarded as priorities for intervention by community services undertaking child health surveillance,[2] and Fleming and Charlton consider that single parents should be particularly targeted.

I have undertaken a survey of baby clinics run by health visitors to determine who attends. These clinics are easily accessible to parents, with no appointment required, and are seen by the health visitors as providing an opportunity to offer advice on feeding and growth, other health promotion advice, and opportunistic immunisations.[3] I looked at two urban practices in west London, which had (from 1991 census figures) 3.4% of households with single parents, 8% unemployment, and 85% of households classified as owner occupied. Information was obtainable for 418 (96%) of the 434 children aged under 2 years for attendances at the clinic and at the general practitioners' surgeries over 13 weeks in 1997-8; attendances by those specifically invited for immunisations, developmental checks, or medicals were excluded.

Children of single parents were significantly less likely to attend the baby clinic than other children (25/91 (27%) *v* 150/345 (43%); $\chi^2 = 7.68$, $P < 0.01$). There was no significant difference in attendance at the general practitioners' surgeries. Advice was offered by health visitors on accident prevention during 2% of attendances (6/320).

As single parents are less likely to bring their babies to the clinic than other parents, health visitors are unable to offer the opportunistic advice and immunisations recommended by Fleming and Charlton, and, unfortunately, general practitioners often have insufficient time during busy surgeries. My local health authority has recently declared that health visitors should do less home visiting, and it is reducing their funding. My survey, in keeping with other work,[4] suggests that maintenance of such home visits is essential, particularly if we are to reach this vulnerable group of single parents and their children.

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1 Fleming DM, Charlton JRH. Morbidity and healthcare utilisation of children in households with one adult: comparative observational study. *BMJ* 1998;316:1572-6. (23 May.)
2 Hall DMB. *Health for all children. Report of the third joint working party on child health surveillance.* 3rd ed. Oxford: Oxford University Press, 1996.
3 Sefi S, Macfarlane A. Child health clinics: why mothers attend. *Health Visitor* 1985;58:129-30.
4 Deal L. The effectiveness of community health nursing interventions: a literature review. *Public Health Nurs* 1994; 11:315-23.