Edwards, Elwyn, and Stott note that risk communication requires further elaboration. A major issue in this elaboration concerns the discourse on expert versus lay perceptions of risk. The existence of a "lay epidemiology"[1 2] shows that we should not underestimate the general population's ability to handle risk information. Nor should we overestimate physicians' ability to do so. Aiming for the "whole truth" in these matters, we may also note that to focus on patients' health resources may prove as fruitful as the present discourse on risk.[3]

Steel draws a line between treatment of diseases and treatment of asymptomatic risk factors. He thereby faces the task of explaining how risk factors figure as diseases in the international classification of diseases and numerous other medical texts. In doing so, he may ask himself who the defining powers are and what interests they have.

As the distinction between health and illness becomes increasingly blurred through the discovery and invention of an infinite number of risk factors,[4] he may also find that there are other implications of the prevention paradox. Lowering the risk thresholds increases the number of individuals who survive risky behaviours,[1] undermining the reliability of health education messages. Furthermore, if we are faced with a sick population,[5] it would be fruitful to look for the factors contributing to this. One possible answer is to see the sick population resulting from a "sick society." Whether this society is sick because it promotes lifestyles that result in obesity, hypertension, and hyperlipdaemia or whether it is sick because it is defining half its population as sick remains open to discussion.

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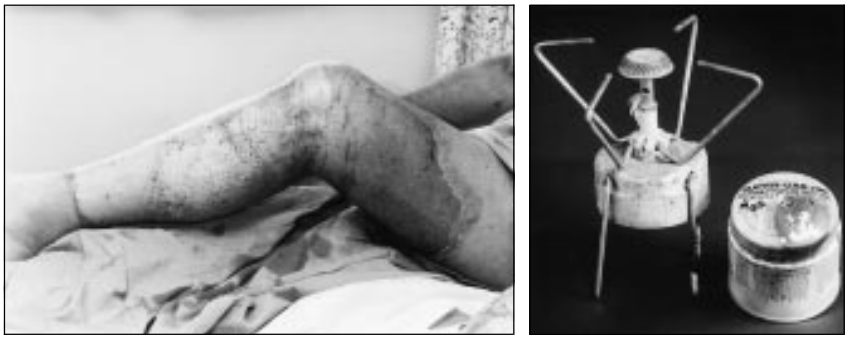
Portable camping stoves continue to cause burns

Editor—During four months last summer we treated nine patients who had sustained burns from portable butane camping stoves. The injuries varied from relatively minor burns, usually occurring in the open, to a 60% burn sustained when a canister exploded in the cab of a lorry.

The figure shows a typical injury: 10% mixed depth burns to both legs, which required excision and grafting. This 48 year old man was fitting a butane canister to a portable stove in his kitchen in preparation for his daughter's camping trip. The canister, which had been bought in a high street camping shop, had no instructions in English on its exterior. He pierced the outer skin of the canister with the sharp point of the burner/valve assembly but was unable to secure it with the metal clips. The butane leaking from the pierced canister was ignited into a fireball by a spark from the electric refrigerator thermostat.



10% mixed depth burns to both legs, which required excision and grafting (left); burns were produced by portable camping stove and gas cylinder (right)

All nine of the patients were injured while changing the canister. There is no fail-safe mechanism to prevent uncontrolled leakage of explosive butane, and if the canister is not secured immediately after it is pierced it acts as a bomb waiting to ignite. Thirteen years ago we drew attention to the danger of these devices[1]; since then, the design has not been changed, nor has the frequency of injury.

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1 Saxby PF, Shakespeare PG. Burn injuries from portable butane camping stoves. *Burns* 1985;11:427-8.

White paper on tobacco takes a laudable stance

Editor—Whatever the domestic health impact of Britain's new white paper on tobacco,[1] it will resonate loudly and positively around the world. The United Kingdom has done what few countries have done to date—it has formally recognised the global nature of the tobacco problem; accepted the necessity of international efforts to complement concerted domestic action; and acknowledged the responsibility of states to help internationally, both financially and technically.

With tobacco on track to be the world's leading preventable cause of death within a couple of decades, with British health and legislative experience sorely needed around the world, and with a British tobacco company as a chief propagator of this carnage all over the globe, it is right that international tobacco control should move to centre stage at Whitehall.

The white paper's pledge of strong and early support for a Framework Convention for Tobacco Control is particularly timely. With operations in more than 170 countries, and revenues exceeding the gross domestic product of many countries in which their subsidiaries operate, global tobacco enterprises such as British American Tobacco adroitly sidestep many domestic tobacco control efforts. Spillover advertising, rampant smuggling, and abusive power politics mean that without effective international coordination of control policies, tobacco's present rapid escalation in the developing world will not be halted.

Britain's stance sets the responsible standard other nations must match. Otherwise, these nations will have to account for why they sat silent and let today's one million annual tobacco deaths in the developing world escalate to seven million annually by 2025.

Finally, a single criticism. Though most of the white paper is laudatory, its call for an international code of conduct for transnational tobacco companies, even while awaiting global legal controls on the industry's marketing, is likely to fail, as other voluntary agreements have done. Codes of conduct—voluntary by definition—have long been prominent in the tobacco industry's attempts to forestall effective controls on its activities.

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1 Department of Health. *Smoking kills: a white paper on tobacco.* London: Stationery Office, 1998. (Cm 4177.)

Paying for nicotine replacement therapy is cheaper than smoking ⩽20 cigarettes a day

Editor—Fowler and Smeeth propose making nicotine replacement therapy available on the NHS, believing its high retail price remains prohibitive to many people.[1] A typical eight week course of patches of 21 mg/24 h bought from a pharmacy costs £17 a week, but smokers of 20 cigarettes a day will save roughly £20 a week through not smoking while using the patches.

In the Cochrane systematic review of 47 trials including 23 000 patients, nicotine

replacement therapy doubled smoking cessation rates at 6-12 months compared with placebo.[2] The authors point out, however, that the absolute probability of abstinence for an individual remains low, and 15 patients would have to use nicotine replacement therapy to produce one extra abstainer. The authors also note that there seems to be evidence of publication bias against negative trials and that compliance with nicotine replacement was lower among smokers treated in primary care.

I am surprised that the editorial overlooks the fact that smokers save money even while paying for their nicotine replacement therapy. This should be borne in mind before yet more pressure is added to the already strained NHS prescribing budget and motivated smokers who currently are using the skills of community pharmacists are encouraged to involve their general practitioner instead.

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Appearance of the hymen in adolescents is not well documented

Editor—As forensic paediatricians, we concur with Rogers and Stark's emphasis on the need for education about the nature of the hymen in postpubertal women.[1] Ten of the 20 women described by Logmans et al had been sexually abused.[2] The appearance of the hymen before puberty and its appearance after sexual abuse has been well described; the appearance of the hymen in adolescents is not well documented. The study by Emans et al[3] is an exception.[4]

In 1997 we surveyed 126 consultants at district general hospitals (68 paediatricians, 54 obstetricians and gynaecologists, and four consultants in genitourinary medicine). We wanted to establish the frequency with which they examined the hymen in adolescents and how confident they felt about the clinical findings.

Altogether 91/126 examined the genitalia of adolescents less than five times each year. Only 28/75 routinely assessed the hymen on genital examination. There was uncertainty regarding the significance of findings. A total of 35 out of 75 clinicians did not know if a complete cleft might be an expected finding in adolescent girls who were not sexually active, and 34/75 did not know if it might be expected in sexually active girls. One respondent thought that complete absence of the hymen might be a common finding in girls who were not sexually active; eight respondents thought that it might be a common finding in sexually active adolescent girls. The frequency of congenital absence of the hymen has been found to be $<0.03\%$.[5] When asked if they thought that frequent sexual activity resulted in ongoing loss or damage to the hymen, 19 consultants thought that it did, 44 indicated that they did not know, and three said that it did not.

In our experience of examining more than 1000 adolescents who had experienced vaginal penetration the most common appearance of the hymen was of indeterminate disruption to the free edge. Complete clefting or significant gaps in hymenal tissue is unusual.

In the prepubertal girl, because of the relative size of the structures, penetration occurs through the hymenal tissue and causes tearing; in the adolescent girl and adult woman consensual penetration occurs into the orifice which thus stretches and yields, resulting in spreading and indeterminate disruption. We agree with Rogers and Stark that so called rupture and bleeding of the hymen is not to be routinely expected after first sexual intercourse.

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Role of conventional ovarian screening is questioned

Editor—It is heartening to read Roylance and Waxman's personal view of cancer screening.[1] They say that current screening schedules are predominantly subjective and are heavily based on individuals' interpretation, and proposed that we should pursue the path of molecular screening technologies.

Three postmenopausal women recently presented to our service with advanced ovarian cancer; of note was the fact that they had been evaluated for vaginal bleeding within the past six months. All three had had examination under anaesthesia, hysteroscopy, and curettage of the endometrium, and two had transvaginal ultrasonography. All findings were negative.

This short interval between negative results of clinical evaluation and the appearance of ovarian carcinoma is of concern to us. In Britain the incidence of ovarian cancer is rising; ovarian cancer has become the fourth leading cause of deaths from cancer among women. Over the past 30 years the cost of management per patient has escalated, with no appreciable change in the survival rate.

Current screening modalities to identify early stage, curable disease have been disappointing.[2] Furthermore, for screening to be worth while in terms of its cost-benefit ratio the minimum interval is normally considered to be one year. The experience with our patients brings into question not only the reliability of pelvic evaluation in identifying ovarian cancer but also the standard time interval of one year.

Conventional screening for ovarian cancer is further complicated by the facts that, unlike cervical and endometrial cancer, there is no well defined preinvasive stage and after five years the postmenopausal ovary shrinks to 0.75 cm^3, which is one fifteenth of its premenopausal size. This is important medicolegally and implies that clinically impalpable ovaries cannot exclude an ovarian carcinoma; if they are palpable there is a 10% incidence of malignancy.[3]

We suggest that women who have been genetically proved to be at high risk of ovarian cancer should be offered prophylactic oophorectomy; those preferring ovarian conservation should be screened with measurement of serum CA 125 antigen concentrations and transvaginal ultrasonography, but at what safe interval? The beneficial effect of prophylactic oophorectomy for women over 40 undergoing pelvic surgery, as well as the positive effect of the combined pill against ovarian cancer, should be emphasised.[4 5]

If the results of the current large multicentre clinical trials of ovarian screening fail to show benefit then we need to search for better clues via the genetic events that predicate ovarian malignancy.

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Perinatal death associated with planned home birth in Australia

Home births are not justified in Australia

Editor—Bastian et al report the risk of perinatal death associated with planned home birth in Australia.[1] I have been criticising the role of home births in Queensland for the past two years, as chairman of the Queensland state committee of the Royal Australian College of Obstetricians and Gynaecologists. In Queensland a registered midwife can (and they do) go into independent mid-