# EU to phase out tobacco advertising despite ruling

Rory Watson *Brussels*

The European Commission is to press ahead with legislation to phase out tobacco advertising and sponsorship inside the union despite losing a landmark case in the European Court of Justice in Luxembourg last week.

The judges ruled that parts of the legislation, agreed by EU governments and the European parliament two years ago and due to take effect from next July, went beyond the powers the union had been given by its treaties. Rather than strike out only the offending measures, the court annulled the entire directive.

The judgment was an initial victory for the German government and the four British tobacco companies that had brought the legal challenge. But the response from supporters of the ban was swift.

The government for England and Wales and the Scottish Executive both announced they would be bringing forward national legislation to achieve the same goals. Public health minister Yvette Cooper said: "It will not deflect us from implementing our manifesto commitment to ban tobacco advertising."

Although initially disappointed by the Luxembourg judgment, the commission was overjoyed that the court recognised that public health protection is a constituent part of other EU policies.

In the clearest statement yet on the issue, the judges ruled: "A directive prohibiting certain forms of advertising and sponsorship of tobacco products could have been adopted" on the basis of the treaty article (100a)—the one used by the commission.

They stipulated, however, that the ban had to be directed at items that were traded across frontiers—magazines, newspapers, periodicals, and international sporting and cultural events—and so ensured harmonised rules to guarantee the free flow of the internal market.

The advertising clampdown could not be introduced by the EU on "stationary" items (such as posters, parasols, and ashtrays) or in hotels, cafes, restaurants, and cinemas. The commission therefore intends to table redrafted legislation early next year, removing the offending articles.

Although this will have to go through the whole decision making procedure and is unlikely to be law before 2004, many of its provisions may be introduced earlier through national legislation. For example, four countries—Finland, France, Portugal, and Sweden—already ban press advertising. Ten have phased out tobacco advertisements in cinemas, and posters are not allowed in five member states. Ironically, this mosaic of different national rules, which the EU measure tried to avoid, could make the tobacco companies' advertising strategies even harder to implement. □

**Yvette Cooper: "EU ruling will not deflect us from our manifesto"**

# Pregnant women with HIV should be started on antiretroviral drugs no later than 28 weeks

Scott Gottlieb *New York*

If pregnant women with HIV infection start receiving treatment for the infection as early as 28 weeks, the length of time that the newborn infants have to be treated to be safe from their mothers' infection can be shortened, a study has shown.

In industrialised countries, many HIV positive women receive antiretroviral drugs throughout pregnancy and labour. Their infants continue to receive drugs for six weeks after delivery. This tactic has cut the rate of vertical transmission to less than 2%.

In the current study, researchers found that a similar, but shorter and cheaper, drug regimen also cuts transmission (*New England Journal of Medicine* 2000;343:982-91). Four regimens of zidovudine were evaluated in 1437 non-breastfeeding women in northern Thailand. The four groups were termed long-long, long-short, short-long, and short-short (representing the length of time that mothers and babies were treated).

The women were given either zidovudine starting at 28 weeks' gestation (the long maternal regimen) or placebo from 28 to 35 weeks' gestation followed by zidovudine (the short maternal regimen).

The infants received either zidovudine for six weeks (the long infant regimen) or zidovudine for three days followed by placebo until they were 6 weeks old (the short infant regimen).

The group of women and infants who received the long regimens (the long-long group) was the reference group as this regimen was similar to the 076 protocol of the Pediatric AIDS Clinical Trials Group.

The infants were fed formula and were tested for HIV DNA at 1 day and at 45, 120, and 180 days. At the first interim analysis, the rates of HIV transmission were 4.1% for the long-long regimen and 10.5% for the short-short regimen. At this point the short-short regimen was stopped.

For the entire study period, the transmission rates were 6.5% (95% confidence interval 4.1% to 8.9%) for the long-long regimen, 4.7% (2.4% to 7.0%) for the long-short regimen, and 8.6% (5.6% to 11.6%) for the short-long regimen.

The rate of in utero transmission was significantly higher with the two regimens with shorter maternal treatment than with the two with longer maternal treatment.

Although the researchers found considerable differences among the three groups (excluding the reference group), transmission rates were lowest among the women in the long-short group, who started zidovudine at the 28th week of pregnancy, with their infants receiving the drug for three days after delivery. In addition, longer treatment of the infant proved to be no substitute for longer treatment of the mother.

The results suggest that when a woman receives the longer course of zidovudine during pregnancy, prolonged treatment of her baby may not have additional benefit, wrote Drs Catherine Peckham and Marie-Louise Newell of the Institute of Child Health in London in an accompanying editorial in the *New England Journal of Medicine* (2000;343:1036-7). On the other hand, if the mother has been receiving zidovudine only for a short time, longer treatment of the infant might be helpful, they wrote.

In addition, the study shows that if a pregnant woman does not receive adequate preventive treatment, doctors still can interrupt HIV transmission to the infant by treating the baby for a full six weeks.

It is well established that antiretroviral drugs can prevent pregnant women with HIV from passing the virus to their infants. But such therapy remains out of reach for women in developing nations.

The simpler—and cheaper—course of treatment identified in this study might prevent vertical transmission as successfully as the standard treatment; this regimen costs $174 (£124), compared with about $800 for the longer regimen commonly used in developed countries. □