Promoting smoking cessation in general practice

EDITOR,—Simon Chapman finds general practitioners wanting in their efforts to stop their patients smoking.[1] As a result of the government's banding scheme for health promotion activities in general practice we distributed a questionnaire to 6530 of our patients who attended our practice over six months. Altogether 1523 smokers were specifically asked if they would like our help in stopping smoking. A total of 365 replied affirmatively, and 100 of these were invited to attend a midweek evening meeting outlining information and help available to enable them to stop smoking. Twelve patients replied: eight accepted, three declined, and one had already stopped smoking.

On the evening six smokers attended. All were counselled on a nearly one to one basis by the health professionals, who included a doctor, a health visitor, a district nurse, a practice nurse, and the district health authority's health promotion coordinator. The health professionals' view on stopping smoking was aired, and a video was shown and carbon monoxide monitoring demonstrated. The group agreed to meet one week later, when five patients attended. Two of these five have continued in their resolve to stop smoking.

We are left wondering whether this operation was worthwhile in terms of its cost and the time required and whether our time might have been better used.

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Stability of vaccines

EDITOR,—Recent correspondence and articles have expressed concern over the unreliability of the cold chain for vaccines, which jeopardises their immunogenic activity, not only in developing but also in developed countries.[1-4] Manufacturers of vaccines have been aware of these problems for many years, and at least one manufacturer has made considerable efforts towards improving the heat stability of vaccines. The table summarises the thermostability of a selection of widely used vaccines manufactured by SmithKline Beecham Biologicals. The data for the hepatitis A and B vaccines were obtained in clinical trials, in which the immune response elicited by batches of vaccine that were stored at the temperatures shown in the table was compared with that elicited by batches stored at recommended temperatures. The data for the other vaccines were obtained in the laboratory.

Although all efforts should be made to store vaccines at recommended temperatures, it is comforting to know that many vaccines can withstand short periods at higher temperatures without losing their potency.

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Stability of vaccines stored at temperatures above those recommended

Vaccine	Temperature recommended for storage (°C)	Temperature at which stored (°C)	Potency maintained after	Reference
Measles (Rimevax)	2-8 Lyophilised	20-25	2 weeks	5
		37	1 week	5
		41	2 days	5
Meningitis (Mencevax AC)	2-8 Lyophilised	22	18 months	6
		45	1 month	6
Poliomyelitis (Polio Sabin (oral))	2-8 or -20	20-25	3 weeks	5
Hepatitis B (Engerix B)	2-8	37	1 week	7
		37	1 month	8
		45	1 week	8
Hepatitis A (Havrix)	2-8	37	1 week	*

*G Wiedermann and F Ambrosch, unpublished data.

Alcohol and bone mineral density

EDITOR,—In their paper on alcohol consumption and bone mineral density[1] Troy L Holbrook and Elizabeth Barrett-Connor cite one of my papers in their discussion. They say: "Although alcohol has been shown to have direct toxic effects on bone and to disrupt bone metabolism [reference to my paper[2] and another], these observations have been largely based on studies of chronic alcoholics." This is an error. I also wish to address the authors' statement at the beginning of the next paragraph of the discussion: "The biological mechanism by which increased alcohol intake could promote higher bone mineral density is unclear."

The study in which colleagues and I showed the existence of a direct toxic effect of alcohol on osteoblasts was performed not in chronic alcoholics but in people with acute ethanol intoxication who were not regular drinkers.[3] We chose these subjects for the reason noted by Holbrook and Barrett-Connor—namely, that in chronic alcoholism the effect on the skeleton of other factors related to alcohol, such as metabolic and nutritional deficits, cannot be excluded. In my review,[2] cited by Holbrook and Barrett-Connor, I postulated, as Laitinen *et al* (the authors cited in conjunction with me) have done, that one way in which alcohol may favour an increase in bone mass is by stimulating secretion of calcitonin.[4] This hormone significantly increases bone mass and significantly reduces the rate of new vertebral fractures, as colleagues and I were the first to show.[5] Our finding was corroborated by a paper published later in the *BMJ*.

Calcitonin has an important effect on bone cells, reducing osteoclastic activity and increasing osteoblastic activity.[6] Alcohol's effect on calcitonin itself may account for the increase in bone mass resulting from alcohol intake. It is unfortunate that Holbrook and Barrett-Connor did not measure serum calcitonin concentrations and correlate them with bone mass, as they did for other variables. Had the correlation been significant it would have clarified one of the mechanisms whereby alcohol intake affects bone mineral density.

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Diagnosis and management of systemic lupus erythematosus

Sun protection is vital

EDITOR,—Photosensitivity is a common precipitant and manifestation of systemic lupus erythematosus. Patrick J W Venables's suggestion that barrier creams should be used to prevent it is an oversimplification.[1] Sensible advice should include advice on avoiding exposure to the sun. In Britain patients should avoid being outside from 11 am to 3 pm from March to September and should wear protective clothing, including hats; patients should holiday in temperate latitudes or during winter. In addition, sun block rather than barrier cream, is essential.[2,3] Barrier creams have been used to protect against irritants, although there is doubt about their efficacy.[4] The best sun block creams are those based on physical blockers, such as titanium dioxide, which will screen out ultraviolet A and B radiation. These simple barrier measures should prove far more effective in preventing photosensitivity than the use of barrier creams.

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Thalidomide modifies disease

EDITOR,—Patrick J W Venables provides a thorough and up to date overview of systemic lupus erythematosus.[1] He does not, however, include thalidomide when discussing drugs that may modify the disease. Empirical treatment with thalidomide has been successful in several inflammatory dermatoses, including cutaneous