Vitamin C depletion and pressure sores

EDITOR,—Helen F Goode and colleagues cite the main risk factors for pressure sores in elderly people—namely, acute illness, poor mobility, long periods on high pressure surfaces, incontinence, and confusion.[1] They did not control for these effects so are unwise to conclude that there is a significant association between vitamin C and the development of pressure sores in elderly subjects with femoral neck fractures, particularly since the patients were unselected.

Rather than seek a "clear cut risk factor which determines why one patient should develop a sore given the same conditions as another patient," the authors could perhaps have used an instrument such as the Waterlow pressure sore assessment score.[2] This instrument acknowledges that the risk of developing pressure sores is multifactorial, but its application allows an appropriate care plan to be constructed, including the allocation of equipment such as mattresses to prevent the condition arising in the first place.[3] Such a system is used routinely in many units caring for elderly people.

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1 Goode HF, Burns E, Walker BE. Vitamin C depletion and pressure sores in elderly patients with femoral neck fracture. *BMJ* 1992;**305**:925-7. (17 October.)
2 Waterlow J. A risk assessment card. *Nursing Times* 1985;**81**(48): 49-55.
3 Waterlow J. Prevention is cheaper than cure. *Nursing Times* 1988;**83**(25):69-70.

EDITOR,—Helen F Goode and colleagues have evaluated the contribution of specific nutritional deficiencies to the risk of pressure sores.[1] There is little doubt that certain groups of patients—particularly those with impaired mobility or sensation—are at great risk of developing sores. High risk patients may be identified by routine use of the Norton pressure sore score. We are, however, alarmed at the extremely high incidence of pressure sores reported in the patients studied by Goode and colleagues (48%).

Pressure sores are unacceptable and, in most cases, avoidable.[2] With adequate nursing care and thorough attention by medical and anaesthetic staff to the risk of pressure sores they may be prevented. The essence of prevention is a two pronged approach to relieving pressure—namely, two hourly changing of position by nurses[3] and the use of special equipment that may reduce the frequency of changes of position needed (ripple mattress, sheepskin fleeces, and pillows).

Prevention of pressure sores starts on the ambulance trolley and continues in casualty, the operating theatre, and the wards. It necessitates a short term outlay of staff time and money that saves a major long term outlay on these resources. Reflecting this long term saving, the incidence of pressure sores developing in hospitals is likely to be used as an outcome measure for rehabilitation services and acute hospital services.[2]

Although we accept the importance of defining biochemical factors contributing to the development of pressure sores, these sores must be seen as unacceptable sequelae to poor nursing and medical care. Until they are seen as preventable by all the team caring for the patient, pressure sores developing in high risk patients in hospital will continue to be an important avoidable expense to both the patients and the health service.

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1 Goode HF, Burns E, Walker BE. Vitamin C depletion and pressure sores in elderly patients with femoral neck fracture. *BMJ* 1992;**305**:925-7. (17 October.)
2 McLellan DL. The feasibility of indicators and targets for rehabilitation services. *Clinical Rehabilitation* 1992;**6**:55-66.
3 Ryan TJ. Diseases of the skin. In: Weatherall DJ, Ledingham JGG, Warrell DA, eds. *Oxford textbook of medicine*. Oxford: Oxford Medical Publications, 1987:20.98-9.

EDITOR,—Helen F Goode and colleagues' paper on the relation between vitamin C and pressure sores in elderly patients with femoral neck fracture[1] accords with observations published in 1969 after a controlled trial of vitamin supplementation in 80 long stay geriatric patients followed up for one year.[2] Mean leucocyte ascorbic acid concentrations were 14·6 $\mu g/10^8$ cells in the controls and 13·6 $\mu g/10^8$ cells in the treated group on entry, 27·3 and 56·5 $\mu g/10^8$ cells respectively at six months, and 23·6 and 57·9 $\mu g/10^8$ cells respectively at 12 months. At the end of the year pressure sores were present in nine of 29 surviving controls and two of 33 survivors who had been treated ($\chi^2 = 6{\cdot}6069$, $p < 0{\cdot}01$).

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1 Goode HF, Burns E, Walker BE. Vitamin C depletion and pressure sores in elderly patients with femoral neck fracture. *BMJ* 1992;**305**:925-7. (17 October.)
2 Brocklehurst JC, Griffiths LL, Taylor GF, Marks J, Scott DL, Blackley J. The clinical features of chronic vitamin deficiency: a therapeutic trial in geriatric hospital patients. *Gerontologia Clinica* 1968;**10**:309-20.

Job advertisements from the tobacco industry

EDITOR,—I object to the placement of an advertisement from Rothmans International Tobacco Limited in the classified section of the *BMJ* of 14 November. The BMA is at the forefront of a campaign directed against the tobacco industry, and to accept an advertisement from a tobacco company implies, whether it is true or not, that the message of the campaign comes a poor second to the advertising revenue of the *BMJ*.

Although the advertisement is not in itself promoting the use of tobacco, it is assisting Rothmans in conducting its activities. The fact that the advertisement has appeared in the *BMJ* lends the company an element of respectability that should not be afforded to it by an association that is the collective voice of the medical community in Britain.

There are other ways to recruit an occupational health physician, a job which I appreciate is important in any organisation. Rothmans could use a head hunting agency or advertise in the national press and still find a suitable candidate for the post. My objection is only that the advertisement was accepted by the journal of one of the most vociferous antismoking campaigners in the world and that the journal has thereby cheapened itself and the antismoking campaign.

I hope that the *BMJ* receives enough letters on this point to adopt a new policy on accepting advertisements from the tobacco industry. Clearly the current policy is not good enough.

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*The *BMJ* has been campaigning on the dangers of tobacco for 30 years and supports a ban on advertising. The *BMJ* Publishing Group has also, this year, started *Tobacco Control*, a journal devoted specifically to the worldwide battle against tobacco. Nobody can doubt our opposition to tobacco.

Nevertheless, the tobacco industry continues to exist, and those who work in the industry have a right to an occupational health service. The *BMJ* is the place in Britain to advertise for doctors, and for us to deny the workers in the industry the chance of finding the best possible doctor would be too extreme a step.—ED, *BMJ*.

Screening, ethics, and the law

EDITOR,—N Wald and M Law[1] assert that the editorial by P J Edwards and D M B Hall[2] gave inappropriate advice by confusing research and service activities. We think that Wald and Law may be confused, as they seem to have misinterpreted the editorial. Edwards and Hall pointed out that informed consent applies equally to research procedures and service activities. Research procedures are reviewed by ethics committees, and service activities are covered by HC(90)22,[3] on which the editorial was based.

We are also concerned that Wald and Law are challenging the advice contained in the editorial without appearing to consider it appropriate to refer to the guidance of the Department of Health. Advice on informed consent in HC(90)22 makes it clear that under common law patients have a right to receive sufficient information in a way that they can understand about the proposed treatments, the possible alternatives, and any substantial risks so that they can make a balanced judgment in deciding whether to submit to medical intervention. This advice applies to operations, investigations, and treatment and certainly includes novel and established screening programmes. Informed consent is aimed at service activities so that patients are not subjected to medical interventions and procedures without understanding them and the risks attached.

In antenatal screening such as that proposed by Wald *et al* for Down's syndrome,[4] when a mother is entered into the programme she needs careful explanation of the screening test and the associated risks before having her blood taken. We believe that Wald and Law are wrong to suggest that details of the screening programme do not need to be fully explained "when offering the initial blood test." The implication is that women may be entered into the programme without fully understanding the consequences—or, to put it another way, without informed consent.

Wald and Law's advice is open to criticism for two reasons. Firstly, we think it is unethical to expose patients to the risks and potential harm associated with any screening programme without their informed consent, and, secondly, disastrous legal consequences may await those who are unwise enough to ignore the Department of Health's advice on informed consent.

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1 Wald N, Law M. Screening, ethics, and the law. *BMJ* 1992;**305**: 892. (10 October.)
2 Edwards PJ, Hall DMB. Screening, ethics, and the law. *BMJ* 1992;**305**:267-8. (1 August.)
3 Department of Health. *Patient consent to examination or treatment*. London: DoH, 1990. (HC(90)22.)
4 Wald NJ, Kennard A, Densein JW, Cuckle HS, Chard T, Butler L. Antenatal maternal serum screening for Down's syndrome: results of a demonstration project. *BMJ* 1992;**305**:391-4.

EDITOR,—Defining the best way of giving people information is an unhelpful objective according to Nicholas Wald and Malcolm Law[1] in their criticism of P J Edwards and D M B Hall's editorial.[2] The reasons they give are that too much information can be as unsatisfactory as too little; setting guidelines may encourage litigation; and decisions about best practice should be left to the discretion of the health professional offering