Letters

Research on preventing road traffic injuries in developing countries is needed

MARK HENLEY/PANOS

EDITOR—The dedication of the World Health Organization's World Health Day 2004 to road safety is recognition of the global threat of road traffic injuries. Increasing population size, vehicle ownership, road infrastructure, and transnational transportation have created a substantial public health burden. However, little epidemiological research has been conducted into preventing road traffic injuries in developing countries. Currently global research and development funding per disability adjusted life year for HIV, asthma, and blindness are $26.2, $10.8, and $5.4, respectively, while only $0.40 for road traffic injuries.[1]

Epidemiological studies of successful interventions preventing road traffic injuries have been conducted in developed countries.[2] But to assume the same effectiveness in developing countries is inappropriate because of behavioural, vehicular, and environmental differences.

A pooled analysis of street lighting intervention data from developed countries shows a protective effect,[3] particularly in pedestrian injury (relative risk 0.56), the most common road traffic injuries in developing countries.

Annually, 1.2 million deaths are attributed to road traffic crashes, 85% occurring in developing countries.[4] If an intervention such as street lighting could reduce deaths by as much as 30%, there is a potential to save thousands of lives.

Various international aid agencies are investing in road infrastructure development. These initiatives could be coupled with the need to develop concrete epidemiological data. Innovative strategies, such as step wedge study design,[5] could lead to the evolution of an evidence based public health approach to this problem.

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Alcohol limit for drink driving should be much lower

EDITOR—For more than a century alcohol has been recognised as one of the principal risk factors for motor vehicle crashes.[1] Nearly half of the roughly 35 000 fatal motor vehicle crashes in the United States each year are alcohol related, meaning that someone in the crash, usually a driver, is intoxicated.

Currently, a blood alcohol concentration ranging from 0.08 to 0.10 mg per 100 ml constitutes prima facie evidence in most countries for driving under the influence of alcohol. In the United Kingdom, United States, Canada, South Africa, and Sri Lanka the legal limit is 0.08 mg per 100 ml, which is too high as driving skills deteriorate and the risk of becoming involved in a crash risk increases from a concentration of 0.02 mg per 100 ml. In their comprehensive review Zador et al estimated that a driver's risk of being in a fatal crash increased significantly from 0.02 mg per 100 ml.[2] Scientific data provide clear evidence that important driving skills are impaired at very low blood alcohol concentrations.

Because the legal blood alcohol concentration in most countries is so high, people often mistakenly believe that they may drive up to a blood alcohol concentration of 0.8 mg per 100 ml, overlooking the fact that driving is impaired at lower concentrations. To set a blood alcohol limit so high that a 72 kg man can drink four bottles of beer and still be under the legal limit has consequences. It may adversely influence people's estimates of their relative risk of injury or death while driving. Drinking and driving policies and decisions about enforcement need to be hinged on the scientific evidence.[3]

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Competing interests: None declared.

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Lithium and motor vehicle crashes

Perhaps bipolar disorder is the risk, not its treatment

EDITOR—Etminan et al found that elderly people taking lithium had approximately double the rate of motor vehicle crashes compared with controls.[1] They imply that lithium is responsible and say that patients must be told of the increased risk. However, both the inference and the advice are unwarranted and unhelpful since lithium is simply a proxy for having bipolar disorder.

As no information is given about the relative risk of having a crash in the presence of bipolar disorder, it cannot be justified to warn patients against taking lithium if they have this condition. It is quite possible—indeed clinical judgment would suggest—that a patient with bipolar disorder may be a much safer driver when taking a mood stabilising agent than when he or she is not.

The authors include a comparison with carbamazepine, presumably to show that the increased risk is restricted to lithium. This

comparison is also likely to be spurious, as most older people taking carbamazepine are probably being treated for other conditions, not for bipolar disorder.

I am surprised that this paper passed statistical review when there is such an obvious confounding variable. As a result, patients will be subjected to probably unnecessary anxiety about their treatment and their fitness to drive.

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Competing interests: None declared.

1 Etminan M, Hemmelgarn B, Delaney JAC, Suissa S. Use of lithium and the risk of injurious motor vehicle crash in elderly adults: case-control study nested within a cohort. *BMJ* 2004;328:558-9. (6 March.)

Authors' reply

Editor—Dening thinks that the increase in the risk of crashes observed in our study may be due to the disease (bipolar disorder) itself and not lithium, hence confounding by indication. We acknowledged this possibility in our paper.

Although our data did not allow identification of subjects with bipolar disorder, another approach to control for confounding by indication is to study a different drug for the same condition, which in this case was carbamazepine. Although an optimal comparative drug would have been valproic acid, the limited number of users of valproic acid in our study did not permit this comparison. The lack of increased risk associated with carbamazepine supports our conclusions of an increased risk of crashes with lithium use, especially given that carbamazepine, valproic acid, and lithium are all considered mainstay therapy for bipolar disorder in older adults.[1] This was especially true in the early 1990s, the time span of our study, as newer pharmacological agents were not yet available.[2]

We can only presume that our paper passed statistical review because the reviewers recognised that confounding by indication can be addressed with a proper comparison drug with similar indication.[3]

Given the plausible biological mechanism for a potential association of a motor vehicle crash and lithium use (delayed reaction time)[4] and the results of our study, we believe that elderly drivers taking lithium should be informed of this potential risk. Further studies of the effect of lithium and other psychotropic drugs on the risk of crashes would be valuable.

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Secondary prevention for stroke and transient ischaemic attacks

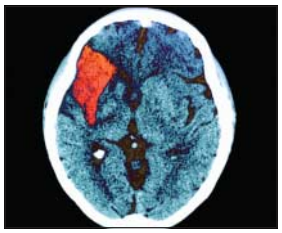
Horizons needs expanding

Editor—Acute stroke and transient ischaemic attacks are emergencies, and Muir in his editorial has presented recent evidence, showing that reduction of blood pressure and cholesterol, regardless of baseline values, have unequivocal benefit in secondary prevention.[1]

There is no real boundary between acute treatment and secondary prevention, which should start very early. This is best done in a dedicated stroke unit, to enhance the multidisciplinary approach and minimise delays, leading to better recovery.[2]

There is evidence that high blood glucose is detrimental after a stroke. Although exact underlying mechanisms remain unclear, evidence shows clinical worsening, with hyperglycaemia and increased risk of a second stroke with poor long term control.[3]

Non-fasting total homocysteine is another independent risk factor in both sexes over 60. Screening for elevated homocysteine concentrations and folate therapy may play an important part in secondary prevention. Concentrations higher than 14 µmol/l are associated with an 80% increase in risk.[4] However, reducing homocysteine has not yet shown a convincing effect, and further data are required.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Although there are resource implications of overdiagnosing transient ischaemic attacks, as Muir says, the estimated risk of a stroke after a transient ischaemic attack or minor stroke is 8-12% at seven days and 11-15% at one month.[5] Public education for seeking urgent medical attention and better organised stroke services are required so that all suspected transient ischaemic attacks or minor strokes are seen immediately for early secondary prevention.[5] However, further research will clarify which interventions or combinations thereof offer maximum benefit.

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PROGRESS is about reducing blood pressure, not promoting drugs

Editor—In his editorial Muir argues for the combination of perindopril and indapamide as preferred agents for lowering blood pressure after stroke or transient ischaemic attack on the basis of the perindopril protection against recurrent stroke study (PROGRESS).[1] Is this justified? PROGRESS did not compare regimens; other evidence shows that lowering blood pressure is more important than choice of drug.[2]

Muir says that several factors favour the PROGRESS regimen.

Firstly, the combination was well tolerated. Without making comparisons with other drugs this seems a sweeping conclusion.

Secondly, he says that dose titration of perindopril is rapid and simpler than other angiotensin converting enzyme inhibitors. This is more relevant to heart failure than hypertension.

Thirdly, he claims that perindopril may reduce blood pressure without impairing global cerebral blood flow, even in patients with moderate to severe carotid stenosis. Where is the evidence on how this compares with other drugs?

The final claim (unreferenced) is that indapamide differs pharmacologically from other thiazides, with less propensity for adverse metabolic effects and some vasodilating actions. Where is robust evidence supporting this statement?

An equally valid interpretation of PROGRESS is that perindopril was an inactive component and all benefit could be attributed to indapamide.[3] This fits with other studies supporting use of thiazides.[4] The trial design allowed doctors to choose whether to use perindopril alone or combined with indapamide, confounding interpretation of this study according to agent. PROGRESS should be used to promote lowering blood pressure after a stroke or transient ischaemic attack, not to promote particular drugs or regimens.

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Author's reply

Editor—Although I agree with Ray et al that increased public recognition of stroke is necessary, it is salutary that 50% of UK stroke patients already reach hospital within six hours: thereafter, institutional barriers delay investigation and treatment.[1] Although logical, acute institution of secondary preventive treatments has not been tested specifically in trials, but if beneficial, the present outpatient referral-based assessment of transient ischaemic attack must be re-evaluated, including anachronistic discrimination based on symptom duration.

Duerden may be correct that blood pressure lowering, rather than specific agents, and indapamide rather than perindopril were responsible for benefit in PROGRESS: both issues were discussed. Chemically, indapamide is a sulfonamide, not a thiazide, and differs with respect to metabolic profile, and possibly regression of left ventricular hypertrophy.[2 3] Perindopril seems not to reduce global cerebral blood flow in stroke patients with carotid stenosis,[4] and data are lacking for other agents. Whether these differences matter in terms of vascular risk reduction is unclear.

Unfortunately, there are few data to permit comparison of drug regimes in secondary prevention, and PROGRESS and PATS included 76% of all randomised subjects (11 770/15 527).[5] Extrapolation from primary prevention trials may be biologically inappropriate (stroke patients are generally older and may have impaired cerebral autoregulation or occlusive extracranial vascular disease) and uninformative since conventionally "normotensive" populations have not been studied. The possible importance of specific mechanisms is indicated by heterogeneity of outcome related to drug class.[5] Further trials in secondary prevention are needed to clarify these issues.

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Competing interests: KM has received honorariums for speaking at educational meetings sponsored by Servier and has received a grant from Servier (value £7000) towards a community study of the prevalence of stroke.

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Compulsory screening of immigrants for TB and HIV

Screening could detect latent infection

Editor—The enormous problem of tuberculosis in many parts of the world and the emergence of drug resistant strains are important matters to consider when revising control programmes for tuberculosis. In many countries a high incidence of the disease among immigrants has led to calls for improvements in detecting and treating latent infection.

Coker questions the suggestion that screening for tuberculosis in immigrants should be compulsory.[1] He says that most active disease develops after immigration and that early diagnosis has not been shown to convey public health benefits. However, screening can also detect latent infection with *Mycobacterium tuberculosis*.[2]

In Norway in 2001 the incidence of tuberculosis was 550/100 000 in African immigrants and 1.9/100 000 in natives.[3] Immigrants represent over 70% of cases of tuberculosis in Norway.[3] The rate of transmission is, however, low, indicating that most immigrants with tuberculosis arrive with latent infection that could be detected by screening on arrival. Similar numbers have been shown in other countries.

Entry screening of immigrants is cost effective and results in public health benefits.[2 4] Also, an imported drug resistant strain of *M tuberculosis* caused an outbreak which could have been avoided if latent infection had been detected and treated in the index case on arrival.[5] Screening immigrants from high-burden countries for latent infection is well grounded in individual and public health interests. People with latent infection can be offered preventive treatment or close follow up.[3 5]

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Competing interests: URD is a scientist working with tuberculosis and has previously advocated the need to improve the screening of immigrants for tuberculosis.

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Broader focus is needed for immigration and health issues

Editor—Coker's editorial highlights the knee jerk response to immigrants and poorly thought through proposals for immigration policies.[1] Immigration is a fact of life that needs apposite management rather than antagonism. Gains are to be achieved for all with properly structured programmes for immigrants.

Immigration has continued for centuries and has waxed and waned depending on international politics and economic and sociopolitical factors. According to the International Organisation for Migration, the total number of migrants worldwide was 84 million in 1975, which increased to 175 million by 2000.[2] The predicted number of international migrants for 2050 is 230 million. Undoubtedly, these trends will bring new threats from communicable diseases to the health system in the United Kingdom. There would be more immigrants and asylum seekers followed by their dependants, and others will trail as visitors and tourists.

The challenge for European countries is to adopt a cohesive "immigration and health" policy that incorporates the issue of communicable diseases on the basis of evidence. Extreme caution should be exercised to prevent stigmatising or discriminating against a group or an individual on the basis of health related issues. An ill conceived, shortsighted attempt to screen immigrants for one or two communicable diseases may be misinterpreted. It could be seen as a tool to discourage immigrants and would be counter-productive.

Policy makers, health service providers, and international bodies should now join forces and produce practical and ethical policies to tackle the ever growing challenges from communicable disease.

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1 Coker R. Compulsory screening of immigrants for tuberculosis and HIV. *BMJ* 2004;328:298-300. (7 February.)
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Review of tennis elbow was biased

Editor—In their review of tennis elbow last year Assendelft et al say that topical non-steroidal anti-inflammatory drugs (NSAIDs) in gel form are beneficial and NSAIDs given orally are likely to be beneficial, whereas local steroid injections are a trade-off between harms and benefits.[1] Physiotherapeutic modalities were deemed as interventions with "unknown effectiveness" and not recommended.

The evidence for NSAIDs consists of five randomised controlled trials, where the patient experiences a short duration of symptoms and few, if any, prior treatments. No steps were taken to exclude poor quality NSAID trials, although one trial was listed as non-randomised in the *Cochrane Library*, and the blinding procedure of another trial was described as "unclear, if blinded at all." Of the remaining three, one trial reported no significant effect from NSAIDs compared with placebo, and another stated: "Difficult to recommend the use of diclofenac in the treatment of lateral epicondylitis."

The reviewers' conclusion on the effectiveness of physiotherapy is based on an old review that excluded nine randomised controlled trials for low method scores.[2] It did not address the question of optimal dose and treatment procedures, although optimal doses of ultrasound, laser, and joint mobilisation have been established recently.[3–5] Most patients in physiotherapy randomised controlled trials had experienced little relief from previous NSAID or steroid injections and had longer symptom duration. Still, 13 out 15 randomised controlled trials with adequate doses presented significant results in favour of physiotherapy.

In view of the important differences in review methods and patients, we consider the recommendations made by Assendelft et al to be biased towards NSAID treatment.

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Internet is indeed useful source for patients with cancer

Editor—Ziebland et al investigated how the use of the internet affected patients' experience of cancer.[1] The experiences reported by the patients they interviewed are certainly consistent with those that patients and families on the wards tell of internet use and are similar to findings of two surveys of Australian patients with cancer in Sydney.[2 3]

JOHN GREIM/SPL

These surveys documented high and rising rates of internet use among patients with cancer (46% in 2001). Importantly patients' perceptions of the impact of the internet on their relationships and discussions with their doctor, decisions on treatment, and coping were overwhelmingly positive.

Among 83 non-users of the internet, recruited from consecutive attenders at the oncology outpatient department, the most common reason for non-use reported was lack of access (60%), as assumed by Ziebland et al. Other reasons for non-use were lack of internet skills (29%), concerns about information found there (7%), time and resource costs (6%), and having sufficient information from other sources (14%).

There is no doubt that the internet is now a cultural norm for information seeking and that this extends to all of us when we require health information. Having accepted this, we need to use the information seeking experience, described in research such as Ziebland et al, to meet patient needs better and contribute to the equal meeting of such needs for all patients.

Specifically oncology services, health departments, cancer organisations, and charities should consider means to facilitate access to the internet, especially for disadvantaged patients or those in remote areas. Organisations and providers can assist patients and their families by ensuring websites contain locally relevant, user friendly, accurate information and links.

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1 Ziebland S, Chapple A, Dumelow C, Evans J, Prinjha S, Rozmovits L. How the internet affects patients' experience of cancer: a qualitative study. *BMJ* 2004;328:564. (6 March.)
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Human tissue bill has impact on professional examinations

Editor—I endorse the views and concerns expressed by Furness and Sullivan on whether the draft human tissue bill will achieve an appropriate balance between the rights of individuals and the benefits to society of the use of human materials.[1] The practicality of monitoring consent for all patients is a major concern, and observations of our own attempts to do this by using a combination of a separate section on the consent form and a declaration on the laboratory request form indicate, despite a huge effort by the laboratories, that this is not a reliable way of recording patients' views.

One aspect of the use of human tissue that has not received much attention is in professional examinations. The examinations of the Royal College of Pathologists provide a critical appraisal of candidates' abilities to recognise disease processes in blood samples, cytology specimens, and tissue biopsy samples. The examiners take great care to select material that will discriminate between those candidates who are competent and those who require further training.

With the current wording of the bill, one presumes that only material from patients who had given consent could be used in examinations. This unintended consequence of the legislation is likely to severely restrict the examiners' ability to set appropriately demanding examinations.

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1 Furness P, Sullivan R. The human tissue bill. *BMJ* 2004;328:533-4. (6 March.)

Editing embargo is bad news for US scientists too

Editor—Dyer's news item reports that US societies are to defy the ban on editing articles from embargoed countries.[1] I am a Cuban psychiatrist and suicidologist. Such an embargo is not news or new for us, with more than 45 years of hostility from successive US governments, but it is bad news for people in the United States, who will not have the opportunity to exchange experiences with us. In my field of knowledge, suicidal behaviour, US suicidologists need our experience in treating Spanish speaking patients with another culture.

It is not possible to block ideas, good relationships between people, and the love of human beings for the sciences.

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Competing interests: None declared.

1 Dyer C. US societies to defy ban on editing articles from embargoed countries. *BMJ* 2004;328:543. (6 March.)