

Treating homosexuality as a sickness

Transvestites might be the new outcasts

EDITOR—Smith et al's article on patients' experiences of treatments for homosexuality since the 1950s should be seen as part of a reconciliation process between society and medicine and lesbian, gay, and bisexual people.¹ The charity Mind has produced an outstanding resource, *Lesbians, Gay Men and Bisexuals and Mental Health*, which provides invaluable information—as well as detailing recent abusive counselling and psychotherapy.²

In the early 1990s I used to volunteer on the Aberdeen Lesbian and Gay Switchboard, and I recall receiving three calls from people who had undergone electroshock therapy in the recent past and from one young man who was undergoing it at the time. I was totally horrified at the extent to which family and religious pressure was seemingly the main driver in trying to cure healthy people by the application of totally inappropriate "medical" treatments.

The United Kingdom has changed for the better, and now some degree of legal protection is afforded to gay, lesbian, and bisexual people. However, I wonder whether people who cross dress (transvestites) are the new outcasts, with a range of treatments applied designed to "cure" them of something that society disapproves of.

I hope that lessons learnt from the recent past of how "medicine" inappropriately treated "homosexuals" will better inform how we treat people whose only disease is not to conform to society's norms.

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Competing interests: None declared.

1 Smith G, Bartlett A, King M. Treatments of homosexuality in Britain since the 1950s—an oral history: the experience of patients. *BMJ* 2004;328:427-0. (21 February).
2 Mind. *Lesbians, gay men, bisexuals and mental health*. London: Mind, 2004. www.mind.org.uk/Information/Factsheets/Diversity/Factsheetgh.htm (accessed 29 Mar 2004).

Time to rethink extent to which social norms determine disease

EDITOR—At the end of her Editor's choice on medicine's shameful past MacDonald concedes that social norms define an

attitude as a disease.¹ If this is the shape of things to come, then it is high time to rethink the "limit" to which our social norms should be allowed to challenge the indications for labelling something as a sickness.

I hope I don't live to see the day when doctors will be penalised for asking people to avoid overconsumption of alcohol just because it may be the social norm at that time to drink as much as you like without any fear of being apprehended. Doctors must subscribe to changing social norms, but at the same time they should endeavour to continue classifying something as a sickness if there is a sound scientific evidence to do so, even if norms have changed. A sickness is not cured if all people acquire it, it only raises more concern to do something more ... don't hang up your gloves for fear of challenging the social norms of the time.

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1 Editor's choice. Lessons from medicine's shameful past. *BMJ* 2004;328. (21 February).

Enlightenment is worrying

EDITOR—I remember reading some psychiatry texts as an undergraduate some 15 years ago that classified homosexuality as a sexual disorder. Now, thanks to progressive "enlightenment," homosexuality has not only been declassified, but also decriminalised—at least in most of the Western world.¹

However, some of us still struggle with these changes for different reasons. Watching a programme on BBC1 (*Question Time*) recently, I learnt that people in one or two European countries adopt a rather more relaxed attitude towards paedophilia (which to my knowledge is still classified as abnormal and criminal) than we do here in the United Kingdom. So what I, as a father of young children, would most like to learn from those who know about these things is how quickly we as a society and profession

are likely to become "enlightened" enough to declassify or decriminalise paedophilia?

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1 Editor's choice. Lessons from medicine's shameful past. *BMJ* 2004;328. (21 February).

Step in the right direction has been taken

EDITOR—Smith et al bring a new voice to a practice that had been hidden in the closet of medical history,¹ and Lovitt is right to say that this openness may start a path to reconcile the psychiatric and gay populations (first letter). Some schools of psychotherapy, however, still view homosexuality as an aberration capable of cure, and several targeted religious programmes of intervention exist that are a hair's breadth away from aversion therapy.

Rape, bestiality, and paedophilia are all crimes because they involve the abuse of victims unable or unwilling to give consent. Homosexuality relates to sexual orientation and, like heterosexuality, in terms of sexual acts relates to consensual intercourse between consenting adults.

Moves at the United Nations to integrate sexual orientation into the antidiscrimination sections of the Human Rights Act are being championed by Brazil and blocked by the Vatican. Liberalisation of civil partnerships in the United Kingdom and United States has been met by legal challenges from the fundamental extremists, and the Gender Recognition Bill, which aims to give more rights to postoperative transgender people, bounces between the two Houses of Parliament in Great Britain.

Medicine is perhaps among the slowest of professions to move to meet the demands of the new millennium's population mix. Removal from medical coding is a step in the right direction, but the real challenge lies in facing up to the responsibilities of being doctors and healthcare professionals and delivering a standard of care that is accessible and appropriate to all.

For mental health professionals, accepting that homosexuality is no longer a disease but is part of an individual that has credence and validity is one step. Delivering care in a way that recognises the rights of same sex partners and the cultural needs of lesbians and gay men outlined over six years ago in diagnosis homophobic



(www.pacehealth.org.uk/homophobic.html) reflect the moves which are still waiting to be made.

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Psychiatric abuses during apartheid era have not been brought to account

EDITOR—Smith et al reveal some of the personal views and experiences of medical and psychology professionals in the United Kingdom who tried to make homosexual men and women heterosexual in the 20th century.¹

These experiences must, however, rank as comparatively mild compared with the appalling events in the South Africa Defence Force (SADF) during the apartheid years, known as the aversion project.² Over 18 years 900 men and women were coerced into having sex change surgery after the crude attempts at behaviour therapy failed.

This atrocity, which must rank as one of the worst abuses in psychiatry since the second world war, went on with the full connivance of the military authorities, which regarded homosexuality as an intolerable defect that had to be weeded out of the conscript ranks. Victims were often handed in for treatment after they had confessed to the regimental chaplain.

Victims were discharged from the force with no support, in some cases with the surgical conversion incomplete. The psychiatrists who ran this system have not been brought to justice.

The South African medical establishment has many sins to account for during the apartheid years. The failure to act, even retrospectively, about these psychiatric abuses is inexcusable.

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1 Smith G, Bartlett A, King M. Treatments of homosexuality in Britain since the 1950s—an oral history: the experience of professionals. *BMJ* 2004;328:429-0. (21 February.)
2 Kaplan R. The aversion project—psychiatric abuses in the South African defence force during the Apartheid era. *S Afr Med J* 2001;90:3:216-7.



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Correspondents point out errors: it was not Marmor who declassified homosexuality but gay and lesbian activists in San Francisco; Marmor borrowed someone else's ideas and declared them as his own; and the Criminal Law Amendment Act 1885, not the Criminal Assessment Act, criminalised all sexual activity between men.

Though correspondents generally support the need to adapt to changing social norms—since it is these that define disease—they see a need to continue classifying something as an illness if there is sound scientific evidence to do so. A legal framework against sexual, financial, or other social discrimination, argues one of them, remains a challenge to nature when biology is concerned.

In response to the patients' paper, correspondents both name what might be seen as current examples of victimisation and warn us that harmful psychological and behavioural tendencies should be eradicated, in the interest of society.

In response to the professionals' paper, one respondent describes a study showing that some homosexuals may be able to reorient themselves sexually as a result of some form of "reparative" therapy, with lower rates of depression reported before and after treatment. Another replies that this study is quoted by both critics and supporters of lesbian and gay people, many of whom, religious or not, do not wish to change and would be incapable of doing so, despite societal pressures. And the General Medical Council requires that doctors must not let their views about their patients' sexuality (for example) prejudice the treatment they provide or arrange—lest we forget.

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Competing interests: None declared.

1 Electronic responses. Treatments of homosexuality in Britain since the 1950s—an oral history: the experience of patients. <http://bmj.bmjournals.com/cgi/eletters/328/7437/427> (accessed 29 Mar 2003).
2 Electronic responses. Treatments of homosexuality in Britain since the 1950s—an oral history: the experience of professionals. <http://bmj.bmjournals.com/cgi/eletters/328/7437/429> (accessed 29 Mar 2003).
3 Electronic responses. Lessons from medicine's shameful past. <http://bmj.bmjournals.com/cgi/content/full/328/7437/0-g#responses> (accessed 29 Mar 2003).
4 Schaler JA. Giving Marmor credit for the idea that homosexuality is not an illness is undeserved. <http://bmj.bmjournals.com/cgi/eletters/328/7437/466#51086> (accessed 29 Mar 2003).

Dicycloverine for persistent crying in babies

Dicycloverine is contraindicated in infants

EDITOR—Gatrad and Sheikh's overview of problem crying in infants may be hazardously misleading because of their comments about the usefulness of dicycloverine (also known as dicyclomine).¹ There is published evidence of the efficacy of dicyclomine, but it is contraindicated in infants (less than 6

months, according to Bandolier²) because of serious side effects, including apnoea, and Prodigy guidelines point out that dicyclomine is unlicensed for use in infants under the age of 6 months.³

Changes in nomenclature have not helped: it would be easy not to realise that dicycloverine and dicyclomine are the same, or the potentially catastrophic consequences of this confusion.

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1 Gatrad AR, Sheikh A. Persistent crying in babies. *BMJ* 2004;328:330. (7 February.)
2 Moore A, McQuay H, eds. *Bandolier* September 2000;7(9):4.
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Beware recommending dicycloverine treatment in babies

EDITOR—Gatrad and Sheikh wrote that there is some evidence that whey hydrolysate milk and dicycloverine can help in infants with colic.¹ However, dicycloverine is associated with an increased risk of anticholinergic side effects. The cited reference by Garrison and Christakis concludes: "Merrill Dow, the manufacturer, no longer considers infant colic an indication for dicyclomine and has contraindicated its use in infants younger than 6 months."²

Since Gatrad and Sheikh discuss persistent crying in babies—who are below 6 months of age—it would have been preferable not to mention dicycloverine as a therapeutic option at all.

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1 Gatrad AR, Sheikh A. Persistent crying in babies. *BMJ* 2004;328:330. (7 February.)
2 Garrison MM, Christakis DA. A systematic review of treatments for infantile colic. *Pediatrics* 2000;106:184-90.

Authors' reply

EDITOR—We thank Goldman and Steinhertz for their helpful comments. Neither of us uses dicycloverine (dicyclomine) in managing babies with persistent crying, but, given that our article aimed to provide, as far as possible, an evidence linked summary of the evidence for managing persistent crying, we thought it important to mention the evidence underpinning treatment with dicycloverine.

Two systematic reviews of randomised controlled trials have shown that dicycloverine is of benefit in infants with colic related persistent crying. The first review pooled results from five trials containing a total of 134 infants (age range 1-14 weeks) and found that dicycloverine was significantly more effective than placebo in reducing crying (standardised mean difference 0.46, 95% confidence interval 0.33 to 0.60).¹

The second systematic review identified three randomised controlled trials included

Summary of responses

The two papers detailing the experiences of former patients and health professionals and the ensuing conflict between psychiatry and sexual orientation, accompanied by the Editor's choice on medicine's shameful past and the obituary of Judd Marmor, sparked a lively debate on bmj.com.¹⁻⁴





in the first review²; although results were not pooled, the authors came to a broadly similar conclusion about the effectiveness of dicycloverine.

As noted in our paper, there is also a risk of clinically important anticholinergic side effects. The evidence of benefit therefore needs to be balanced against known risks.³ Current consensus is that the risk profile of dicycloverine is such that it should not be given to infants under 6 months, and we concur with this position.⁴

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- 1 Lucassen PLBJ, Assendelft WJJ, Gubbels JW, van Eijk JTM, van Geldrop WJ, Neven K. Effectiveness of treatments for infantile colic: a systematic review. *BMJ* 1998;316:1563-9.
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- 3 Kilgour T, Wade S. Infantile colic. *Clinical Evidence* 2004. www.clinicalevidence.com/ceweb/conditions/chd/0309/0309.jsp (accessed 4 Mar 2004).
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Treatment of acute pyelonephritis in children

Conclusions should have been more cautious

EDITOR—The evidence supporting one of Craig and Hodson's major conclusions, that oral and intravenous antibiotics are equally safe and effective for acute pyelonephritis in children, has important caveats.¹

None of the two trials (one published, one ongoing) comparing oral and parenteral antibiotics have found significant differences in the frequency of renal scars after six months to one year of follow up.^{2,3} However, they were not specifically designed to assess whether the two treatments were equivalent. Rather, they aimed to determine whether there were differences between them. Failure to show differences in a randomised controlled trial does not mean that they are equivalent.^{4,5}

The largest study, conducted by Hoberman et al, illustrates the issue.² Renal scarring

was found in 11 out of 140 and in 15 out of 132 children assessed six months after treatment with intravenous cefotaxime and oral cefixime, respectively. The absolute rate difference in the frequency of this outcome is -3.5%, but its 95% confidence interval (-10.9% to 3.6%) shows that the rate with oral treatment could be almost 11% higher than that observed with parenteral treatment. The evidence shows that the treatments could be equivalent but does not (yet) rule out clinically important differences.

Craig and Hodson should be more cautious in their conclusions. A well designed equivalence randomised trial needs to be conducted before recommending oral antibiotics as an alternative to parenteral treatment in children with acute pyelonephritis.

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- 1 Craig JC, Hodson EM. Treatment of acute pyelonephritis in children. *BMJ* 2004;328:179-80. (24 January.)
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Author's reply

EDITOR—Lozano's letter is a useful reminder about equivalence and no difference detected. Although I agree that this point should be considered whenever research data are interpreted, the weight given to the width of the confidence intervals is context specific. We believe that our conclusions are reasonable for intravenous or oral antibiotics in children with acute pyelonephritis.

Firstly, the point estimates for all outcomes favour oral and intravenous treatment equally. A benefit of intravenous treatment was not shown in any outcome.

Secondly, the net harms (intravenous cannulation, family separation, risk of nosocomial infection, admission with separation) and costs of intravenous compared with oral, home based, antibiotics are clear. The unproved benefits of intravenous treatment need to be traded against these certain harms.

Thirdly, Lozano suggests that a defect on dimercaptosuccinic acid (DMSA) scanning at six months is clinically important. I disagree. DMSA defects are surrogate end points with uncertain clinical importance, and they continue to resolve for years after development.¹ The mismatch between the frequency of DMSA scan abnormalities after urinary tract infections (40% of infections) and clinically important renal disease (hypertension and end stage renal disease,

about 1 in 10 000 urinary tract infections) is considerable,² and in 10% of cases scans are reported as normal by one observer and abnormal by another.³

Waiting for a well conducted equivalence trial with these clinically important outcomes related to DMSA defects is an option, but we estimate a trial of several hundred thousand children with urinary tract infection would be required. In the meantime, oral antibiotics as first line treatment for most post-neonatal infants and children with febrile urinary tract infection remains our preferred option.

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"Drink plenty of fluids"

No harm in fluids for colds and flu

EDITOR—The article by Guppy et al as a systematic review of evidence for the effects of fluid intake¹ on the course of acute respiratory infections has been interpreted in the press as a warning against fluid intake while suffering from infections of the acute upper respiratory tract, such as common cold or flu.

Headlines in newspapers and the internet warn that the "age old advice on fluids for colds" is now disputed by research out of Australia. The authors have mischievously taken old folklore on fluids and colds and presented evidence on severe infections of the lower respiratory tract in infants to make a case that intake of fluids may be harmful. The press and public have got the wrong message because of the confusion in the article. The saying "Drink plenty of fluids" is generally accepted to refer to common colds and is not usually associated with acutely ill and hospitalised infants. By linking these two together the authors have created a scare story, but they have not addressed the main issue of the folklore.

There are no controlled clinical trials in the literature to support any beneficial effect of maintaining fluid intake for an acute infection of the upper respiratory tract, but neither is there any evidence that indicates that this remedy is harmful in any way when applied as intended to colds and flu.

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1 Guppy MPB, Mickan SM, Del Mar CB. "Drink plenty of fluids": a systematic review of evidence for this recommendation in acute respiratory infections. *BMJ* 2004;328:499-500. (28 February.)

Argument was not convincing

EDITOR—I am not convinced by the paper by Guppy et al that drinking fluid is harmful to all patients with respiratory infection.¹ Thinking that increased secretion of antidiuretic hormone secretion in infections of the lower respiratory tract is a common phenomenon is not correct. Hyponatraemia is a well known complication of infections of the lower respiratory tract, but it is not common.

Furthermore, it is difficult to prove whether the incidence or the death of patients with hyponatraemia related to infections of the lower respiratory tract was associated with increased water intake. Hyponatraemia could still occur even with normal fluid intake.

Fluid restriction may not be helpful to all infections of the lower respiratory tract. To restrict fluid to the extent of causing dehydration may even be harmful. The authors' data cannot be extrapolated to patients with upper respiratory infection because there was no definite evidence. In Hong Kong the newspapers quoted the study and said that plenty of fluid in flu can be harmful. I worry that the community might have a misconception about the findings of this study.

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Recommendations are not supported by data

EDITOR—Guppy et al, the authors of the recent article "Drink plenty of fluids": a systematic review of evidence for this recommendation in acute respiratory infections,¹ may have left readers with recommendations and implications that are not supported by the data they have reviewed.¹

Infections of the upper respiratory tract and episodes of bronchitis are very common and presumably outnumber episodes of pneumonia by a factor of more than 100. The only data they give to show that excess fluid is potentially harmful in acute respiratory infections is from studies with moderate to severe pneumonia. Although Guppy et al give a number of theoretical reasons for why antidiuretic hormone may be increased in

respiratory infections, most of those mechanisms would not be relevant in conditions where pneumonia was not present. Their article would have been better entitled "Drink plenty of fluids": a systematic review of evidence for this recommendation in moderate to severe pneumonia."

The title of their article has implications for all respiratory infections, including those of the upper respiratory tract. I, however, do not believe the data they have reviewed should be used to extrapolate for conditions other than moderate to severe pneumonia (and with these latter cases one would hope close medical or hospital supervision was taking place and so hyponatraemia could be avoided). We need to ensure that we do not leave the community with the implication that this advice applies to the much more common infections of the upper respiratory tract.

As Guppy et al say in the first paragraph of their paper, it seems self evident that there are many benefits in keeping patients with less serious respiratory tract infections well hydrated. They have presented no data to show that this "common sense" approach should not continue to be the case.

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1 Guppy MPB, Mickan SM, Del Mar CB. "Drink plenty of fluids": a systematic review of evidence for this recommendation in acute respiratory infections. *BMJ* 2004;328:499-500. (28 February.)

Authors' reply

EDITOR—We carefully worded our systematic review: there is no direct empirical evidence to support or refute the advice; we ask only that more research is undertaken, and that in the meantime we exercise caution with the age old advice. That the press has run away with a slightly different, sensationalised, slant probably will surprise few, and outrage fewer.

But let us look deeper at the indirect evidence. Although an observational study of children with infections of the upper respiratory tract with respiratory syncytial virus showed no increase in secretions of antidiuretic hormone,¹ two case reports describe children with only infections of the upper respiratory tract with hyponatraemia and seizures—one a bottle-fed 10 week old child with a mild cold who was given water and herbal teas over three days²; the other a 5 week old with upper respiratory symptoms, conjunctivitis, and poor feeding for two days.³ In infections of the lower respiratory tract, observational studies show that increased secretion of antidiuretic hormone occurs in bronchiolitis, where it is the norm, not just very ill patients with pneumonia.^{1 4 5} It is becoming standard management to

advise careful monitoring and restriction of fluid intake with bronchiolitis.

Would it be responsible to continue to advise the wholesale overhydration of children with acute respiratory infections, even in the absence of empirical data?

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WHO Framework Convention on Tobacco Control has major flaw

EDITOR—The study by Sinha et al on the use of tobacco products as dentifrice among adolescents in India has highlighted a major flaw in the World Health Organization's Framework Convention on Tobacco Control treaty: the smokeless tobaccos and derivatives of tobacco that are used as medicinal or cosmetic products were not adequately covered.¹

Tobacco as a dental health product that cleans and strengthens the teeth is a myth that has found great resonance in many groups in the United Kingdom and India. Manufacturers, homoeopaths, and herbalists who market smokeless tobacco exploit and misrepresent the myths of Ayurvedic therapies (Indian system from 2000 BC) by including tobacco within four main areas of their clinical metaphors: as a "cleanser" of the body system—builds immune system; as a "digestive aid"; as an "antiseptic" or cosmetic; and as a mouth freshener or dental health product.

Smokeless tobacco products now need to be targeted through a major amendment to the WHO framework convention treaty on tobacco if the oral health of many developing countries is to be protected and improved.² Swedish *snus* (a moist to semi-moist, ground, oral tobacco product) is now marketed as "less harmful" and messy than *gutkha*, which is sold and chewed traditionally.

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- 1 Sinha DN, Gupta PC, Pednekar MS. Use of tobacco as dentifrice among adolescents in India: questionnaire study. *BMJ* 2004;328:323-4. (7 February.)
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