LETTERS

Widow's fight for husband's sperm

Intervention by BMA's ethics committee was ill judged

EDITOR,—The involvement of the BMA's ethics committee in the recent decision by the Human Fertilisation and Embryology Authority to refuse to allow Mrs Diane Blood to be inseminated with sperm obtained from her husband after his death was ill judged.[1] In a letter to the authority Dr Stuart Horner, the chairman of the ethics committee, said, "ethically, whether the consent is in writing or given orally is irrelevant. The essential issue is the quality of that consent." No reasonable person would be likely to disagree with that sensible statement. However, he went on to say, "From the information portrayed in the media there is no evidence that Mr Blood had clearly thought through the issue."

Many people are extremely concerned that the ethics committee made representations to the authority on the basis of evidence purely derived from the media. As it happens, there is ample evidence that both Mr and Mrs Blood had considered this issue extremely seriously before Mr Blood's sudden death.

It is unfortunate and highly inappropriate for an ethics committee to arrive at its conclusions in a particular case in this way. It was unethical to have done so, particularly as this was an attempt to influence the outcome on the basis of hearsay evidence. Apart from doing a serious injustice to both Mr and Mrs Blood, actions such as this can serve only to reduce the BMA's standing in the community at large.

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1 Dyer C. Widow's case raises issues of informed consent. *BMJ* 1996;313:1351. (30 November.)

Reply from chairman of BMA's medical ethics committee

EDITOR,—The issue on which the BMA has focused in the recent controversy is the principle of informed and considered consent. We looked beyond the case in hand to its potential impact on one of the cornerstones of medical practice, being profoundly aware that the final result may set precedents regarding the extraction and use of genetic material from dying or dead people. A letter was sent to the Human Fertilisation and Embryology Authority because aspects of the case under its consideration (and on which it alone could adjudicate) have implications for the fundamental principle of the individual's rights over his or her own body.

The BMA has consistently emphasised that informed consent is a central principle of medical practice. The special nature of genetic material, which is used to create new life, makes it particularly important that genuine and explicit consent is obtained for its use. Expert committees have consistently emphasised the special nature of genetic material and the need for additional measures to safeguard its use.

When such material is intended for use after the donor's death the donor should ideally have had the opportunity to have expert advice and counselling and a chance to consider such factors as how the material will be obtained, the welfare of the future child, and the possibility of insemination failing. Individuals may waive their entitlement to advice, but we expect the adjudicating body to require reasonable evidence that genuine informed consent has been obtained. This was the BMA's central concern.

We did not seek details of the couple's private life precisely because our concerns were about the principle. Naturally, we expected that those who had additional information would present it to the Human Fertilisation and Embryology Authority. We note that, having considered all the relevant facts, the authority reaffirmed its earlier decision. The BMA has not sought to intervene in the authority's adjudication process, but it has a responsibility to speak out on issues of principle that will affect future decisions about the extraction and use of genetic material from men and women who are comatose or dying. Society currently requires unambiguous consent for all procedures that do not prolong life, prevent deterioration, or promote health in such vulnerable patients. The BMA wishes to ensure that this safeguard is not inadvertently or unadvisedly relaxed.

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No one can give consent on behalf of an incompetent adult patient

EDITOR,—The case of the widow who was refused permission to use her dead husband's sperm continues to be the subject of passionate debate in the press.[1] The husband did not consent in writing to the use of his sperm after his death, and this is a specified requirement under the Human Fertilisation and Embryology Act 1990. The Human Fertilisation and Embryology Authority had no option but to act according to the statute, and this was confirmed by the High Court. What about the doctors who obtained the sperm from the husband when he was unconscious and on a life support machine? There is no doubt that they acted in good faith and with compassion, but did they act lawfully or wisely?

The legal position was determined in the case of Re F in 1990, when it was stated that in the case of unconscious or incompetent adults a doctor will not be acting unlawfully if he or she acts in the patient's best interests.[2] "Best interests" was defined in that case by Lord Brandon: "The operation or other treatment will be in their best interests if, but only if, it is carried out in order to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health."

No one, not even a court, can give consent on behalf of an incompetent adult patient, and this, by definition, includes the wife in this case. It seems from the press reports that the doctors complied with the wife's request that a sample of sperm be taken with a view to posthumous insemination. This may have been in the best interests of the wife but was hardly in the best interests of the patient.

Did the doctors act wisely in this case? I personally would hesitate to take semen from a patient dying of meningococcal septicaemia. Is there not a risk of the semen being infected or the sperm being damaged as a result of the infection or treatment? This is a case in which scientific progress clashes with human rights and which lends itself to ethical debate, with a wide range of professional and lay interests being represented.

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1 Dyer C. Widow's case raises issues of informed consent. *BMJ* 1996;313:1351. (30 November.)
2 Re F [1990] 2 AC 1.

Allergy to peanut, nuts, and sesame seed in Australian children

EDITOR,—Pamela W Ewan's study of nut allergy and Hugh A Sampson's accompanying editorial focus on an important public health issue.[1 2] We have reviewed our database of the results of allergen skin tests undertaken by the department of allergy, Royal Children's Hospital, Melbourne, Australia. This is the main paediatric tertiary referral service for the state of Victoria (population 4.4 million, including 943 000 children under the age of 14 years). The range of clinical problems consisted essentially of atopic eczema in infants and anaphylaxis to food in

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When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

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Letters will be edited and may be shortened.

young and older children. During 1990-6 sensitisation (≥3+, wheal diameter approximately 3 mm) to peanut was found in 1601 infants and children, and sensitisation to a tree nut (almond, brazil, cashew, hazelnut, or walnut) in 590; 491 were sensitised to both (fig 1). This represents a combined prevalence of sensitisation of at least 0.2%. Sensitisation occurred early: 920 children aged under 24 months were sensitised to peanut and 270 to a tree nut.

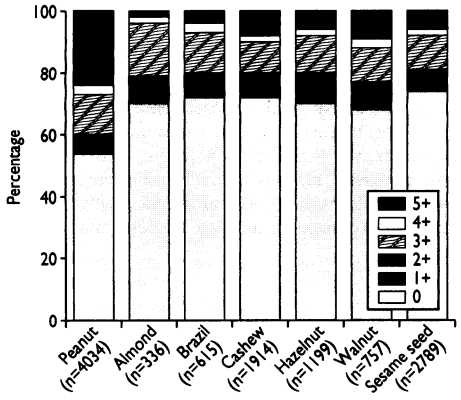

Fig 1—*Maximum recorded sensitisation score for each child tested, 1990-6 (n = 4078). Sensitisation to nut extracts (Hollister-Stier, USA) was scored by comparing diameter of skin wheal in reaction to extract with that of wheal in reaction to histamine 1 mg/ml (on average 3 mm): 1+ if less than half diameter of histamine wheal, 2+ if equal to half diameter, 3+ if equal to diameter, 4+ if equal to twice diameter, and 5+ if greater than twice diameter*

While skin sensitisation to allergens does not always correlate with clinical problems, we have found a strong association with increasing levels of sensitisation to specific foods.[3] Open challenge of 75 children with peanut butter gave an immediate (within 30 minutes) reaction in 85% of those with a skin test result of ≥4+. Conversely, only 13% of children with minor (≤2+) evidence of sensitisation reacted on formal challenge.

We have also seen an increase in infantile eczema and anaphylaxis to food associated with sensitisation to sesame seed (fig 1). The number of children sensitised to sesame seed (531) was higher than the number sensitised to any one tree nut. Altogether 294 children were sensitised to both sesame seed and a tree nut, while 448 were sensitised to both sesame seed and peanut. Sesame seed is becoming common in the diet of this community and is found in tahini (ground sesame seed), dips, vegetable burgers, and muesli bars.[4] Sensitisation also occurred early, being found in 317 children (60%) aged under 24 months. This was illustrated by an 11 month old infant who developed facial oedema, generalised urticaria, and wheeze when given his first taste of tahini, which his mother had consumed during pregnancy and lactation.

Our previous studies have shown that multiple sensitisation to food allergens is common, especially in infants and young children undergoing expansion of their diets.[5] The public health issue is not only the need for mandatory food labelling but also the need for paediatricians, trained in allergy, to evaluate infants and children who have adverse reactions.

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1 Ewan PW. Clinical study of peanut and nut allergy in 62 consecutive patients: new features and associations. *BMJ* 1996;312:1074-8. (27 April.)
2 Sampson H. Managing peanut allergy. *BMJ* 1996;312:1050-1. (27 April.)
3 Hill DJ, Duke A, Hosking CS, Hudson IL. Clinical manifestations of cow's milk allergy in childhood. II. The diagnostic value of skin tests and RAST. *Clin Allergy* 1988;38:481-90.
4 Kagi M, Wuthrich B. Falafel-burger anaphylaxis due to sesame seed allergy. *Lancet* 1991;338:582.
5 Bishop JM, Hill DJ, Hosking CS. Natural history of cow milk allergy clinical outcome. *J Pediatr* 1990;116:862-7.

Peanut allergy

Study's results were predictable

EDITOR,—J O'B Hourihane and colleagues believe that they have provided evidence for an increase in the prevalence of peanut allergy among successive generations.[1] All three pieces of evidence for this proposition are, however, entirely predictable and provide no evidence in either direction.

Firstly, the authors report an increase in peanut allergy among successive generations of relatives of probands with this condition. The inheritance of peanut allergy is clearly complex, but a reduction in prevalence with successive degrees of relatives is hardly surprising. The difference in prevalence between parents and siblings can be explained by inferring the need for a genetic contribution from both parents. Had the authors shown a higher prevalence among first cousins than among parents their assertion would be more plausible.

Secondly, consumption of peanuts was found to be higher among mothers of probands aged 5 and under than among mothers of probands older than 5. Half of the group of probands older than 5 were aged over 16. Consumption of peanuts has increased over that time. It is thus inevitable that the mothers of any group of young children will have consumed more peanuts during pregnancy than a comparable group of older children and adults.

The authors further report that the age at onset of peanut allergy was inversely correlated with year of birth. This is again inevitable for any condition that can occur throughout life. A subject can have developed a condition only at an age less than his or her current age; thus a population of older people with any such condition, be it diabetes, epilepsy, or allergy, will include subjects who developed the condition later than those in a younger population. If the authors statistically corrected for this phenomenon they do not mention it.

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1 Hourihane JO'B, Dean TP, Warner JO. Peanut allergy in relation to heredity, maternal diet, and other atopic diseases: results of a questionnaire survey, skin prick testing, and food challenges. *BMJ* 1996;313:518-21. (31 August.)

Authors' reply

EDITOR,—Rollo Clifford comments that the prevalence of peanut allergy in the siblings of subjects with peanut allergy is unsurprising, considering the rates of parental atopy. Our conclusion simply stated that this "probably reflects similar early exposure of offspring of atopic parents to peanuts." Information about cousins would have been unreliable compared with that about the presenting family. The rate of proved peanut allergy in the siblings of our subjects (3/39 (8%)) is significantly higher than that in the general population[1] (6/981 (0.6%) children aged 4 living on the Isle of Wight) ($\chi^2 = 5.14$, P = 0.0002, odds ratio 13.54 (95% confidence interval 3.52 to 56.31)) and is also significantly higher than that shown in Zeiger *et al*'s study of 2 year olds at high risk of atopy.[2] Out of 288 infants whom Zeiger *et al* studied, three were shown to have peanut allergy ($\chi^2 = 5.14$, P = 0.023, odds ratio 7.91 (1.54 to 40.7)). Being the sibling of someone with peanut allergy confers a higher risk of peanut allergy than simply coming from a non-specifically high risk family.

With regard to Clifford's second point, we agree that there has been an inevitable increase in consumption of peanuts by mothers of young children (not just mothers of children with peanut allergy). We are suggesting that an association may exist between this and the decreasing age at onset of peanut allergy.

Comparison of peanut allergy with diabetes is not valid. Diabetes often starts in adolescence and adulthood, whereas peanut allergy starts almost universally in childhood. Altogether 73% of our subjects, both children and adults, reacted to their first exposure to peanuts. Clifford is right to say that everyone reports onset of illness at an age younger than their current age. He has missed the more relevant point that there is no statistical or sampling reason why older subjects should not have developed peanut allergy in the first years of life. The lower left quadrant of our graph is empty of subjects because of the biological reason that older subjects were not exposed to peanuts at a young age and did not develop peanut allergy until they were so exposed. Our finding is supported by reanalysis with Lowess regression smoothing that uses iterative locally weighted sampling of least squares.

Our research confirms many suspicions of doctors and health workers regarding the increasing prevalence of peanut allergy and its major impact on young members of atopic families.

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1 Tariq SM, Stevens M, Matthews S, Ridout S, Twiselton R, Hide DW. Cohort study of peanut and tree nut sensitisation by age of 4 years. *BMJ* 1996;313:514-7. (31 August.)
2 Zeiger RS, Heller MSN, Mellon MH, Forsythe AB, O'Connor RD, Hamburger RN, *et al*. Effect of combined maternal and infant food-allergen avoidance on development of atopy in early infancy: a randomised study. *J Allergy Clin Immunol* 1989;84:72-89.

Should breast reduction surgery be rationed?

Only a third of women studied completed both questionnaires

EDITOR,—Anne Klassen and colleagues conclude from their study that breast reduction surgery improves the health status of women and should be included in NHS purchasing contracts.[1] We are concerned, however, about the high number of patients excluded from the crucial analysis.

Of 166 patients deemed to be studied, only 128 (77%) responded to the preoperative questionnaire. Why 10 of the 166 patients were excluded is not clear. The response rate to the postoperative questionnaire was even worse: of the 128 patients who responded to the preoperative questionnaire, only 85 were operated on and only 58 (68%) completed the postoperative questionnaire. Finally, only 54 women (that is, 33% of the initial 166) completed both the preoperative and the postoperative questionnaires; this is the most important group of patients. Although there was no significant difference in most variables between non-