ciation with the use of high treatment doses and large fraction sizes. I believe that the culprit is overlap between fields. This could potentially more than double the biologically effective dose received by the brachial plexus and the problem would be magnified in those centres using higher doses or larger fraction sizes.

Need for a fair hearing

The women belonging to RAGE have tried all reasonable avenues to achieve their goals and have reached an impasse. They have been to their consultants but were not always greeted sympathetically. After appealing to the Department of Health they received a "so sorry but don't worry" letter from Baroness Hooper enclosing the Macmillan Fund leaflet *Help is There*, which lists some cancer information telephone numbers. They have had a tea party with the President of the Royal College of Radiologists and have written to all the cancer research charities. They are becoming a bit more aggressive and I believe they deserve a fair hearing. The alternative is to leave it to the law—an expensive and often time consuming way to provide a solution. Here the test will be whether a reasonable body of medical opinion would, using the knowledge available at the time, have sanctioned the treatment received.

One way out of the current impasse would be an independent inquiry to consider all the evidence. The inquiry could determine whether compensation is indicated, thus saving expensive lawsuits later. It could also consider the need for special clinics for these women, where counselling and specialist physical help would be available. The clinics could work in collaboration with the treatment centres, which would also allow a proper register of these patients to be compiled. There are precedents for this type of process—for example, the inquiry into the use of factor VIII contaminated with HIV in haemophilia. The inquiry's findings would benefit not only affected patients but all women who are treated for breast cancer now and in the future. Action needs to be taken quickly as the media could make mincemeat of the professional complacency some have shown so far.

British radiotherapy services are overstretched. Staffing and equipment shortages are well documented.[7] There is also good evidence of wide variation in the doses and technique used to treat many patients.[8] Such variation does not make sense. Why should one hospital use 15 fractions and another 30 to treat exactly the same disease? Either one is using suboptimal treatment or the other is wasting resources. This variation, the RAGE women, and the large scale dosimetric errors seen in Exeter and Stoke together with several so far unpublished problems elsewhere highlight the need for an urgent and comprehensive review of Britain's cancer services.

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All Africa conference on tobacco control

Simon Chapman, Derek Yach, Yussuf Saloojee, David Simpson

Department of Community Medicine, University of Sydney, Sydney, Australia
Simon Chapman, *senior lecturer*

Essential Health Research Group, Medical Research Council, Pretoria, South Africa
Derek Yach, *group executive*

Tobacco Action Group, Johannesburg, South Africa
Yussuf Saloojee, *director*

International Agency on Tobacco and Health, London
David Simpson, *director*

Correspondence to:
Dr Chapman, Department of Community Medicine, Westmead Hospital, Westmead NSW 2145, Australia.

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Although the health hazards of smoking are now generally accepted in most Western countries, the arguments have not had much impact on poorer nations. A conference on tobacco control held in Harare, Zimbabwe, in November last year was the largest to tackle this problem. The conference heard how threats of epidemics of tobacco related disease in the distant future held little weight with governments of countries that often already had massive public health problems. More immediate effects needed to be emphasised. Speakers gave three cogent arguments; firstly, the loss of capacity for foreign trade in essential goods, since most African countries are net importers of tobacco; secondly, the extensive deforestation which is occurring to fuel the flue curing of tobacco; thirdly, evidence from Papua New Guinea that raising taxation on tobacco provides governments with increased income for many years before a decrease begins.

The largest and most important pan-African conference on tobacco control to date took place in Harare, Zimbabwe, on 14-17 November. One hundred and ten delegates from 16 African nations and seven other countries attended, along with a huddle of representatives of tobacco growers. Well before the opening session the organisers knew the conference was being taken very seriously by the tobacco industry. Zimbabwe is the second largest exporter of tobacco leaf in the world and derives more than a quarter of its export earnings from the crop so the political sensitivities surrounding Zimbabwe's hosting of the meeting were acute. Proof of industry concern was contained in a local magazine that commented that "the world's tobacco manufacturers are extremely alarmed [since] the conference will attract a wide cross section of the anti-smoking industry's groupies who are known to be particularly virulent, if not necessarily well-informed."[1]

Symbolically, the opening session was momentarily disrupted by a brass band playing *Nkosi sikeleli Afrika* (Zimbabwe and the African National Congress's national anthem) at a function in an adjoining room. The uplifting strains seemed to portend a coming of age from a decade of rather tentative participation by African health and development workers in workshops and meetings. Much of this participation had been focused around the preoccupations of the World Health Organisation and the International Union Against Cancer that the health consequences of tobacco use will add to the continent's current burden of death and disability caused by communicable, parasitic, and vector borne diseases including AIDS, and by poverty, hunger, and violence.

Strength of the disease prevention argument

The appropriateness and immediate political appeal of using disease prevention as the basis of campaigns for tobacco control in Africa was often questioned at

the Harare meeting. Annie Sasco, from the International Agency for Research in Cancer at Lyons, reminded delegates that, apart from South Africa, there were only three national cancer registries in the whole of Africa (in Mali, Algeria, and the Gambia) and that national mortality data are available for only three tiny countries (Mauritius, São Tomé and Princípe, and the Seychelles).[2] Estimates of total mortality from cancer for western and eastern Africa (13/100 000) are much lower than those for western Europe (93/100 000),[3] with unquestionable evidence of a significant and rising incidence of tobacco caused mortality being available only for South Africa[4,5] and several north African countries.

The present imperatives to give tobacco caused disease high priority are therefore understandably weak in most African nations. Yet plainly, action now could prevent future epidemics of tobacco related disease. Advocates of tobacco control need to strategically marshal arguments with immediate appeal rather than predict apocalyptic death rates 20 or 30 years in the future (well beyond the term of any current health minister or government). The Harare meeting served up persuasive cases for at least three of these.

Negative balance of trade

The first argument concerned the deficit in balance of trade for tobacco. All but four African nations currently import more tobacco than they export.[6] Indeed, only 22 of the 44 African countries which trade tobacco export any tobacco. Malawi (with over 75% of export earnings from tobacco) and Zimbabwe (with over 25%) have been heralded by the tobacco industry's public relations machinery as the Eldorados of African tobacco. Yet their cases are both outstandingly atypical of the continent and highly precarious. Ninety four per cent of the entire continent's export earnings from tobacco are achieved by these two countries, with the remainder of trading nations experiencing an aggregate deficit balance of trade (£278m ($417m) in 1985).

Some of the world's poorest countries are thus using precious capacity for foreign exchange to purchase tobacco. But the losses do not stop there. They also include money paid to foreign shareholders from profits taken by companies like British American Tobacco, which creamed £299m ($448m) from its African operations between 1986 and 1992. As the conference met, headlines in the local press reported that Zimbabwe had had the lowest returns from its tobacco auctions in the country's history because of international oversupply and falling demand in many Western nations.[6] Zimbabwe's banks are currently being called on to finance a tobacco stockpile worth more than £1000m ($1500m).[7] The Food and Agriculture Organisation's 1990 report on tobacco predicted that developing countries would increasingly consume more of the tobacco that they produce, because of rising population, economic transition, rising smoking prevalence, and reduced consumption in industrialised nations.


GILING/PANOS

Developing countries are consuming an increasing proportion of the tobacco they produce

Shrinking markets

Zimbabwe is in a particularly awkward situation. The health minister, Dr Timothy Stamps, stated in his presentation that there was a "need to separate production of a commodity from the consumption of a commodity" when framing national policy on tobacco control. His unequivocal statements at a later press conference about the need to take steps to promote the health of Zimbabwian citizens were questioned by journalists, who pointed out the obvious ethical dilemma involved in expressing concern for the health of local citizens while actively seeking to unload tobacco on to world markets. Dr Stamps also noted that the tobacco manufacturers were diversifying into non-tobacco activities and remarked: "If your buyer is getting out of the market it is time for you to consider where you are going as a producer."

The conference focused on possibilities for agricultural diversification in countries like Zimbabwe. Ronald Watts, an agricultural consultant from Zambia with 40 years' experience in Africa, listed 53 possible alternative crops and land uses that were worth developing. These ranged from maize (which has been estimated to return 36% more profit per hectare than tobacco[8]) to fruit, ostrich farming, nuts, and fibre crops.

Watts's paper received a mixed reception from the growers who were present. While some scoffed at talk of diversification, others hinted that they could see the writing on the wall. Mr Henry Ntaba, president of the International Tobacco Growers' Association in Africa, described himself as "a farmer first, and a tobacco farmer second," while David Walder, the association's chief executive, said quite candidly; "It may well be that a large part of what divides us is one of timing. We are thinking relatively short term; you are thinking, very properly, long term. How do we balance those requirements?"

It would be unwise, though, to see these brief admissions and the generally olive branch spirit with which the health delegates greeted the growers as signs of any radical change in the adversarial relationship between the industry and public health. The growers lost little time in trotting out the usual industry counterarguments. "Health cannot be guaranteed in the absence of tobacco... we still have AIDS," implored Mr Ntaba. "Tobacco or health, or tobacco *and* health. I prefer the latter expression," he told the meeting. Mrs Lisa Eddington, an American apparently fresh from a course in industry style epidemiology, questioned with complete seriousness whether tobacco could be bad for health when there were many examples of heavy smokers who lived into old age. From there things deteriorated, with the departing words about continuing dialogue between growers and health groups hovering somewhere between routine diplomacy and a sense that at least a start had been made to easing a strategic wedge between growers and manufacturers. The odds of success, however, must remain very long.

Deforestation

Journalists working in Kenya, Uganda, and Tanzania presented three papers on the environmental and social consequences of tobacco growing. These were the most exciting and important of the conference. For many years the tobacco control community has received fragmentary reports about the deforestation caused by land clearing and tree felling to provide fuel for flue curing in areas where other fuels are unavailable. Many of these reports have been anecdotal and outrageously exaggerated. The three papers, which will be published in *Tobacco Control*, provided detailed accounts of the extent and consequences of deforestation and of the disruption to social life that tobacco growing causes local communities in these countries. They showed that industry estimations of surviving trees from reforestation projects were utterly fanciful and seem certain to ignite major concerns about the environment, particularly in the West.

Price policy

David Sweanor of the Canadian Non-smokers Rights Association presented compelling information on elasticities of demand for tobacco products under different taxation and excise conditions. He argued that if other developing countries follow the pattern found in Papua New Guinea (the only developing country in which the relation between tobacco consumption and taxation has been studied[9]) price policy will not only reduce tobacco consumption but swell national tax receipts for many years before a point of diminishing return is reached. At the end of the conference he took the same message to a workshop in South Africa, where his message was warmly received by the government's commissioner of excise and customs, representatives of the African National Congress's macroeconomic planning group, and local media. The main national business newspaper gave editorial support to a tax increase.

Tobacco advertising is widespread throughout most of Africa, with the exceptions of Sudan and Mozambique, which have total bans. Paul Wangai, a physician from Kenya, screened several British American Tobacco advertisements currently being shown throughout the country from mobile cinemas. Advertisements ranged from scenes of footballing prowess and leaping Masai tribesmen, and promises of just reward for hard toil, to a depiction of a highly upwardly mobile young couple, replete with sports car, high fashion clothing, romantic poses, and under the table gropings, that would have broken practically every rule of even the weakest voluntary advertising code operating in the 1960s and 1970s in many Western countries. This was the first advertisement any of the delegates had seen from Africa which explicitly targeted women. Doubtless, the British directors of British American Tobacco would respond that the company advertises responsibly within the laws and guidelines of the country being targeted.

The main resolutions of the conference contained the usual litany of recommendations about advertising bans, tax rises, health education, and bans on sales to children. Important new recommendations included the need to increase the number of people working on tobacco control in Africa. This needed to be given priority by international donors and take precedence over ad hoc research projects and seminars—the usual way of doing things until now. Several recent World Bank reports, including the 1993 world development report, highlight the need for tobacco control to be seen as a priority in public health policy but have not specified how this should occur. Most advocates of tobacco control in Africa have heavy responsibilities in other jobs, so the development of a core group of networked advocates is fundamental to making progress.

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Lesson of the Week

Dangers of oral fluoroquinolone treatment in community acquired upper respiratory tract infections

Roland J Körner, David S Reeves, Alasdair P MacGowan

Department of Medical Microbiology and Regional Antimicrobial Reference Laboratory, Southmead Health Services NHS Trust, Westbury-on-Trym, Bristol BS10 5NB
Roland J Körner, *registrar in medical microbiology*
David S Reeves, *professor of medical microbiology*
Alasdair P MacGowan, *consultant medical microbiologist*

Correspondence to:
Dr Körner.

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Respiratory tract infections are among the commonest presenting to general practitioners. Upper respiratory tract infections of bacterial origin, such as acute otitis media and sinusitis, are commonly caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Streptococcus pyogenes*, and *Moraxella catarrhalis*. Lower respiratory tract infections, such as pneumonia, are most commonly caused by *Streptococcus pneumoniae*[2,3] followed by *Mycoplasma pneumoniae*.[4] The antimicrobial agents most often used for empirical treatment of these infections are amoxycillin, co-amoxiclav, and erythromycin. We have noticed that fluoroquinolones such as ciprofloxacin and ofloxacin are increasingly being used to treat community acquired upper respiratory tract infection even though they have poor activity against *S pneumoniae*. We report here two cases of life threatening systemic pneumococcal infection originating in the upper respiratory tract in which a fluoroquinolone was prescribed unsuccessfully as first line empirical antibiotic treatment.

Case 1

A previously fit 28 year old woman was admitted with acute onset of severe headache and subsequent confusion and agitation. Two weeks earlier she had experienced a flu-like illness, with migraine-like headache, worsening cough, and large amounts of pus discharging from her nose. In the early morning before admission she had woken up with severe frontal headache worsening when leaning forward. She was seen urgently by her general practitioner, who found her blood pressure normal, a pulse rate of 90 beats/min, and a temperature of 39·5°C. She was