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NEWS

China's tainted infant formula sickens nearly 13 000 babies

Jane Parry HONG KONG

The number of children admitted to hospital in China after drinking infant formula tainted with melamine has risen to 12 892, with 104 seriously ill. Across the country 39 965 children have already been treated and discharged, China's Ministry of Health has said.

The incident, which has so far claimed the lives of four children, has led to the resignation of Li Changjang, head of China's quality watchdog organisation, say reports from the state news agency.

A 4 year old girl in Hong Kong became the first known victim outside mainland China when she was discovered on 19 September to have kidney stones as a result of drinking tainted milk.

The World Health Organization, which was informed of the problem only on 11 September, has criticised China's internal communication and food safety systems. "Evidently there is a problem with internal communications, as it seems that some people already knew about this problem for some time but did not share the information," said Shigeru Omi, WHO's director for the western Pacific region, at a press conference in Manila.

Dr Omi said, "Recent events point to weakness in China's food safety system, and there is much room for improvement in surveillance, laboratory testing, and coordination between the Ministry of Health and Ministry of Agriculture. When you go down from the national level, the harsh reality is that some local authorities do not have the capacity for quality control, and both the government and private sectors have to work together to improve this, particularly at the local district level."

WHO has received requests from Beijing for technical support on risk assessment and testing for melamine, said Tony Hazzard, a regional adviser for food safety at WHO.

Cite this as: *BMJ* 2008;337:a1802

SIPA PRESS/REX

A baby who developed kidney stones after drinking formula milk tainted with melamine receives medical treatment at a hospital in China

English patients must consent to on screen records being viewed

Michael Cross LONDON

Five years after embarking on an IT programme to make health records available electronically, the NHS in England has conceded that patients should be asked for permission before their data are called up on screen.

A new consent procedure, announced last week, will bring English practice into line with that of Wales and Scotland and promises to defuse one of the bitterest controversies over the NHS national programme for IT.

The process involves the summary care record. This is a set of basic data about each registered NHS patient, such as current drugs and allergies, made available to all NHS organisations through a national system called the "spine."

The programme has always insisted that by registering for NHS treatment patients give implied consent for these data to be shared. It has offered patients who object two levels of opting out.

However, privacy groups and medical professional organisations, led by the BMA, argued that patients should be required to opt in to the system.

In May an independent evaluation of a pilot scheme in five primary care trusts found that the opt-out consent procedure was widely seen as unworkable and unethical.

Last week's decision, agreed by the NHS Care Records Development Board, adopts a procedure known as "consent to view." While still presuming that patients have given consent to create electronic records unless they opt out, the new procedure requires clinicians to ask permission before the summary care record is viewed.

Gillian Braunold, clinical director of the Summary Care Record and HealthSpace Programme at the IT agency NHS Connecting for Health, said that consent to view is a more solid base of informed consent than an opt-out negotiated in advance.

"It is much more appropriate to discuss this at the point of care, where it's meaningful," she said. The BMA gave qualified support.

Vivienne Nathanson, head of science and ethics, said, "The BMA has been involved in discussions on the new model and welcomes the changes, pending finer details."

Dr Nathanson said that the BMA would be looking for assurances that the care record systems were secure enough to ensure that "only people with a legitimate reason to view electronic health records are able to do so and that the audit trails will rapidly identify and stop any inappropriate access."

Dr Braunold said that the new policy would "put to bed the practical issues on consent and allow us to move forward." However, the new procedures will require modifications to computer software, raising the possibility of further setbacks to the much delayed programme.

Cite this as: *BMJ* 2008;337:a1814

Southall is allowed to return to child protection work

Clare Dyer BMJ

David Southall, the paediatrician who accused a father of murdering his two baby sons after watching a television interview with him, has won the right to return to child protection work.

Dr Southall was found guilty of serious professional misconduct by the General Medical Council and banned from child protection work for four years after he claimed that it was "beyond reasonable doubt" that Stephen Clark had killed his sons (*BMJ* 2004;329:366). At the time of the interview Mr Clark's wife, Sally, was serving a life sentence for the murder of the two boys but was later cleared on appeal.

MARTIN RICKETT/PA

Dr David Southall was said to have shown insight

Dr Southall reported Mr Clark to the child protection team after seeing the interview in which he told how his eldest son, Christopher, had had a nose bleed and breathing difficulties in a hotel room in 1996, when Mrs Clark was absent. Christopher died nine days later, and his younger brother Harry died the year after.

He wrote a report for the solicitors acting for the Clarks' third son, who was briefly taken into care, pinning the blame on Mr Clark. He admitted he had not interviewed the Clarks or seen medical records or post-mortem examination reports.

The GMC banned him from undertaking child protection work for three years in 2004 and extended the ban for a further year in 2007. But this week the ban was lifted with immediate effect.

Andrew Reid, chairman of the GMC's fitness to practise panel, told Dr Southall: "You have acknowledged that you have learnt a lot from these proceedings and that it will impact on all the work you do. You have expressed regret for the impact that the PCC [professional conduct committee] findings have had on the profession and remorse that your actions have contributed to the fear that now exists amongst paediatricians involved in child protection work.

"The panel considers that you have demonstrated considerable insight into your previous failings."

Cite this as: *BMJ* 2008;337:a1811

Catch-up MMR vaccine scheme nets a quarter of those eligible

Lisa Hitchen LONDON

A catch-up campaign managed to vaccinate only a quarter of London children who had missed out on vaccinations against measles, mumps, and rubella (MMR) when they were infants, the annual meeting of the Health Protection Agency heard last week.

Lessons learnt could help to inform plans for the country-wide campaign, which is due to start shortly, the audience heard. All primary care trusts in England were sent a letter last month asking them to reduce the risk of a measles epidemic by offering the MMR vaccine to every unvaccinated child younger than 18.

In the catch-up campaign in London parents of less than half the children returned consent forms, 80% of children whose forms were returned had already been vaccinated, and only 70% of the rest received the jab.

Immunisation coordinators from the London campaign thought that there had been too little time to plan the scheme, with most saying that they had been given less than six weeks. High absenteeism from schools in winter, when the campaign was run, also made it difficult. Involving key stakeholders, such as school nurses and local authorities from the start of the campaign, would have improved its success rate, they said.

More than 530 000 consent forms were sent to parents of children at primary schools in 26 London boroughs. More than 200 000 forms were returned, a response rate of 46.5%.

Of those who responded, children of a fifth had not been vaccinated the first time, although it is known that in the capital as a whole about a third of children were unvaccinated. Almost 70% of these unvaccinated children were given the vaccination.

So a total of about 43 000 children out of about 176 000 unvaccinated children in London received the vaccine, or about 24%.

Conference participants also heard the details of how one hospital had found that health professionals had been reluctant to be given the measles, mumps, and rubella vaccination during a measles outbreak.

Lewisham Hospital NHS Trust dealt with a measles outbreak from January to March 2008. The trust declared the outbreak to be "a major incident" when nine cases had been picked up. The final toll was 10 cases.

By the end of February all staff had been tested for immunity to measles. By early March the ninth patient had been discharged and there were no longer any potentially infectious patients.

Several problems arose in the outbreak. One was the unwillingness of staff to be vaccinated without having first had a blood test to check their immunity.

More than 95% of staff tested were found to be immune. Those who were not immune were more willing to have the MMR jab once their lack of immunity had been established, she added.

See www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1212650869934.

Cite this as: *BMJ* 2008;337:a1797

Law might change to protect people who

Lisa Hitchen LONDON

The laws that govern computed tomography (CT) might have to change to protect vulnerable patients, an expert from the UK Health Protection Agency has said. Scans of the full body that people without symptoms have as part of preventive health checks are not covered by the existing regulations.

Commercial companies offer such scans to the public, with advertisements in the national press or leaflets delivered to people's homes, said Ron Wheelton of the Health Protection Agency's radiation protection division at the agency's conference in Coventry last week.

But the Justification of Practices Involving Ionising Radiation Regulations 2004 and the Ionising Radiation (Medical Exposure) Regulations 2000 do not cover such scans for people who have no symptoms, pointed out Steve Ebdon-Jackson of the agency's medical exposure department.

"Is this a new type of practice? Is examination of asymptomatic individuals with CT part of diagnosis or part of treatment? Is it part of a healthy screening programme? If it is, where does it fit in? These individuals are not a set population where the benefits have been properly assessed," he said.

He said that the agency had come up with an alternative title—individual health assessments. "So should we

MARTIN BOND/SPL

Sellafield: public interest in employees' medical records outweighs the need for confidentiality

Judge allows disclosure of nuclear workers' medical records after death

Clare Dyer BMJ

A High Court judge in London ruled last week that doctors' duty of confidentiality "arguably" survives a patient's death but gave the go ahead "in the public interest" for the disclosure of medical records of dead nuclear plant workers to an independent inquiry.

The order by Mr Justice Foskett removed a barrier to the release of the records of dead workers to the public inquiry looking into the removal of hearts, lungs, and other organs from the bodies of employees in the nuclear industry for testing for plutonium after their deaths.

The inquiry, conducted by Michael Redfern QC, was set up by the government last year after it emerged that the consent of next of kin might not have been obtained for the body parts of former workers at Sellafield to be removed and analysed.

The inquiry covers workers at Sellafield who died between November 1962 and August 1991, and was extended to include former employees at other UK nuclear facilities, including Harwell and Dounreay.

Nicholas Lewis, occupational health physician and custodian of 30 000 records at Aldermaston, was concerned that disclosure might breach his duty of confidentiality to the dead patients and the health professionals whom they had consulted. He was willing to disclose the records to the inquiry but sought the court's approval.

There is no binding legal authority for the proposition that the duty of confidentiality survives the patient's death, the judge said. It was unnecessary for him to decide the matter definitively because the court has the power to order disclosure regardless of whether confidentiality survives death, if such disclosure is in the public interest.

Concerns had been expressed that if the right to confidentiality died with a patient "a doctor who treated a celebrity suffering from AIDS during his final illness" would be free to sell intimate details to a newspaper once the patient died, the judge said.

After reviewing the Hippocratic oath, guidance from the General Medical Council, and the views of medical authorities in other countries, he concluded that there were "strong pointers" towards the acceptance of the proposition that a doctor's duty of confidentiality survives, "or is at least capable of surviving," a patient's death.

However, he had "not the slightest doubt" that this was a case in which the public interest in disclosing the material outweighed the interest in maintaining confidentiality, provided proper safeguards were put in place.

"There is plainly a public interest . . . in determining what happened and why in connection with the very difficult and sensitive issues that arise from these matters," he added. "Those families that know broadly what happened are entitled to fuller answers to the questions raised if they wish to have them, and there is a wider public interest in maintaining confidence in the NHS and the nuclear industry."

He said that confidence might be fortified "either by the results of the investigation of the inquiry or by the recommendations of the inquiry if past practices are found to have been wanting and improvements are suggested."

Cite this as: *BMJ* 2008;337:a1794

have computed tomography scans

change regulations to include this new category of exposure?"

The agency's job is to advise the government but not to make decisions on such changes, he said.

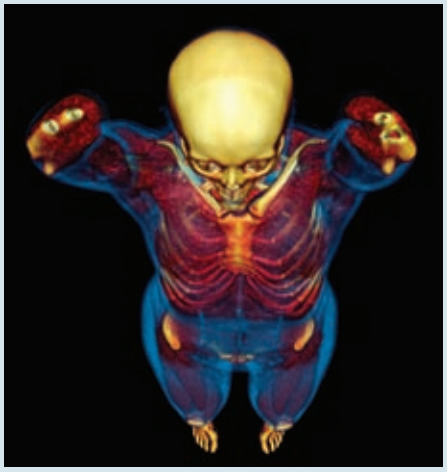
The Committee on Medical Aspects of Radiation in the Environment, an independent advisory group coordinated through the agency, produced a report on the subject after concerns about the new computed tomography services being offered and a request from the Department of Health. The report was published in December and the consultation period on the document ended earlier this month (*BMJ* 2008;336:14-5).

The report recommended that

- The government consider regulation of these services against agreed standards
- Commercial companies provide comprehensive information on eligibility criteria for scans, radiation doses used, and the risks of such scans
- Whole body scans are stopped immediately because there is no evidence of benefit.

"We are fairly sure that whole body scans are not offered at the moment in the United Kingdom, but there is no guarantee that a company won't set up and say 'we will do one' because it is offered in other countries," Emma Petty, also of the agency's medical exposure department, told the *BMJ*.

Cite this as: *BMJ* 2008;337:a1729



ANTOINE ROSSET/SPL

Three dimensional computed tomography scan of a female as viewed from above

Italy plans to publish surgeons' success rates from next year

Michael Day MILAN

Italy looks set to become the latest country to tackle the controversial matter of publishing surgeons' performance figures.

From next year its surgeons will have to make their curriculum vitae and surgical success rates available to the public, the country's public administration minister Renato Brunetta has announced.

DAANILO SCHIAVELLA

Minister Renato Brunetta used "truculent language"

Details on precisely how surgeons' performance will be monitored and presented were not given.

Announcing his intentions, Mr Brunetta justified his decision by saying, "If I have to have an operation I have a right to know whether my doctor is a butcher or an efficient operator—if he's going to kill me or save my life.

"This might make waves, but the first to back the plan will be the good surgeons," he added.

The announcement drew a mixed response from the profession. Several leading figures supported the idea of giving the public more information about their surgeons.

There was, however, concern about how the data would be presented and some consternation about what surgeons saw as the minister's belligerent tone.

"Our profession has given much to society and now to be treated with such truculent language is offensive. We are, however, ready to collaborate," said Amedeo Bianco, president of the Federation of Colleges of Doctors and Dentists.

Roberto Tersigni, president of the Italian Society of Surgery, told the *BMJ*, "Surgeons are not afraid of publishing their résumés. Italian surgery is considered among the best in the world.

"And I absolutely support the use of scores, providing they are presented in an accurate and fair way—and this means taking into account the state of the hospital and how well run it is. I do object to the language used by the minister, however."

One of Italy's most famous surgeons, the cancer specialist and senator Umberto Veronesi, welcomed the idea of informing the public but feared that the criteria the government planned for compiling scores might be too crude.

This concern was shared by the former health minister Elio Guzzanti. He had doubts about whether sufficient statistics were yet available for meaningful scores to be published. "For this we would need very refined measurements," he told *Corriere della Sera* newspaper (18 Sep, p 23).

Cite this as: *BMJ* 2008;337:a1787

Urban children in Ethiopia

Peter Moszynski LONDON

A study in Ethiopia shows profound differences between the health outcomes of children born in urban and rural parts of sub-Saharan Africa, with urban areas conferring a big advantage (*Journal of Perinatal and Paediatric Epidemiology* 2008 Sep 10, doi:10.1111/j.1365-3016.2008.00974.x).

This is thought to be the first occasion that a group of African children have been followed in detail from birth to adulthood, and it gives a useful insight into why only one in four such children survive until their 18th birthday.

The research identifies the hazards that face rural Ethiopian children, including death shortly after birth, risks from common infections such as malaria and pneumonia, and nutritional problems. Researchers also found marked local differences between children living in the highlands and the lowlands, and rural versus periurban areas.

"Survival varied considerably between Butajira town, the rural highlands, and the rural lowlands . . . The hazard ratio for mortality in the rural areas compared with the town was 3.34 (95% confidence interval 2.05 to 5.43)," the study says.

Researchers examined a group of children born during 1987 in and around Butajira, a small market town in a rural area on the edge of the rift valley. A total of 1884 live births formed the cohort, corresponding to a birth rate of 0.31 per woman a year. Perinatal mortality was 22 per 1000 live births, and infant mortality 65 per

Unicef calls for more action to reduce maternal deaths and

AUBREY WADE/PANOS

Health aid Bintu Koroma examines Mabinti Kamara at a community health centre in the Kroo Bay slum in Freetown, Sierra Leone, which has one of the highest mortality rates in the world

John Zarocostas GENEVA

Progress has been "far too slow," and interventions must be scaled up to reduce maternal deaths, a Unicef report says.

Each year more than half a million women die through complications in pregnancy and childbirth, with more than 99% of deaths occurring in poor countries, says the report. Each year an estimated 10 million women also experience injuries, infections, disease, or disability, which can cause lifelong suffering, it adds.

"Most of these deaths and disabilities are avoidable. Where deliveries are overseen by skilled health personnel and access to emergency obstetrical care, and where women receive adequate nutrition and basic health care services, the risk of maternal death is less," said Ann Veneman, Unicef's executive director.

have better survival rates than rural children

1000 live births. Overall survival from birth to 18 years was 760 per 1000.

The study was undertaken by the Butajira Rural Health Programme in collaboration with the Centre for Global Health Research at Umeå University, Sweden.

The children in the cohort received no special care or attention from being in the study, and so the result "probably accurately represents the harsh realities of growing up in rural Ethiopia at the turn of the millennium."

The researchers conclude that "there is clearly a huge survival advantage of living in the town," which might be explained by "various advantages such as the hospital, electricity, water, and availability of transport."

The lead author, Peter Byass, guest professor in global health at Umeå University, told the *BMJ* that, despite the comparatively small size of the survey, the area in which it was conducted was so geographically and socially varied that it "probably reflected an accurate microcosm of the whole country."

Professor Byass said that the data indicated that "a child born in a rural area is far more likely to die before adulthood than one from a periurban locality." He thinks that the "the randomness of birth over a few kilometres had a major impact on the risks to which children were exposed." Some facilities "that much of the world takes for granted in raising children, such as having piped water," were also found to be "significantly associated with child survival."

"It's amazing in this day and age to still be exposing settings that have such major disadvantages for child survival. The world knows what needs to be done in order for almost all children to survive into adulthood, yet there remain millions, particularly in sub-Saharan Africa, for whom safe and healthy childhood is not assured.

"We need to do much more on the political, economic, and healthcare fronts to turn around this scandal of the 21st century," he said.

See www.butajira.org.

Cite this as: *BMJ* 2008;337:a1765

PETER BYASS

Rural villagers in Butajira, like this mother and child, suffer from poor access to health care, electricity, and water

morbidity in Africa and south Asia

"The causes of maternal mortality are clear, as are the means to combat them," said Peter Salama, Unicef's chief of health. "Yet women continue to die unnecessarily."

The report, Progress for Children: A Report Card on Maternal Mortality, says that most of these women's deaths are attributable to no, or limited, access to heath care or to poor quality of care.

"They die due to haemorrhage, sepsis, hypertensive disorders, unsafe abortion, and prolonged or obstructed labour complications that can often be treated in a health system that provides skilled personnel facilities to handle emergencies when they occur and postpartum care," he said.

Dr Salama told reporters that a broad consensus has been reached on the best evidence based and cost effective health interventions to reduce maternal deaths.

He said that it includes family planning, in accordance with national policies and standards; skilled attendance at birth, with a referral system to emergency obstetric care; and postnatal care for women and their newly born children.

Depending on epidemiology by country, he said, there also needed to be more antiretroviral treatment, in particular for pregnant women; more malaria prevention and care; and more prevention and control of undernutrition.

Dr Salama said that there was also a need to "address women's status in society."

"There's no doubt the factors that affect women's rights in countries, whether it's early child marriage, female genital mutilation, or attitudes to sexuality, have an impact on women's health."

The report is at www.unicef.org.

Cite this as: *BMJ* 2008;337:a1800

Germany debates change to law to reduce late abortions

Ned Stafford HAMBURG

The German parliament is likely to vote in the next few months on a law to reduce the number of late abortions.

Current German abortion law allows unrestricted abortions for women up to 12 weeks of pregnancy but requires them to be counselled about their decision, and to wait three days before the operation.

After 12 weeks of pregnancy abortions are allowed if the pregnancy or birth poses a risk to the physical or mental health of the mother. This can include abortions performed if the mother learns she would give birth to a baby with severe disabilities. However, in these cases German law does not require counselling and a three day wait.

The new law would extend these requirements to all abortions.

Hans-Jörg Freese, a spokesman for the German Medical Association, said that the association thinks that counselling and a three day waiting period should be mandatory in all abortions that pose a health risk.

The association has issued statements saying that the woman's "situation is considerably more difficult" in late abortions, adding that counselling would help balance the child's right to life with the health needs of the woman. Asked whether the ultimate goal of the association was a new law to reduce the number of late term abortions, Mr Freese said, "Yes, correct. The law needs to be changed."

He added, "Pregnant women in that [late term] stage should know what help they can get when they have a handicapped child. And as long as life of the woman is not in danger there should be time for consideration to avoid a spontaneous reaction."

The association and the German Society for Gynecology and Obstetrics drafted a bill that would amend the current law. They submitted it in December 2006 to the parliamentary leadership of the centre-right coalition government, but it has hung in political limbo for 20 months.

That changed last week when the Christian Democratic Union-Christian Social Union party threatened to break with the Social Democrats (SPD). That prompted SPD politicians to break with their own health experts and rejoin discussions with the CDU-CSU.

Cite this as: *BMJ* 2008;337:a1803

IN BRIEF

MRSA infection rate falls: The number of meticillin resistant *Staphylococcus aureus* (MRSA) infections in England has fallen by 57% compared with 2003-4, when the target was set, figures published by the Health Protection Agency show. It brings the risk of becoming infected with an MRSA bacteraemia to its lowest for five years. See www.hpa.org.uk.

Patient with multiple sclerosis allowed to grow own cannabis: The Netherlands' Supreme Court has ruled that a patient with multiple sclerosis can continue to grow his own medicinal cannabis. Prescription medicinal cannabis, produced under government licence, had caused him side effects. Experts argued that the man had found a plant from the wide variety of cannabis that best suited him. The court judged he had "no real alternative" in this "exceptional" case.

Health care is safest profession: Health professionals have the lowest risk of occupational deaths and serious injury, a study has shown. The occupational death rate per 100 workers is zero, and the rate of serious injury per 100 is 0.04648. This compares to a death rate of 0.01886 and a rate of serious injury of 0.30009 for the most hazardous job, skilled agricultural work (*Labour Economics* 2008;15:938-57).

India to introduce smoking ban: India will ban smoking in public places, including all workplaces, from 2 October 2008, and tobacco products sold in the country will have to display images of diseased lungs from 1 December. India's health ministry will also work with other arms of the government to coax farmers to stop cultivating tobacco.

Quitting smoking halves complications after operation: Patients who stop smoking four weeks before an operation have half the complications, such as infections and slow wound healing, as patients who continue to smoke, a study from the Karolinska Institute in Sweden has shown (http://diss.kib.ki.se/2008/978-91-7409-071-0). One third of patients who stopped smoking before their operation were still non-smokers one year later.

Cite this as: *BMJ* 2008;337:a1801

Guidelines call for mystique of HIV testing to be removed

Jacqui Wise LONDON

All healthcare professionals should view HIV testing as a normal part of the diagnostic process and a duty of care, says guidance published and disseminated by the Department of Health.

A booklet on HIV testing, produced by the Medical Foundation for AIDS and Sexual Health, challenges the commonly held assumption that pre-test counselling must be lengthy and should only be carried out by specially trained counsellors.

More testing may help to diagnose the many people with HIV who are unaware that they are infected, the guidance says.

The booklet has been released alongside the new UK National Guidelines for HIV Testing 2008 produced by the British Association for Sexual Health and HIV, the British HIV Association, and the British Infection Society.

"Over the past 25 years HIV has been seen as a condition that needs special skills when offering testing but this is not the case," says Rachel Baggaley, author of the booklet. "We need to take away the mystique and recognise that HIV is an infection like any other."

The booklet says that there is no need for special counselling skills beyond that required for normal clinical practice. It says the term "pre-test discussion" is more appropriate than "pre-test counselling," which implies the need for in-depth counselling. With a well informed, reasonably low risk person the discussion may take just a minute or two. It says that "normalising" HIV testing will help to reduce stigma and increase uptake.

Lisa Power, head of policy at the Terence Higgins Trust, welcomed the booklet's guidance, "We have long abandoned the need for intensive counselling. Any doctor or nurse should be able to give advice and offer a leaflet and a telephone number if the patient wants to talk further. It is not rocket science."

It is estimated that more than 73 000 people in the United Kingdom have HIV, but almost a third of these are undiagnosed. A delayed diagnosis accounts for at least 35% of deaths related to HIV.

Routine screening of the whole population is not recommended in the UK because the overall HIV prevalence is lower, at 0.1%. However, the guidelines recommend offering routine HIV testing to all patients in an area where diagnosed HIV prevalence in the local population exceeds 0.2%.

The booklet *HIV for Non-HIV Specialists: Diagnosing the Undiagnosed* is at www.medfash.org.uk.

Cite this as: *BMJ* 2008;337:a1796

Doctors should be alert to new virulent

Lisa Hitchen LONDON

Doctors should be vigilant for cases of community acquired *Staphylococcus aureus* infections, the Health Protection Agency has warned this week.

Recorded cases of Panton-Valentine leukocidin associated *S aureus* (PVLSA) infections in England and Wales have risen more than sixfold from 2005 to 2007, when there were 1361 cases recorded.

Whether there is a true rise is uncertain, explained Angela Kearns of the agency's Centre for Infections at the agency's conference in Coventry last week.

"We are seeing a year on year increase in numbers but it could be better recognition." She said that the agency needed more data to be sure that it was a real and serious rise.

The bacteria has a gene that produces a toxin, Panton-Valentine leukocidin (PVL), which destroys white blood cells, making it far more virulent than some other stains.

Many strains of PVLSA can be treated with a range of antibiotics, but some are resistant to meticillin. At present less than 2% of clinical isolates of S aureus in the United Kingdom submitted to the National Reference Laboratory carry the gene that codes for PVL, whether sensitive or resistant to meticillin.

Sixty per cent of cases involve skin and soft tissue infections in moist sites such as the groin, said Ms Kearns. Boils and abscesses are common and can reoccur. Some need much more aggressive treatment than skin conditions infected with non-PVL strains, she said.

Twenty per cent are invasive disease, and the remaining 20% of recorded cases derived from screening swabs.

Most people who contract the infection are younger than 40 with less developed immune systems. Close contacts, sharing personal items, and skin trauma are all risk factors for infection. Finding cases in the community was "complex and challenging," said Ms Kearns, with asymptomatic carriers linking pockets of cases.

Germany's plans to reduce use of alcohol provoke protests from industry and politicians

SIPA PRESS/REX

Germany's federal drug commissioner wants to cut annual alcohol consumption by a fifth

Ned Stafford HAMBURG

Plans being drawn up by the German Ministry of Health to reduce alcohol and tobacco use have triggered strong protests from industry groups and politicians, with some of the sharpest criticism coming from the Bavarian health minister.

Proposals were debated at a hearing on 15 September in Berlin. The hearing was closed to the public and press but was attended by representatives of about 30 groups, including representatives from the German Medical Association (Bundesärztekammer), public health insurers, the public pension system, alcohol and tobacco industries, advertisers, sports associations, and addiction prevention groups.

Sabine Bätzing, Germany's federal drug commissioner based in the health ministry and the plan's driving force, told the *BMJ* that it was needed to reduce German alcohol and tobacco consumption, which is among the highest in Europe.

"We have an increasing consumption, especially with young people," she said, adding that annual consumption of beer, wine, and spirits in Germany is 10 litres of pure alcohol per person. "That is a lot," she said. Her long term goal would be to reduce that to 8 litres.

The hearing followed last year's request from Mrs Bätzing for the Drug and Addiction Council to develop recommendations for reducing Germany's alcohol and tobacco consumption. Alcohol proposals include putting pictograms on containers that warn pregnant women not to drink alcohol and lowering the limit of the concentration for driving from 50 mg of alcohol per 100 ml blood to 20 mg. But the most controversial recommendations are regulation of advertising of alcohol products and sponsorship of sporting events.

Opponents have attacked the plan. The Bavarian health minister, Otmar Bernhard, a member of the centre-right coalition of the Christian Democratic Union and Christian Social Union party last week said, "With Mrs Bätzing, one has the impression that she wants to fight against alcohol and not alcohol misuse."

Cite this as: *BMJ* 2008;337:a1727

strain of bacteria

Jeorge Orendi, consultant microbiologist at the University Hospital of North Staffordshire NHS Trust, recounted his hospital's experience of a recent outbreak.

The first case was a nurse who worked at the hospital infected with the ST30 strain of PVLSA. This previously healthy 33 year old woman developed pneumonia, septic shock, and died. Sixteen other cases were identified in the next three months, including eight other healthcare workers. "Fourteen out of 17 cases lived in five households and were all from the Philippine community," said Dr Orendi. Some healthcare workers seem to have acquired the infection through patients while in hospital and passed it on to their families, he added.

All infected hospital staff were excluded from contact with patients until they and all household members screened negative. After decolonisation, staff returned to work but were followed up at one, four, and 12 months.

Cite this as: *BMJ* 2008;337:a1739

New reported risks add to concern about bisphenol A in plastics and lining of aluminium cans

Janice Hopkins Tanne NEW YORK

New worries about a chemical found in many plastic food containers were raised by a report in *JAMA* and an accompanying editorial (2008;300:1303-10).

The study attracted much media attention. It followed a report by the Food and Drug Administration last month that said that the chemical was safe (*BMJ* 2008;337:a1429) and a report in April by another US government agency, the National Toxicology Program, that raised concerns about the chemical.

Bisphenol A is used to make polycarbonate plastic food and drink containers, such as baby bottles. It is also used in the lining of aluminium cans, in dental sealants to prevent decay, in "carbonless" paper for receipts, and in other household products.

Activists claim that the chemical is unsafe because animal studies have shown that it is an endocrine disrupter. They say that many adverse effects occur in animals at concentrations below the recommended US allowance.

The *JAMA* study analysed concentrations of bisphenol A in the urine of 1455 US adults in the US national health and nutrition examination survey 2003-4.

The researchers said that higher exposure to the chemical may be associated with avoidable mortality. All the participants had urinary concentrations less than the recommended exposure. But the study found that people with the highest concentration of the chemical were twice as likely to have cardiovascular disease or type 2 diabetes.

The draft document for the meeting is at www.fda.gov/ohrms/dockets/ac/08/briefing/2008-0038b1_01_00_index.htm.

Cite this as: *BMJ* 2008;337:a1766