LETTERS

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CHILD ABUSE CONTROVERSY

Don't ignore preventive message of baby Jayden's case

We read the judgment of the prosecution of the parents of baby Jayden with sadness and interest.[1] It is accepted that Jayden had congenital rickets—he was born with it, probably because his mother was vitamin D deficient during pregnancy. He was entirely breast fed; one of the sad facts is that, unbeknown to his mother or those advising her, this contributed to his vitamin D deficiency.[2]

His mother attended all antenatal and postnatal appointments and engaged fully with all health services, including immunising and exclusively breast feeding her son. Because she was in a high risk group when pregnant (being under 18), the government's Healthy Start scheme should have guaranteed that she received free Healthy Start vitamins, which contain folic acid, vitamin C, and vitamin D.

The main source of vitamin D is skin synthesis during exposure to sunlight, a rare commodity in northern Europe for at least half of the year. Half of adults have insufficient vitamin D levels, and one in six is severely deficient during winter and spring.[3] Advice to eat well and breast feed exclusively for six months will not stop this deficiency passing from mothers to babies, particularly in those with pigmented skin. On many occasions this family should have been encouraged to take vitamin supplements, including vitamin D, which would have helped prevent rickets.

The National Institute for Health and Clinical Excellence recommends that all pregnant women who are eligible or likely to be eligible for Healthy Start should be offered the vitamin supplement,[4] but awareness of this is probably low. Rapid responses from *BMJ* readers to a review on vitamin D report poor awareness among mothers and poor access to the vitamins.[3]

Jayden's case illustrates the need for all health professionals delivering care to pregnant women and young children to be aware of the simple preventive action of ensuring Healthy Start vitamins are reaching families.

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Competing interests: None declared.

1 Dyer C. Prosecution of parents over baby's death raises controversy over diagnosing child abuse. *BMJ* 2012;344:e2932. (23 April.)
2 London Borough of Islington v Chana Al-Alas, Rohan Wray, Jayda Faith Al-Alas Wray. Neutral citation number: 2012. EWHC 865 (Fam). www.judiciary.gov.uk/media/judgments/2012/lb-islington-al-alas-wray-judgment-19042012.
3 Pearce SH, Cheetham TD. Diagnosis and management of vitamin D deficiency. *BMJ* 2010;340:b5664.
4 National Institute for Health and Clinical Excellence. Guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers and children in low income households. 2008. www.nice.org.uk/PH011.

Cite this as: *BMJ* 2012;344:e3386

BAD MEDICINE: HEALTH PROMOTION

Stop relying on drugs to prevent lifestyle induced chronic disease

Spence's article is based on the misleading claim that health promotion in England costs £3.7bn (€4.6bn; $6bn) a year.[1] This figure is taken from table 3 of the 2009 NHS Public Health and Expenditure report and includes drugs (£1.4bn), dental check-ups (£1bn), the heavily drugs oriented Quality and Outcomes Framework (£0.5bn), screening programmes (£300m), and all other elements of the "prevention of non-communicable disease."[2] Advice on lifestyle, diet, and smoking, which Spence repeatedly refers to as examples of wasteful health promotion, attracted only £172m of NHS funds in 2006-7. This is under 5% of total expenditure on the prevention of non-communicable disease and is only 0.018% of the total 2006-7 NHS budget (£93.5bn). He makes no great effort to research and test the best ways to help people improve health behaviours.

The incongruity of these figures is obvious: poor lifestyles (mainly inactivity, smoking, and poor diet) cause the current epidemic of chronic disease that uses much of the £93.5bn taxpayer expenditure, but we invest a mere 0.018% in dealing with the core problem. It seems senseless to attack this badly funded and neglected area and wiser to propose more research into health coaches, brief interventions in primary care, motivation training, and other promising ways to reduce this burden. The outcomes of this research will help medicine move away from oversimplistic and mechanistic approaches, such as the almost exclusive focus on drugs for preventing lifestyle induced chronic disease.

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Competing interests: None declared.

1 Spence D. Bad medicine: health promotion. *BMJ* 2012;344:e2755. (17 April.)
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Cite this as: *BMJ* 2012;344:e3214

ANTIBIOTIC DRUG RESEARCH

Existing antibiotics may be the best we will ever have

Paccaud emphasises economic incentives for new antibiotic discovery to tackle antibiotic resistance.[1] An ecological perspective suggests that new drug discovery may not make a major contribution.

The ideal target for antibiotic action is a crucial step in bacterial physiology with no parallel in mammalian cells—for example, penicillin targets a step in cell wall synthesis. Because there is no parallel in mammalian cells there is little dose related cellular toxicity. Because biological motifs are generally conserved in evolution, the number of ideal targets is probably limited. Many compounds (including penicillin) that disrupt crucial bacterial pathways exist naturally, so many environmental bacteria have systems to neutralise their effects.

Therefore, pre-antibiotic microbial biodiversity had two valuable aspects: the number of ideal targets was limited and most common pathogens had few antibiotic neutralisation systems because they were not needed within their animal host. These factors made it relatively easy to find the early "magic bullets."

Human activity has resulted in a profound transformation of preindustrial microbial biodiversity. Therapeutic antibiotics, disinfectants, and biocides have generated intense selection pressures for bacteria on our body and at the interface between the body and environment (sewage systems), thus shaping pathogens with systems to protect those few

ideal targets. This effect of antibacterial agents is compounded by weak or non-existent infection control, population density, environmental contamination (for example, sewage), and global travel.

We have limited expectations from a "renewable pipeline of products." We hope for some modest success, but the existing classes of antibiotics are probably the best we will ever have. We are wary of creating an expectation that economic incentives can generate a pipeline to compensate for our squandering of this non-renewable resource.

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Competing interests: None declared.

1 Paccaud J-P. Antibiotic drug research and development. *BMJ* 2012;344:e2591. (11 April.)

Cite this as: *BMJ* 2012;344:e3369

SALTY FOOD LEAGUE TABLE

The risks of reducing salt levels

Six of the 10 authors of the study of salt levels in fast foods across six countries, reported by Roehr,[1] are members of WASH (World Action on Salt and Health). The singular goal of WASH is the international reduction of salt consumption, and its decade long campaign against salt has been characterised by the complete denial of any peer reviewed clinical evidence that counters this agenda and cautions against salt reduction. This has become more conspicuous during the past two years, when the overwhelming clinical evidence has clearly highlighted the risks of reducing current salt levels.

Recent peer reviewed medical studies have cautioned against population-wide salt reduction,[2-4] and the latest one has shown that anyone who follows the 2010 dietary guidelines for sodium will end up with a highly unbalanced and nutritionally inadequate diet.[5] This evidence proves beyond all doubt that this guideline will do the public far more harm than good. Unfortunately, our public health authorities have neither the courage nor conviction to put things right. It is a pity that they have forgotten that they work for consumers.

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Competing interests: MS is employed by the Salt Institute.

1 Roehr B. US tops salty fast food league table. *BMJ* 2012;344:e2769. (17 April.)
2 Taylor RS, Ashton KE, Moxham T, Hooper L, Ebrahim S. Reduced dietary salt for the prevention of cardiovascular disease: a meta-analysis of randomized controlled trials [Cochrane review]. *Am J Hypertens* 2011;24:843-53.
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5 Maillot M, Drewnowski A. A conflict between nutritionally adequate diets and meeting the 2010 dietary guidelines for sodium. *Am J Prev Med* 2012;42:174-9.

Cite this as: *BMJ* 2012;344:e3205

WIND TURBINE NOISE

Editorial ignored 17 reviews on wind turbines and health

Hanning and Evans, who declare histories of anti-wind farm activity, say that a large body of evidence now exists that wind turbines within permissible distances from housing disturb sleep and impair health.[1] They are correct about a large body of evidence, but not in their interpretation of its conclusions.

There are 17 reviews of the evidence, nearly all with an "independent" provenance.[2] None are referenced in the editorial. These reviews strongly state that the evidence that wind turbines themselves cause problems is poor. They conclude that:

- Small minorities of exposed people claim to be adversely affected by turbines
- Negative attitudes to turbines are more predictive of reported adverse health effects and annoyance than are objective measures of exposure
- Deriving income from hosting wind turbines may have a "protective effect" against annoyance and health symptoms. Opponents claim that turbine hosts sign "gag" clauses that prevent them from complaining. I have seen contracts from different Australian firms and none say anything about gags. No contract could preclude citizens from pursuing negligence claims in common law.

I have compiled an ever growing list (currently 105) of deaths, diseases, and symptoms in humans, animals, and even earthworms said to be caused by turbines.[3] The diffuse and sometimes bizarre nature of many of these claims, considered alongside the complete absence of "wind turbine syndrome" on PubMed, suggests this phenomenon is a prime example of a contemporary psychogenic illness.[4 5]


SPL

Within hours of the editorial being published, I was sent gloating emails by wind farm opponents, jubilant that a prestigious journal had published it. In this instance, the *BMJ* needs to look at the adequacy of its peer review process.

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Competing interests: SC is a member of the Climate and Health Alliance, Australia, and has often publicly questioned the legitimacy of "wind turbine syndrome." He had never received support of any sort from the wind industry or agents acting on its behalf.

1 Hanning CP, Evans A. Wind turbine noise. *BMJ* 2012;344:e1527. (8 March.)
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5 Boss LP. Epidemic hysteria: a review of the published literature. *Epidemiol Rev* 1997;19:233-43.

Cite this as: *BMJ* 2012;344:e3366

Authors' reply

Chapman insinuates that our histories of anti-wind farm activity automatically invalidate our opinions. We are not against wind farms in general, only those placed too close to human habitation, a public health objective that should surely meet with his approval. As a member of the Climate and Health Alliance, which advocates renewable energy, Chapman could be described as having a history of pro-wind farm activity.

We focused on sleep disturbance as the major adverse effect of wind turbine noise. We did not mention "wind turbine syndrome" or other symptoms that have been attributed to it. Chapman asserts that the claims of ill health are the product of mass hysteria, but objective evidence to support this is lacking. Conversely, obvious mechanisms can explain how wind turbine noise disturbs sleep.

Chapman makes much of his list of 17 reviews: at least five were written before most of the studies we cited were published. One is only a draft, one reviewed the potential contribution of low frequency noise to annoyance, and the independence of the rest, written in association with the wind industry or government departments, is doubtful. The onus of proving safety should fall on those introducing new forms of environmental pollution, including noise pollution, not on those exposed to it.

Others have called for a review of current guidance for wind turbine noise and independent

research. Hanning referenced 11 doctors and acousticians who have recommended greater setbacks and lower noise levels.[1] The evidence for harm at currently permitted distances and noise levels is such that regulators should commission independent research. If wind turbines are as benign as Chapman asserts he cannot object to research being undertaken. There is not a single published study showing a lack of adverse effects on sleep and health.

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Competing interests: None beyond those given in the editorial.

1 Hanning C. Wind turbine noise, sleep and health. 2010 www.windvigilance.com/about-adverse-health-effects/wind-turbine-noise-sleep-and-health-by-dr-hanning.

Cite this as: *BMJ* 2012;344:e3367

COLLABORATION WITH DRUG INDUSTRY

Towards greater transparency in the life sciences

After the recent publication of guidance on collaboration between healthcare professionals and the drug industry,[1] the *BMJ* printed two letters of criticism to which we would like to respond.[2 3] This guidance is just the first step in a series of work by the Ethical Standards in Health and Life Sciences Group (ESHLSG) to tackle problems in the relationship between industry and healthcare professionals. Over the coming months, the life sciences sector and wider healthcare community will be developing several initiatives regarding industry's support of medical education, clinical trial transparency, and the declaration of payments to healthcare professionals.

It is unfortunate that readers have misinterpreted the guidance. It does not aim to answer every question and reject every concern: we understand that the industry's support of medical education is contentious, and we are working together to remedy this, just as we are looking at concerns about transparency of clinical trial data. This document is one stage in the process of improving transparency across the life sciences sector—it may not be the definitive step, but it is an important one.

The ESHLSG aims to ensure that relationships between health professionals and the industry are open, transparent, and aligned to patient benefit. Transparency, better understanding, and the sharing of expertise between the professions and industry can only help improve clinical care and the education of all involved, especially as collaborative working becomes an increasingly important way for the NHS to tackle key health challenges in a constrained budgetary environment.

Both the NHS and drug industry want to improve patient care and clinical outcomes through high quality cost effective treatment; by pooling our expertise and resources we can tackle disease more effectively. Surely that is a positive thing?

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Deepak Khanna president, Association of British Pharmaceutical Industry, London, UK

Competing interests: RT and DK are co-chairs of the Ethical Standards in Health and Life Sciences Group.

1 Dyer C. Collaboration with drug industry won't affect clinical decisions, says new guide. *BMJ* 2012;344:e2489. (2 April.)
2 Rogers W, Zutlevics T, Raven M, Jureidini J. Guidance offers little in the way of ethics or transparency. *BMJ* 2012;344:e2910. (24 April.)
3 Yates TA, Reyn CJ. An alternative set of principles for consideration. *BMJ* 2012;344:e2927. (24 April.)

Cite this as: *BMJ* 2012;344:e3371

PREGNANCY AND RASH EXPOSURE

Policy change on VZIG in the US to match UK recommendations

An important policy change announcement in the US coincided with publication of my article on investigating pregnant women exposed to a child with a rash.[1] I stated: "The recommended time frame for VZIG [varicella zoster immune globulin] varies. US guidance advises VZIG within 96 hours of exposure, but in the UK, VZIG can be given to a household contact within 10 days of onset of the rash in the index case." This discrepancy no longer applies, however, since the Food and Drug Administration approved a longer period of 10 days during which patients may receive VZIG after exposure to varicella zoster virus.[2]

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Competing interests: None declared.

1 MacMahon E. Investigating the pregnant woman exposed to a child with a rash. *BMJ* 2012;344:e1790. (26 March.)
2 Centers for Disease Control and Prevention. FDA approval of an extended period for administering VariZIG for postexposure prophylaxis of varicella. *MMWR Morb Mortal Wkly Rep* 2012;61:212.

Cite this as: *BMJ* 2012;344:e3207

ACTION ON HEARING IMPAIRMENT

Support needed

Sinha and colleagues' audit of the recording of patients' hearing status in a hospital elderly care department is encouraging.[1]

Before retirement I identified several people diagnosed as having dementia who in fact were just unable to respond to tests because of deafness. With another retired doctor, I now support primary and secondary care teams in Devon and Cornwall who wish to improve their care—55% of patients over 60 (90% over 81) years have hearing loss.

Action on Hearing Loss has similar resources in other parts of the UK and a website with clinical resources, patient material, and information line (www.actiononhearingloss.org.uk/).

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Competing interests: TL has hearing impairment and is a volunteer with Action on Hearing Loss (formerly RNID).

1 Sinha N, Raw J, Zafar S. Identify hearing impairment and take action. *BMJ* 2012;344:e2577. (10 April.)

Cite this as: *BMJ* 2012;344:e3059

SCALY RASH ON THE HANDS

Defining the fingertip unit

We agree that the fingertip unit is useful,[1] but it covers twice the area of a handprint (adult palm plus fingers),[2] not twice the area of the palm alone as Reddy and colleagues' suggest.

A fingertip unit is the amount of ointment squeezed from the distal interphalangeal crease to the end of the finger.[3 4] When squeezed from a standard 5 mm diameter tube nozzle, this amount of ointment weighs about 0.5 g. This concept can be helpful when estimating prescription needs and when explaining to patients how much topical steroid to use.

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Competing interests: AYF, with others, originally described the fingertip unit.

1 Reddy H, De Vittoris A, Wahie S. A scaly rash on the hands. *BMJ* 2012;344:e2252. (28 March.)
2 Long CC, Finlay AY, Averill RW. The rule of hand: 4 hand areas=2 FTU=1 g. *Arch Dermatol* 1992;128:1129-30.
3 Finlay AY, Edwards PH, Harding KG. "Fingertip unit" in dermatology. *Lancet* 1989;2:155.
4 Long CC, Finlay AY. The finger-tip unit—a new practical measure. *Clin Exp Dermatol* 1991;16:444-7.

Cite this as: *BMJ* 2012;344:e3061

BLACKOUT AT PFI HOSPITAL

Facts were not entirely correct

As the anaesthetist in charge during the operation conducted during a hospital blackout, may I make some corrections?[1] Staff did not hand ventilate the patient: the ventilator kept working on battery power, and the patient was at all times carefully and skilfully monitored by myself. Also,

we were not in total darkness—the ambient lighting was working. However, the potential for more serious sequelae is obvious.

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Competing interests: None declared.

1 Christie B. Blackout at PFI hospital forces surgeon to operate by torchlight. *BMJ* 2012;344:e2949. (24 April.)

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Smartphones shed light

A Greek obstetrician at the public Hospital of Samos came up with an ingenious solution on the night of 2 July 2011, when both hospital generators failed to light up the operating room.[1] He invited relatives from the waiting room into the operating theatre, and light from the large screens of their smartphones enabled the procedure to be swiftly and safely completed. This new application of the smartphone should always be kept in mind: it could save lives.

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Competing interests: None declared.

1 Christie B. Blackout at PFI hospital forces surgeon to operate by torchlight. *BMJ* 2012;344:e2949. (24 April.)

Cite this as: *BMJ* 2012;344:e3379

STREPTOCOCCUS B IN PREGNANCY

Time for rapid testing in labour

As McCartney points out,[1] screening for group B streptococcus at 35-37 weeks of pregnancy omits the preterm babies most at risk of the infection. An additional problem is that carriage of the organism during pregnancy is intermittent, so women with positive results at 35-37 weeks may have negative results at the time of labour, and the other way round.[2]

A solution is rapid molecular testing when women are in labour. Tests based on the polymerase chain reaction have 98.5% sensitivity and 99.6% specificity compared with conventional culture, with results available within 75 minutes.[3] As point-of-care tests, they could be performed by midwives or healthcare assistants rather than laboratory staff, and results would be available any time of the day or week. This approach would better prevent neonatal streptococcus B infection and avoid unnecessary antibiotic prophylaxis in unaffected women.

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Competing interests: None declared.

1 McCartney M. Streptococcus B in pregnancy: to screen or not to screen? *BMJ* 2012;344:e2803. (18 April.)
2 Goodman JR, Berg RL, Gribble RK, Meier PR, Fee SC, Mitchell PD. Longitudinal study of group B streptococcus carriage in pregnancy. *Infect Dis Obstet Gynecol* 1997;5:237-43.
3 El Helali N, Nguyen J-C, Ly A, Giovangrandi Y, Trinquart L. Diagnostic accuracy of a rapid real-time polymerase chain reaction assay for universal intrapartum Group B streptococcus screening. *Clin Infect Dis* 2009;49:417-23.

Cite this as: *BMJ* 2012;344:e3368

RESPONSE

Group B Strep Support replies to Margaret McCartney

We of Group B Strep Support (GBSS) were disappointed that Margaret McCartney reiterated some myths about screening for group B streptococcus during pregnancy.1 We challenge four of her statements.

(1) "The risks of antibiotic use include anaphylaxis, which is thought to be fatal in one in 10 000 women treated."

This is an unreferenced statement from the UK National Screening Committee's 2008 review of antenatal screening for streptococcus B. Fatal anaphylaxis is extremely rare. Law et al reported that 1.8 million women in the US were given benzylpenicillin (or ampicillin) between 1997 and 2001 with no deaths from anaphylaxis reported.[2] Their review of UK data showed no adverse drug reactions attributable to benzylpenicillin in a population of 630 000 over six months. They conclude that the risk of death is negligible.

(2) "Broad spectrum antibiotics lead to resistant organisms . . . The potential for long-term persistence of early-colonising bacteria suggests that much more thought should be given to the late consequences of perinatal broad-spectrum antibiotics."

This is of great concern to GBSS's medical advisory panel, one of whom (ABR) coauthored an article quoted by McCartney (and has responded separately with her co-author).

Studies in the US have not shown an increase in antibiotic resistance in response to antibiotics for early onset prophylaxis against streptococcus B except in very low birth weight babies; resistant *Escherichia coli* infection was increased in those whose mothers were given amoxicillin. Anxieties raised by the ORACLE II study follow-up findings of increased cerebral palsy at age 7 applied only to babies of women in threatened preterm labour given broad spectrum antibiotics for up to 10 days, not to those of women given high dose intravenous benzylpenicillin for 4-12 hours in established labour (the ORACLE I study of antibiotics given to women with ruptured membranes did not show any functional impairment at age 7).

(3) "In several of the case studies in the media stories, the screening test for streptococcus B would not have helped."

This may be true, but the policy recommended by cost benefit analyses is to screen at 35-37 weeks and give benzylpenicillin to all women in preterm labour. This policy is applied in countries that screen, including the US, Australia, France, and Spain, where the incidence of early onset streptococcus B infection has reduced on average by over 80%.[3]

(4) "It may be that risk management rather than universal screening is more beneficial but will require nuanced discussion."

Perhaps, yet research repeatedly finds universal screening more cost and clinically effective for the UK than the risk based strategy, even ignoring the inconsistent application of the Royal College of Obstetricians and Gynaecologists' 2003 guidelines. A recent UK study showed that 81% of mothers who should have been offered intrapartum antibiotic prophylaxis because of risk factors were not, with an estimated 48% of babies developing avoidable early onset streptococcus B infection.[4] A risk based strategy may be too complex—any effective strategy needs to be easy to understand and implement.

The potential benefits of screening are reduced morbidity and mortality from early onset streptococcus B infection. Countries implementing screening strategies show substantial reductions in incidence. The UK incidence has risen since the Royal College of Obstetricians and Gynaecologists' 2003 risk based prevention guidelines were introduced, and it continues to do so. The Health Protection Agency found that voluntarily reported cases in England, Wales, and Northern Ireland rose from 229 in 2003 to 302 in 2010.[5] The incidence is now 0.41 per 1000 live births, higher than in the US after universal screening (0.34 per 1000 live births in 2008).

It is in everyone's interest to explore fully the issues around screening, presenting information about potential benefits and harms equally accurately. The public consultation on the review of streptococcus B screening by the UK National Screening Committee starts in June 2012. Recently the committee agreed to pilot screening for maple syrup urine disease, saving perhaps seven lives a year,[6] yet streptococcus B has a much higher incidence and mortality.

GBSS wants women to be given accurate information about streptococcus B and offered a sensitive test for carriage late in pregnancy. They should not be forced into screening, rather they should be entitled to information, sensitive testing, and the option to say yes or no. Wouldn't it be great if we could agree evidence based information and give women a proper choice? Revolutionary even.

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Competing interests: PS, ABR, ACMcC, and PC are the medical advisory panel of the charity Group B Strep Support.

For the full rapid response and references 2-6 see http://bit.ly/JznzGX.

References are in the version on bmj.com.

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