

comment

When it comes to welfare, collective pride is often replaced with simmering media outrage. Good welfare is in our interest. When it fails, the NHS fills the gaps

NO HOLDS BARRED Margaret McCartney

Welfare is not a dirty word

The UK chancellor's budget originally proposed to cut personal independence payments (PIPs) by £1.3bn. An outcry, and a new secretary of state for welfare and pensions, reversed this proposal.

PIPs are not means tested and should allow people with disabilities to take part in life and work with equal opportunity. These payments should proudly promote equality. PIPs were overhauled from the old disability living allowance, supposedly to make savings. Because people may have been assessed only once, so the theory went, they may subsequently recover. This resulted in people with clearly lifelong, worsening, or terminal conditions being subjected to the stress of uncertain outcomes from medical examinations and then long delays in payments.

The organisations in a position to help with the complex forms, such as Citizens Advice, also had funds cut.¹ The contracts were outsourced to companies that the National Audit Office has found to have missed performance targets.²

Over at employment and support allowance (formerly incapacity benefit)—for people who cannot work—cruel and inflexible sanctions have been applied to some, including a man who missed an appointment to attend to his partner having their stillborn child.³ These kinds of strains put pressure not just on patients and families but also on the NHS. A recent Channel 4 programme found some assessors boasting of making £20 000 a month in incentives while denigrating patients.⁴



There are wider problems in how people on benefits are perceived. The King's College, London, researcher Adam Perkins, in his recent book on welfare has claimed a causal link whereby people “voluntarily increase contraceptive use if the generosity of benefits is reduced and vice versa.” He wants benefits to be set at a level that reduces the number of children born to people claiming them, so that fewer children experience “personality

damage due to being born into disadvantaged households.”⁵ His use of statistics has been challenged.⁶

A paper that Perkins cited mentioned tax credits, for low paid people in work, as a supposed stimulus to reproduction.⁷ But is he seriously suggesting that already low paid people should be given less in benefits to encourage fewer children? These claims filtered into the media with little critical reflection.

British people are prouder of the NHS than of the royal family, the army, or Team GB.⁸ This reflects a British tradition of fair play. Civic participation is dear and natural to us. Yet, when it comes to welfare, collective pride seems often to be replaced with simmering media outrage.

Good welfare is in our interest. When it fails, the NHS fills the gaps. We are not a country of “scroungers.” Disability is normal, and our normal response should be one of pride in civil fairness.

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MORE ONLINE COMMENT ABOUT E-CIGARETTES (see Douglas Kamerow, p 277)

- ▶ Evidence about electronic cigarettes: a foundation built on rock or sand? *BMJ* 2015;351:h4863
- ▶ Nicotine without smoke—putting electronic cigarettes in context *BMJ* 2016;353:i1745
- ▶ E-cigarettes help up to 20 000 smokers in England quit each year *BMJ* 2016;352:i1243

Doctors should be able to prescribe exercise like a drug

Few think that brief advice can change behaviour

About a quarter of men and a third of women in the United Kingdom describe themselves as physically inactive.¹ These make for worrying statistics, given that a sedentary lifestyle is responsible for about 5.3 million premature deaths a year globally.²

The UK medical royal colleges and others have called for healthcare professionals to help tackle the problem,³⁻⁵ urging primary care professionals to lead the fight and to “question patients about their physical activity and exercise habits at every meeting.”³

Such calls seem to be going unheard, however. Some 92% of 346 GPs and 99% of 206 nurses surveyed agreed or strongly agreed that promoting physical activity was important.⁶ But saying and doing are not the same thing: professionals instigate brief physical activity interventions opportunistically in only a quarter of appropriate

Saying and doing are not the same thing: professionals instigate brief physical activity interventions opportunistically in only a quarter of appropriate instances

instances, the National Institute for Health and Care Excellence has found.⁷ Also, as few as 46% of patients have reported receiving advice about physical activity and exercise from their GP.⁸

Clinicians’ reasons for not giving such advice include time constraints, a lack of tools, and—in my opinion, a key factor—scepticism about whether such counselling actually works: only a third of healthcare professionals surveyed thought that their brief advice would be successful in changing patient behaviour.⁶

Is exercise medicine?

This scepticism includes doubt among practitioners and their patients about whether brief physical activity interventions count as medicine. The evidence for physical activity as medicine is predominantly underpinned by data from observational studies that are confounded in their estimated



effects,⁹ which may not be replicated in randomised controlled trials. In addition, information on optimal “formulation” and “dosage” is scarce,¹⁰ as is information on where more evidence is needed and on which patients would benefit most from having physical activity prescribed.

These factors are likely to have a negative effect on the belief that exercise is medicine, if not on its application in practice. A recent assessment of the quality of reporting and replication in trials of exercise based cardiac rehabilitation

Progress on dementia in hospital

England’s health secretary, Jeremy Hunt, used a speech in March to rehash the long running prime minister’s challenge to raise standards of care for people with dementia. All Hunt really said about acute hospitals was that patients with “high dependency” would get consultant ward rounds twice a day and that some may have dementia—part of his “seven day services” crusade.¹ This was a missed opportunity to celebrate good, progressive government initiatives and to rise above party politics.

The national dementia strategy was started by the Labour government in 2009,² but the 2010 coalition continued the programme,³ reinforced by the prime minister’s

challenge.⁴ This strategy made the care of hospital inpatients with dementia a priority. Calls for action from the Royal College of Physicians and the King’s Fund noted that the care of inpatients with dementia was now everyone’s business.^{5,6} We can’t solve the problem by wishing patients away, and some patients really need to be in hospital for other reasons—however much we invest in services closer to home.

As many as 40% of hospital patients over 75 have dementia.⁷ It travels with them, although they’re generally admitted for other primary reasons. They’re more likely to die in hospital and to experience decompensation, depersonalisation, and harms.⁸



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Two reports, from the NHS Confederation and the Alzheimer’s Society,^{9,10} found that people with dementia occupy about a quarter of beds in acute hospitals. They stay about a week longer on average. Nurses feel untrained, unskilled, and less confident in assessing or treating them. Carers are often unhappy with the care and communication available.

Since 2010, more than 50 organisations have joined an



highlighted some of these issues and called for improvements in methodological reporting.¹¹

A commentary offered viewpoints that echoed my own, such as, “Effective translation of exercise as medicine goes beyond simply telling patients to ‘exercise’ or ‘exercise several days a week’” and, “Proper implementation of exercise guidelines in clinical practice requires that exercise be prescribed for patients in a manner analogous to a drug prescription.”¹²

To aid this effort my colleagues and I are looking in detail at

umbrella group, the Dementia Action Alliance.¹¹ The Royal College of Nursing has developed and shared good practice models.¹² John’s Campaign encourages many hospital wards to welcome and involve carers with open visiting.¹³

We’re seeing growth in liaison psychiatry models within acute hospitals, in training the whole hospital workforce in dementia skills, and in hospitals employing their own dementia nurse practitioners. Many have created “dementia-friendly” ward environments using evidence based design.¹⁴ Others have employed activities coordinators. The Care Quality Commission has made dementia a key theme in its inspections.

evidence in favour of physical activity for preventing and treating major chronic disease.¹³ We have assessed 54 reviews of 20 medical conditions, including 1168 randomised controlled trials, 107 706 participants, and more than 500 outcomes. The goals are to provide an overview of the quality of evidence for physical activity and exercise as medicine and to compile a much needed taxonomy of interventions that will help develop a formulary for prescribing physical activity.

Such scrutiny can yield better information about the benefits and harms of physical activity for prevention and treatment, but the act of scrutinising has value in itself. By applying the same standards of critical analysis to the evidence underpinning physical activity interventions as to those applied to drug treatments, healthcare practitioners will be more inclined to engage with the ethos and practice of prescribing physical activity and believe that “exercise is medicine.”

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Of course, these inputs are no use without tangible gains for patients and families, but we are seeing some. The Royal College of Psychiatrists’ national audit has described dementia care in several domains, standards, and systems for 8000 patients in 210 hospitals.¹⁵ Sure, the audit shows variation and care gaps, but it’s nonetheless an improving picture, unrecognisable from a decade ago.

We soon forget how far we’ve come and the importance of celebrating success, no matter who helped to start or tend the fire.

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YANKEE DOODLING Douglas Kamerow

Finally the US regulates e-cigarettes as tobacco

It seems a long time coming. We watched electronic cigarettes grow without regulation from an oddity to a pastime of nine million Americans, from boutique businesses to a \$3.5bn (£2.4bn) industry dominated by major tobacco companies. Now e-cigarettes are more popular among US high school students than tobacco.¹

In 2014 the Food and Drug Administration announced new draft rules after it gained authority in 2009 to regulate tobacco products. More than two years later the FDA has finally issued 500 pages of regulations for e-cigarettes, cigars, pipe tobacco, and hookahs.^{2,3} They include most of the regulation that the public health community wants. From 8 August sales to under 18s will be banned, as will vending machine sales and free samples. By May 2018 all packets of e-cigarettes that contain nicotine must include a warning that it is addictive.

By August 2018 e-cigarette and e-juice manufacturers must submit their products to the FDA for premarketing review, registering them, listing their ingredients, and specifying any harmful substances that they include. The FDA then has a year to decide whether to give marketing clearance.

I’d rather have big, regulated companies producing something I’m going to put in my lungs, even if it means sustaining their sales and growth

This is all good news. Youngsters will have a much more difficult time getting e-cigarettes, starting very soon.

To my mind, the regulations have two major gaps, however. Firstly, they do not restrict flavorings, very popular among young people.³ Secondly, the regulations still allow advertising on cable television, in magazines, and on the internet. Many of them are attractive to young “vapers” and could have been banned with good effect.

Some harm reductionists will say that the difficult and expensive applications and testing that the FDA now requires will play into the hands of the major cigarette companies, which alone can muster the resources to continue to produce and market e-cigarettes. I’m not thrilled about this either, but I’ve been in a few vape shops and watched them mix their e-juices. Not a reassuring sight. I’d rather have big, regulated companies producing something I’m going to put in my lungs, even if it means sustaining their sales and growth.

We may discover that e-cigarettes can provide a safe and effective way for smokers to reduce or stop smoking combustible cigarettes. If so, and as long as kids can’t get them, I’m happy for e-cigarettes to be produced by big tobacco.

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OBITUARIES

Ian John Davis

Retired consultant anaesthetist
Worcestershire Royal Hospital (b 1939; q London 1963; DA, FFARCS), died from adenocarcinoma of the lung on 8 March 2016.



After service in the Royal Army Medical Corps, where he attained the rank of major, Ian John Davis worked for the British Aircraft Corporation in Saudi Arabia. His prompt evacuation of the base after an accidental release of chlorine gas, prevented many casualties. After anaesthetic training in the south west, Ian was appointed to a consultant post in Worcester in 1978. He retired in 2007. He was lead consultant anaesthetist for obstetrics and, as faculty tutor, trained many future anaesthetists at the beginning of their careers. In retirement he enjoyed music, reading, gardening. Married twice, Ian leaves three children and one grandchild.

Christopher Maile

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Leonard Jacobs

General practitioner (b 1925; q Guy's Hospital Medical School, London 1949; MRCGP), d 25 January 2016.

In 1978 Leonard Jacobs and his family practice moved to the purpose built Lisson Grove Health Centre. By the end of the decade, under his leadership, the centre had established itself as one of the few health centres in the country with a health visitor, district and community nurses, a community physiotherapist, a social worker, a health adviser for elderly patients, and a marriage counsellor. He was a member of the local medical committee from 1976 to 1995, and lectured on community care for the RCGP and Middlesex Hospital. Alongside his medical work, he was an active member of the Labour Party, chaired the Westminster Society for People with Learning Disabilities, and was closely involved in starting up Voluntary Action Westminster (now One Westminster), both of which continue to deliver services. He leaves three children and three grandchildren.

Colin Jacobs

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Donald Macdonald

Retired medical officer
Jordanhill College, Glasgow (b 1919; q1943), died from septicaemia on 18 July 2015.



As a teenager, Donald Macdonald wanted to be Bing Crosby, or Alistair Cooke, or H L Menken. Or all three at once. Despite this, and mainly to please his father, he qualified as a doctor and achieved field rank in the Royal Army Medical Corps. From 1950 till 1968 he was a GP in a busy industrial practice, and then for 10 years a principal lecturer at Jordanhill College, Glasgow. In his own words: "As I write, I have enjoyed 20 years of retirement—longer than I endured general practice. Now as I exit left, waving, whatever became of my grandiose adolescent ambitions? Not a lot. I write occasional play reviews for the local paper and have some facility for comic verse—but nobody asks me to sing." Predeceased by his wife, May, Donald Macdonald leaves three children.

Donald Macdonald

Cite this as: *BMJ* 2016;353:i2305

John Victor Sowton

GP and GP trainer Redhill Surrey (b 1934; q King's College London 1956; FRCGP), d 4 September 2015.



John Sowton was a much loved GP in Redhill, Surrey, for 31 years. He was a strong supporter of the Royal College of GPs and an enthusiastic trainer, remembered fondly by his many trainees. He had a lifelong interest in doctor-patient communication, stimulated by participation in a pioneering Balint group in the 1970s. He was also a GP mentor and a counsellor for doctors in difficulty, and many benefited from his calm and caring approach. He was a talented trumpet player and musician and had a strong interest in local history and his local community at Nutfield Marsh. He leaves Anne, his wife of 56 years; four children; and 11 grandchildren.

Tim Sowton

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CORRECTION In the fourth sentence of this obituary (*BMJ* 2016;353:i2072, print publication 30 April 2016, p 192), we incorrectly referred to Norman Philip Watson as "Johnson." We apologise for this editorial error.

Xianming Wang

General surgeon (b 1929; q Dalian Medical University 1954), d 3 June 2015.



Xianming Wang was born in Shandong, China. A dedicated and passionate general surgeon for more than 40 years, he served as Shenyang Red Cross Hospital's surgical director. His other positions included that of a professor, government medical consultant, and general director of the Chinese Medical Association. His major achievements include the development of innovative techniques for various surgical procedures. He had rich clinical experience in the surgical treatment of thyroid diseases, pioneering research, and more than 30 publications. Because of his excellent surgical skills, his responsible and professional attitude, and his civility and kindness, people referred to him as "the number one scalpel." He leaves his wife, three children, and two grandchildren.

Jingyan Pan

Cite this as: *BMJ* 2016;353:i2110

Mildred Hilario Genesio de Souza

Former consultant physician Ministry of Health Uganda and diabetician Goa, India (b 1925; q Grant Medical College Bombay, India, 1951; FRCP Glas), died from prostate cancer on 4 February 2016.



Born and raised in Uganda, Mildred Hilario Genesio de Souza ("Hilary") went to school in Goa and to university in Bombay. He returned to Uganda, where he worked in several hospitals. With the exodus of persons of Indian origin ordered by the military dictator Idi Amin, he returned to Goa and busied himself in private practice. He was president of the Indian Medical Association in Panjim and founder of the Diabetes Association of Goa, under sponsorship of the local Rotary Club. He migrated to Australia, settling in Brisbane where his daughter, Joy, a veterinarian, had made her home. He continued to write articles on diabetes in local newsletters. He leaves his wife, Clea; three daughters; four grandchildren; and two great grandchildren.

Krishna Somers

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Lord Walton of Detchant

Neurologist and crossbench peer who founded Muscular Dystrophy UK

John Nicholas Walton, Lord Walton of Detchant (b 1922; q Durham/ Newcastle 1945; FRCP Lond; DSc, MA (Oxon)), died from glioblastoma multiforme on 21 April 2016.

Hansard's last reference to the crossbench peer Lord Walton of Detchant was on Monday 7 March 2016.¹ That morning the retired neurologist would, as usual, have caught the 6 30 London train from Berwick-upon-Tweed, staying at either the Athenaeum or the Royal Society of Medicine (Walton was president of the RSM from 1984 to 1986).

Four days later the 93 year old collapsed at the House of Lords and was admitted to St Thomas' Hospital across the Thames. A private ambulance organised by his eldest daughter, Ann McNeil, subsequently drove him to Newcastle's Royal Victoria Infirmary (RVI), where, she says, he spent two weeks giving bedside lectures to "budding neurologists" before being allowed home.

Commonplace

John Nicholas Walton, with his grasp of detail and "colossal memory," would have relished such circumstantial detail, a point noted in a 1993 review of his Pooterish autobiography *The Spice of Life: From Northumbria to World Neurology*.² *The BMJ's* reviewer, Ruth Holland, also hailed Walton's "grasp of the function of the commonplace in human relationships," a quality that served him well in both clinical medicine and medicopolitics. He was president of the BMA between 1980 and 1981, and GMC president from 1982 to 1989. He was also warden of Green College, Oxford, from 1983 to 1989.

Walton's overriding neurological interest was in muscular dystrophy, and his encounters with two families as a young researcher helped lead to the discovery that it is a hereditary condition with a female carrier.

In 1954 he and Fred Nattrass, who had appointed Walton as his

research assistant in his work on neuromuscular diseases, published a paper that classified the different types of muscular dystrophy based on their research.³ In 1959 he cofounded Muscular Dystrophy UK with Nattrass and the businessman Joseph Patrick. The neuromuscular laboratories he developed at Newcastle General Hospital in the years that followed grew into an internationally recognised research centre. It was officially opened in 1970, the year in which Walton became chairman of Muscular Dystrophy UK, a position he held for 25 years.

Robert Meadowcroft, chief executive of Muscular Dystrophy UK, recalls Walton telling him, "I often sit on the red benches of the Lords and wonder what I'm doing here, just a Geordie lad from County Durham." The Geordie lad's parents, both teachers, instilled a capacity for hard work in their three children. They all became doctors. John Walton attended Alderman Wraith Grammar School, Spennymoor, where he met his future wife, Betty Harrison (they married in 1946).

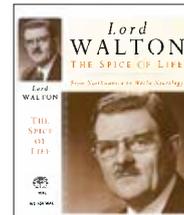
He qualified from Newcastle Medical School—then part of the University of Durham—in 1945, and became a consultant neurologist in 1958 and professor of neurology a decade later. From 1971 to 1981 he was dean of medicine at the university. He was knighted in 1979 for his services to medicine and became a crossbench peer a decade later. In 1980 he was made a Freeman of the City of Newcastle.

Walton report

Meadowcroft met Walton in the Lords when he moved a key amendment through that helped lead regulations to permit stem cell research to be approved by parliament. It became known as "the Walton amendment." Walton was a key member of an all party group that conducted a parliamentary inquiry in 2008 into muscle wasting conditions. The result was called the "Walton report," and



A real lesson in how a doctor can make an important contribution



became the benchmark by which future services were developed.

Sheila Hollins, a former president of the BMA and the Royal College of Psychiatrists, adds, "When I first entered the House in 2010 as a crossbencher, he would have been in his late 80s. He was very nice and supportive, but not in a fussy way. He never used notes, always spoke clearly and concisely. It was a real lesson in how a doctor can make an important contribution." Like the RVI's budding neurologists, Hollins had first encountered Walton as a medical student when she read his textbooks, including *Essentials of Neurology* (1975), and *Introduction to Clinical Neuroscience* (1983). He was also editor in chief of the *Journal of Neurological Sciences* and joint editor of the *Oxford Companion to Medicine*.

Six days before Walton's death the National Institute for Health and Care Excellence (NICE) recommended that the drug Translarna (ataluren) gain NHS funding. It is the first drug available on the NHS to treat an underlying cause of Duchenne muscular dystrophy.

Ms McNeil says of her "eternal optimist" father, who had one son, two daughters, five grandchildren, and 10 great grandchildren, "Whenever we spoke on the phone, the weather was always wonderful in Northumberland."

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EMERGENCY GENERAL SURGERY

ASiT's concerns about Nuffield report

The Association of Surgeons in Training (ASiT) is concerned about views expressed in the Nuffield Trust report on emergency general surgery (This week, 16 April).

We do not believe that modern general surgery trainees with special interests are inadequately trained to provide an emergency general surgery service. Furthermore, although we wholeheartedly agree with changes to training that improve standards and promote excellence, we fundamentally disagree with shortening training to create emergency general surgeons who lack specialist skills. We strongly oppose truncated training pathways with a view to specialisation after the certification of completion of training.

We are also worried about the ever-decreasing numbers of doctors in training, from 24 874 in 2004 to 14 106 in 2014. While recognising the value of the wider surgical team, we have concerns about the potential effect on surgical training of the increasing use of non-surgeons in emergency general surgery.

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GOVERNMENT AND PUBLIC HEALTH

Huge potential is being lost in implementation

Devakumar et al (Editorial, 9 April) state that “public health budgets were initially ringfenced.” This is true for public health grants but not for council public health budgets. All councils previously spent money on public health, so the grant was inevitably used for programmes previously funded from mainstream budgets. Consequently, overall public health spend was falling even before recent grant reductions.



LETTER OF THE WEEK

Emergency general surgery skills are not lost

We welcome the Nuffield Trust's contribution to the debate on provision of emergency general surgery services (This week, 16 April). Its report comments on the loss of generalists—surgeons who can provide the necessary preoperative, intraoperative, and postoperative care for patients presenting to an emergency general surgery service.

The report suggests that trainees with a special interest within general surgery are less likely to obtain the recommended level of experience than those without a special interest. The evidence presented to support this statement comes from work carried out using joint committee on surgical training data, which we feel have been misinterpreted. Only two trainees in this study did not have a special interest, whereas the special interest groups contained 27-47 trainees. We believe that such a suggestion cannot be made on the basis of a group containing only two trainees.

The 2013 general surgery curriculum gives equal weight to the development of skills in a special interest and in emergency general surgery, recognising the importance of both for good patient care. The curriculum requires all trainees to attain the skills needed to provide emergency general surgery care at consultant level.

We do not believe that the development of a separate special interest in emergency general surgery is appropriate because doctors with a certification of completion of training in general surgery are trained to manage most general surgical emergencies.

W H Allum, Gareth Griffiths (gareth.griffiths@nhs.net), Jon Lund

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In Sheffield, within two years, a third of the grant was diverted to programmes previously funded by the council.

In addition to the reduced workforce, many directors of public health posts have been downgraded. Before 2013, they were always executive directors of the primary care trust. Now, many are third tier officers, divorced from strategic decision making. No wonder morale is low and many posts are vacant. The huge potential from putting public health into local government

is tragically being lost in the implementation.

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Authors' reply

Reduced public health budgets, disempowerment of public health directors, and suspension of mandated services underline the serious situation facing public health in England.

In 2002, the Wanless report cautioned that securing good health for the population

would require effective public health policy and widespread engagement with preventive measures. Without a skilled workforce embedded in local decision making and equipped with a budget to tackle determinants of poor health, public health in England will have valuable expertise sidelined rather than harnessed to tackle the burden of an ageing population.

A recent Scottish review recommended strengthening public health, including the director of public health role, to meet growing health challenges such as obesity and poor mental health. We hope that the government inquiry into public health in England will reach similar conclusions.

Delan Devakumar (d.devakumar@ucl.ac.uk), Kate L Mandeville, Jennifer Hall, Shailen Sutaria, Ingrid Wolfe

[Cite this as: *BMJ* 2016;353:i2590](#)

ZIKA VIRUS STUDY

Zika studies in *The BMJ* and *NEJM* are different

Our paper in *The BMJ* (Research, 16 April) is a different study from that published in a *New England Journal of Medicine* letter on 6 April 2016. The letter, by Hazin et al, was published after our paper was accepted on 1 April 2016. Both studies looked at 23 cases of Zika virus congenital infection but we evaluated computed tomography (CT) and magnetic resonance imaging (MRI) findings, whereas Hazin et al reported CT findings only. Ten of our patients were girls versus 13 in Hazin's study.

An author on both studies checked the patient lists and confirms that only one of our 23 children was in Hazin's series (patient 17) and had changed treatment centre.

That both studies looked at the same number of patients from the same city is simply coincidence.

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