approach is even greater with salt reduction than other lifestyle modifications. In contrast to cigarette smoking, where use is evident to the consumer, the salt content of our diets is not readily apparent: over 75% of consumed salt comes from processed foods.⁸

Hence, any meaningful strategy to reduce salt intake must involve the efforts of food manufacturers and restaurants, either voluntarily (by persuasion) or involuntarily (by regulation). The latter may be required, given the initial response of commercial bodies to the American Medical Association's proposal. The need for public health approaches is also apparent, given the global burden of hypertension (estimated worldwide prevalence of 972 million persons in 2000⁹) and the limited success of lifestyle interventions designed to reduce individuals' salt intake. Such interventions have been notoriously difficult to implement, especially in the setting of a food supply containing "hidden" salt.

In clinical trials, intensive interventions that focused just on salt reduction have shifted mean intake to about 100 mmol (2.3 g) of sodium (equivalent to 5.8 g of salt) a day.¹⁰⁻¹² When efforts to reduce salt intake were combined with weight loss¹¹ or as part of a comprehensive lifestyle intervention programme,¹³ salt reduction was more modest, probably because of the complexity of making multiple lifestyle changes and potential trade-offs when there are several lifestyle goals.

The proposal by the American Medical Association may represent a turning point in public health efforts that have so far been largely ineffective in the US. The actions of doctors and their leadership carry enormous weight, as they did for tobacco control efforts. It is reasonable to conceive that physicians' actions have been an integral, if not essential, component of tobacco control efforts in the US, given their influence on individual patients, their communities, and healthcare policy.

Advice to reduce salt intake has been issued for about 30 years, despite persistent and highly aggressive attempts by commercial interests to weaken recommendations. With publication of the US Dietary Guidelines report⁴ and a subsequent "harmonisation" process, salt recommendations are now uniform and accepted by all branches of the federal government. Recommendations are also more stringent—the currently recommended upper limit of sodium intake is 100 mmol a day in the general population and 65

mmol a day in people who are especially sensitive to the adverse effects of sodium (African-Americans, middle aged and older individuals, and people with hypertension, diabetes, or chronic kidney disease).⁴

The critical issue in the US, as in most other countries, is developing a comprehensive strategy to achieve meaningful, population-wide reduction in salt intake. In this setting, the association's proposal is a logical and coherent framework for accomplishing this vitally important public health objective.

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Non-cephalic presentation in late pregnancy

Best diagnosed by ultrasound at 36 weeks

Caesarean section rates continue to increase around the world. Although non-cephalic presentation is not the most common indication for caesarean section, it may be one of the most preventable.¹ Timely diagnosis of this condition, and an attempt at external cephalic version at about 36 weeks' gestation, has been shown to safely reduce the need for caesarean section.¹⁻³ However, timely and efficient diagnosis of fetal malpresentation requires a screening test with a high sensitivity and high specificity.

In this issue of the *BMJ* Nassar and colleagues report a cross sectional study of the diagnostic accuracy of clinical examination for the detection of non-cephalic presentation in late pregnancy.⁴ Their findings are worrying: non-cephalic presentation was correctly diagnosed in only 70% (91/130) of cases and in only 38% of obese women (3/8). The authors correctly point out that missing the diagnosis of non-cephalic presentation precludes the ability to offer external cephalic version and increases the likelihood

Research p 578

BMJ 2006;333:562-3

of caesarean section and adverse outcomes associated with the spontaneous onset of labour in women with a malpresentation. Consequently, opportunities to prevent caesarean delivery—and various related adverse birth outcomes—are being missed.

A better way to diagnose fetal malpresentation would be to perform an ultrasound examination routinely at 35-36 weeks' gestation on every pregnant woman. However, as noted by the authors, the cost and resource implications of this approach would need to be considered. Further, it is important to consider two factors that were not a part of this study: the skill of the clinician and the confidence they have in their examination. Common sense suggests that an experienced clinician who is confident in their examination would be more likely to determine fetal lie correctly than a less experienced and confident clinician. However, variable accuracy in this task has been documented even among experienced clinicians.⁵

US family physicians who attend deliveries care for 20-60 prenatal patients a year, and obstetricians care for 80-150. If persistent breech presentation occurs at a rate of 3-4%,⁶ then an average family physician's practice will contain a late third trimester malpresentation 0-3 times a year and an average obstetric specialist's practice will contain a malpresentation 2-6 times a year. If the findings of Nassar and colleagues' study are applied, and failure to diagnose non-cephalic presentation correctly at 36 weeks' gestation occurs 33% of the time, then a non-cephalic presentation will be missed by a family physician once every two years and by an obstetrician once or twice a year.

This may not seem to be common enough to prompt a change in clinicians' behaviour. However, other tests are routinely used to guide the diagnosis and treatment of relatively rare but important conditions, such as gestational diabetes, group B *Streptococcus* colonisation, and HIV infection. Because fetal malpresentation can often be successfully managed with either external cephalic version or elective caesarean section, diagnosis and treatment of non-cephalic presentation just before term should be included in the list of possible important prenatal screening activities.

The findings of Nassar and colleagues may not be strong enough to support a call for routine ultrasound

examination of all pregnant women at 35-36 weeks' gestation, but the study should remind all clinicians to assess fetal lie routinely at 36 weeks' gestation. If a clinician is well trained, is confident that a fetus has a vertex presentation, and has a good track record of correctly identifying malpresentation, then ultrasound screening is probably unnecessary. If a clinician is relatively inexperienced, is unsure of their examination, or has a history of missing the presence of a fetal malpresentation, then ultrasonography is probably indicated. The findings also showed that patient factors, such as maternal obesity, might increase reliance on ultrasound examination to determine fetal lie.

Despite the known risks of external cephalic version, birth outcomes clearly could be improved if all women were accurately screened for malpresentation before the onset of labour.^{7,8} The increased use of ultrasound examination to determine fetal lie, at least in questionable situations, would increase the accuracy of such screening.

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Size of the needle for infant vaccination

Longer needles reduce incidence of local reactions

Research p 571

Vaccine safety is a contentious issue, and parental concern continues.¹ An online survey (Harris Poll) in 2004 showed that half of parents are concerned that a child might develop a long term medical condition as a result of vaccination, and 10% are "uncomfortable" having their child vaccinated owing to "health reasons."² These parental concerns may be fuelled by the increasing number of websites making serious allegations about vaccine safety.³

Independent bodies—for example, the US Institute of Medicine—have reviewed the evidence for several vaccines and have generally found them to be safe,

albeit with rare risks such as anaphylaxis.⁴ However, local reactions to vaccines are common—ranging from 6% to 50%, depending on the vaccine, definition of local reaction, and dose number in a series—and this can contribute to the safety concerns expressed by parents. Local reactions can be reduced either by using less reactogenic vaccines, such as acellular pertussis vaccines, or using less reactogenic administration routes.

In this issue of the *BMJ* a randomised controlled trial by Diggle and colleagues compares the effect of vaccinating infants with needles of varying length and gauge.⁵ They found significantly fewer local reactions

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