that the Sugar Bureau will not take advantage of this opportunity to gain spurious scientific respectability from the association. It is unwise for the council to become involved with an organisation that clearly has an ulterior motive and cannot be considered to be interested solely in scientific matters.

We hope that our colleagues in the medical profession will note this strange policy of the Medical Research Council and be warned of any further association it may develop in future with a body whose prime purpose is to promote a product known to be harmful to health.

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1 Committee on the Medical Aspects of Food Policy. *Dietary reference values for food energy and nutrients for the United Kingdom*. London: HMSO, 1991. (Report No 41.)

**We sent this letter to the Medical Research Council and received the following reply.

SIR,—The Medical Research Council is well aware of the Sugar Bureau's activities as a pressure group but does not believe that they are a reason to exclude it from objective scientific discussion of a subject in which it has an interest. The aim of the meeting is educational: to ensure that industry is fully informed about the implications of research findings and future plans for dental research so that it can play an active part in reducing caries. The Sugar Bureau's financial contribution to the day will be to meet the limited costs entailed. The council is not conducting any research funded by the Sugar Bureau, nor does it have any plans to do so.

MARY RICE

Medical Research Council,
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Dealing with disasters

SIR,—I support A D Redmond's view that the royal colleges have a part to play in identifying suitable personnel to help with emergencies or disasters overseas.¹

International Health Exchange (formerly the Bureau for Overseas Medical Service) recently established the United Kingdom's first emergency and disaster relief register for health personnel. The register can be used by any agency recruiting for emergencies, including the Overseas Development Administration. The Overseas Development Administration has formally asked the International Health Exchange to be the key provider of health personnel for its disaster response action plan, which was announced by the minister for overseas development in August last year. The

emergency and disaster relief register is based on the International Health Exchange's existing database and 12 years' experience of helping agencies recruit for developing countries.

The register is a list of appropriately qualified health personnel, who are selected according to criteria agreed with agencies experienced in relief work. These include Save the Children Fund, Oxfam, and the United Nations High Commission for Refugees. Personnel required range from those experienced in establishing and organising health interventions through to health practitioners, trainers, and coordinators. Relevant experience of developing countries and emergencies is required along with experience in, for example, public health, feeding, rehydration, mother and child health, or control of communicable diseases.

The International Health Exchange is aware of the existence of surgical and accident and emergency teams with experience in the NHS and overseas and will be inviting them to join the register. It will also be asking the royal colleges to help in identifying suitably experienced doctors from their own memberships. Further dialogue with health authorities will be necessary to facilitate quick release of personnel for emergency work overseas. I look forward to cooperating with these bodies to ensure a quick, effective response when necessary.

ISOBEL MCCONNAN

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1 Redmond AD. Medical response to disasters overseas. *BMJ* 1992;304:653. (14 March.)

SIR,—Reading about the Edinburgh MEDIC 1 team's response to the Kurdish refugee crisis left me with some doubts.¹ Though the authors speak lightly of themselves and their mission, this is, in my opinion, a good example of the wrong kind of help.

Most of the diagnoses presented for the two refugee camps (gastroenteritis, malnutrition, etc) are common in developing countries. These conditions could probably be treated better by Kurdish primary health care staff, who have the advantage of knowing their patients' culture and language. Instead of sending the wrong experts for a short mission (I cannot understand how Western emergency personnel are qualified to work with malnourished children and infectious diseases or to deal with hygiene and sanitation in a developing country) it must be better to help developing countries to become better prepared to deal with disasters themselves.

The cost of this mission is not mentioned and can only be guessed. Most certainly the money could have been used in a better way for the Kurdish people.

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1 Parke TRJ, Haddock G, Steedman DJ, Pollock AJ, Little K. Response to the Kurdish refugee crisis by the Edinburgh MEDIC 1 team. *BMJ* 1992;304:695-7. (14 March.)

Injuries caused by unsecured contents of vehicles

SIR,—M Dudley's report of a front seat passenger in a car who suffered a penetrating injury to the head caused by a garden fork¹ prompts me to report the perineal injuries sustained by the three occupants of a car involved in a head on collision at high velocity, with a combined impact speed of 160 mph.

Although two passengers suffered relatively minor perineal trauma, the worst injury was the complete division of the anus and sphincters in a 24

year old man. The incised wound penetrated to the level of the ischial spines. Primary repair of the sphincter with temporary faecal diversion was followed by a return to normal continence. Shards of plastic from broken audiocassette boxes, one of which was removed by a fireman from the perineum of the patient with the severe injuries, were thought to be the missiles responsible for all the perineal injuries.

Seemingly, unsecured articles of any size, from garden forks to tape cassette boxes, may be injurious during rapid deceleration.

R J REYES

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Tunbridge Wells,
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1 Minerva. *BMJ* 1992;304:326. (1 February.)

Seat belts in pregnancy

SIR,—We fully support Malcolm Pearce's and Malcolm Griffiths' and colleagues' advice that seat belts should always be worn in pregnancy and agree that the belt should be worn above and below the bump.^{1,2} The authors have obviously never been pregnant or they would know that it is extremely difficult to keep the lap belt over your thighs: it tends to ride over the symphysis, and this can be uncomfortable.

From personal experience of pregnancy we suggest placing a small cushion under the belt. This in no way distorts the belt's position but makes it much more comfortable. Women will also find it reassuring when driving a car to have some protection, albeit psychological, between the bump and the steering wheel. The cushion is also useful between the lower abdomen and seat belt after a caesarean section and, indeed, any lower abdominal surgery with consequent scar.

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1 Pearce M. Seat belts in pregnancy. *BMJ* 1992;304:586-7. (7 March.)

2 Griffiths M, Usherwood M McD, Reginald PW. Antinatal teaching of the use of seat belts in pregnancy. *BMJ* 1992;304:614. (7 March.)

Cycling and health

SIR,—In reviewing the BMA's report *Cycling: Towards Health and Safety* Fiona Godlee correctly mentions that its recommendations are far from new.^{1,2} The unique relevance of cycling to the promotion of health, however, has been poorly recognised by the medical profession, probably because of an understandable concern about the consequences of encouraging cycling in the current hostile traffic conditions.

As the author commissioned to write the report, may I point out that, in addition to assembling much existing evidence on the wide ranging issues surrounding cycling (particularly the medical and health aspects), the report does break new ground. It includes an analysis aimed at relating the loss of life years through deaths of cyclists to the gain of life years through increased longevity from the improved fitness resulting from regular cycling. The analysis shows that the gains far outweigh the losses at present and could do so even more as the environment for cyclists is made user friendly.

This has implications for health and transport policies and, indeed, for policies on the environment and energy conservation. Far from it being irresponsible, owing to the risk of injury, to encourage the general population to transfer from motorised transport to the bicycle whenever