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... or elsewhere

EDITOR,—The report of the Interdepartmental Working Group on sensible drinking¹ has aroused critical comment.² The core recommendation is an increase in the safe limits for drinking from 21 units a week to 3-4 units a day for men and from 14 units a week to 2-3 units a day for women. The apparent aims are to discourage binge drinking and to promote health through moderate daily consumption.³

We investigated how drinkers had interpreted the new guidelines and what effect the guidelines would have on their drinking. Over the Christmas period we interviewed 100 randomly chosen people in 12 pubs in four areas of England. Ninety were aware that the guidelines on drinking had changed and were interviewed further. Of these, all believed that safe drinking limits had been increased. When asked to quote the new guidelines 47 gave the correct weekly totals; they all, however, gave a weekly, not a daily, limit. Nearly all the subjects (97%) said that the new guidelines would not affect the amount they drank or the pattern of their drinking. The others were occasional drinkers who said that they might increase their drinking because of the health benefits. When asked if the new guidelines would make them spread out their drinking more, only 3% said that they would.

We conclude from our survey that, whatever the intended effect of the guidelines, they have been widely misinterpreted. Despite this, nearly all our subjects denied that the guidelines would change their drinking habits.

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Civil servants should be congratulated for rejecting "whole population theory"

EDITOR,—Griffith Edwards's editorial¹ criticising the Department of Health's report *Sensible Drinking*² is misleading in asserting that the recommendation to raise the "safe" limits of alcohol consumption "was unsupported by either new analysis or new evidence." On the contrary, the report states quite explicitly, citing appropriate references, that the change in policy is based on a rejection of the "whole population theory" as promulgated most recently by a joint committee of the royal colleges chaired by Professor Michael Marmot. The specific question that needs to be addressed is whether the committee that produced the report was right to do this.

Although apparently representing the "current medical consensus," at least among public health academics, the whole population theory—otherwise known as the "population strategy"—is both scientifically and ethically highly contentious.³ The fundamental premise seems to be that the number of problem drinkers can be influenced by a small shift downwards in the average per capita consumption of alcohol, just as it is claimed that the incidence of stroke can be lowered by a small reduction in the per capita consumption of salt.⁴

Epidemiologists may find this an elegant solution, but there is no empirical evidence that such a strategy has ever worked—nor, in biological terms, is there any reason why it might do so.

The second problem is that ordinary people, to whom this type of health advice is presumably addressed, find the logic behind the population strategy difficult to grasp. While they can readily perceive that those people who harm their health by drinking to excess should cut down, they find it inconceivable that a reduction in their own modest intake should influence the heavy drinking of others.

The third disturbing aspect of the population strategy is that it legitimates—on allegedly scientific grounds—yet further interference by the state in ordinary people's lives: by definition, if the whole population is deemed to be "sick" then health advice must be directed at all the state's citizens.⁵

There are thus substantial reasons for disputing the population strategy, on the grounds that it is scientifically unproved, obscure, and illiberal. Rather than casting aspersions on the motivation and competence of the civil servants who drafted *Sensible Drinking* we should be congratulating them for calling the profession's bluff in rejecting the strategy.

In the meantime, doctors will no doubt get on with tackling the problem of alcohol dependence with the more traditional strategy (but one that at least has the merit of being practicable) of identifying those at high risk and helping them to cut down.

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Hepatitis B in the Chinese community in Britain

EDITOR,—E H Boxall commented recently¹ on the results of studies of screening for hepatitis B virus in antenatal clinics in the Netherlands² and recommended a policy of universal antenatal screening in Britain. We are concerned about policies as they affect the Chinese community in Britain, a population with a high prevalence of carriers of hepatitis B.

Other aspects of the policy for controlling hepatitis B in Britain besides universal antenatal screening need to be reinforced. Protection of infants born to mothers infected with hepatitis B relies on assiduous follow up of infants receiving immunisation against hepatitis B. We are aware of cases in which infants of carrier mothers have not been immunised or have received only incomplete courses of vaccine. Those at risk of infection by sexual contact also need protection. We have seen cases of acute hepatitis in partners of people of Chinese origin who are positive for hepatitis B e antigen. These cases occur as a result of a lack of knowledge and awareness of hepatitis B in the Chinese community and a failure of health care services to implement existing immunisation policies fully.

To raise the awareness of the communities most affected we recently undertook a limited exercise to inform the Chinese community of the risks of hepatitis B. We placed announcements in four Chinese newspapers and journals and on three radio and television channels used by the Chinese community. A telephone helpline was set up and

received calls from all parts of Britain. It was clear that there was much concern but a lack of knowledge about hepatitis B among many of those members of the Chinese community who responded.

It is estimated that, because of the constitutional changes that will occur in Hong Kong in 1997, up to 200 000 residents have been given permission to settle in Britain. The public health impact of such an influx may be substantial, and a re-evaluation of the size of the problem of hepatitis B in this and other ethnic minorities is required. In addition to Chinese people from Hong Kong there are many people from other countries in the region that have a high prevalence of hepatitis B (>7% positive for hepatitis B surface antigen), including Vietnam, China, Singapore, and Malaysia. Well targeted health promotion activity is needed to increase awareness both within these communities and among the health care professionals who serve them.

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Effect of paediatric retrieval service on clinical activity

EDITOR,—The correspondence¹ generated by the report by Joseph Britto and colleagues on a specialised paediatric retrieval service² prompts us to highlight the effect that such a service has had on our clinical activity. We have assessed the increased workload generated by our paediatric retrieval service by comparing the outside referrals to our unit over two consecutive two year periods, 1992-3 (before the start of the service) and 1994-5 (when the service was operating).

Comparison of data by calendar month (for example, January 1993 compared with January 1994) showed that the median number of patient episodes per month increased after the introduction of the service (20.0 v 35.5, $P < 0.0001$), as did the median number of bed days per month (83.0 v 177.5, $P < 0.001$, Mann-Whitney U test). Not only did the number of referrals for paediatric intensive care increase but a higher proportion of patients were retrieved (median retrieved each month in 1994 compared with 1995, 62.5% v 75.5%, $P < 0.03$), with two thirds of retrievals occurring between 1800 and 0800. Despite the large increase in patients being accepted for retrieval significantly fewer patients were refused admission (14/484 (3%) v 40/224 (18%), $P < 0.0001$, Fisher's exact test; odds ratio 6.1 (95% confidence interval 3.2 to 11.5)). Organisational changes to support this level of clinical activity have included the presence of two full time residents at night and the appointment of three full time fellows in paediatric intensive care.

We agree with A Raffles that local hospitals must not become deskilled as the care of critically ill

children becomes concentrated in large, tertiary paediatric intensive care units.¹ Training junior doctors in more than just the basic skills of resuscitation will be easier in centres with a high throughput of patients, and ultimately this will enable a higher standard of care to be delivered in local hospitals, where most of these doctors will eventually work.

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Premature coronary deaths in Asians

EDITOR,—Sandeep Gupta and colleagues discuss ways in which premature coronary deaths in Asians in Britain might be avoided.¹ When cooking, many people in India and Pakistan use a semisolid fat obtained by partially hydrogenating vegetable oils. This product, called vanaspathi or vegetable ghee, contains high levels of *trans*-fatty acids, which adversely affect blood lipid concentrations and are thus likely to increase the risk of coronary heart disease.²

As part of a pilot investigation conducted at the National Institute of Cardiovascular Diseases in Karachi to assess the feasibility of a case-control study we collected specimens of subcutaneous fat from 48 subjects. The samples were collected by a modification of the technique described by Beynen and Katan,³ stored at 70°C, and transported to the United States on dry ice. Fatty acids were extracted and analysed by capillary gas chromatography with a 100 m column. We found that the 14 subjects who used vegetable ghee for both cooking and frying had significantly higher percentages of *trans*-fatty acids and lower percentages of linoleic and linolenic acid in adipose tissue than the 21 subjects who used only non-hydrogenated vegetable oils (table 1). The adipose tissue of the remaining 13 subjects, who used a combination of different fats, had an intermediate composition.

These data indicate that consumption of vegetable ghee is associated with changes in the fatty acid composition of body fat that are likely to

increase the risk of coronary heart disease. Vegetable ghee is also consumed by south Asians who have settled overseas, and this may help explain their higher mortality from coronary heart disease.^{1,4,5}

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Information about prenatal testing does not necessarily increase uptake

EDITOR,—J G Thornton and colleagues report the effect of giving women extra, non-directive information about prenatal screening.¹ They found that ultrasound examination to look for structural abnormality in the fetus was almost universally accepted (99%) whereas screening for Down's syndrome was accepted by only about one third of the women.

In the first half of a normal pregnancy expectant women are usually offered a scan to enable them and their partner to see their baby, to check the baby's size, or to search for structural abnormality. A search for structural abnormality is not performed until 18-20 weeks, when most of the fetal organs can be assessed. If a woman would like to see her baby but considers abortion to be morally

wrong she can have a scan earlier in pregnancy. This is practical from 12-13 weeks, when the examination is brief and usually includes measurement of the baby's head, which may help the assessment of gestational age.² Additionally, the woman can choose to have a detailed ultrasound examination much later in pregnancy. If a structural abnormality is found at that stage she will be cared for jointly by a consultant obstetrician and a consultant neonatal paediatrician.

It is unclear if this information was available to the women in the authors' study before the first antenatal visit, an occasion when women face information overload.¹ Most women are aware of screening for Down's syndrome before they become pregnant and may have preconceived attitudes towards it; they are usually unaware of the scope of ultrasonography at different gestational ages in the first half of pregnancy.

I share the authors' suspicion that many women choose screening if to do so is perceived as normal. Experience has taught me, however, that uptake of screening for fetal structural abnormality at 18-20 weeks is less than 99% when women and their partners have had the opportunity to consider choices in ultrasonography before the first antenatal visit.

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One and two view mammography in breast cancer

Are carcinomas detected by one and two view mammography similar?

EDITOR,—Nicholas Wald and colleagues detected 24% more carcinomas with two view mammography than with one view mammography in the prevalence round of breast cancer screening, and they recommend that two view mammography should be standard practice.¹ They calculate the potential effect of this on mortality. Implicit in such calculations is the assumption that the behaviour of the carcinomas detected only by two view mammography is the same as that of the carcinomas detected by one view mammography.

The proportion of carcinomas that were invasive (rather than purely in situ) and 10 mm or less in diameter was similar in patients who had only one view mammography and patients who had only two view mammography. No comment is made about the pathology of carcinomas in patients who had two view mammography with one view interpreted by one radiologist and both views by another—which allows comparison of carcinomas detected only by two view mammography with the carcinomas detected by one view mammography.

For invasive carcinomas, standard pathological prognostic factors would be useful: tumour size, histological grade, histological type, and axillary nodal status. Although prognostic factors are less well defined for in situ carcinoma, the size, type, architecture, and grade or differentiation would be of interest. The study by Wald and colleagues has major implications for breast cancer screening. Ideally, carcinomas detected by one and by two view mammography would be compared with survival analysis, but this would require an enormous number of patients and long follow up. Pathology has been used as a surrogate marker in the assessment of breast cancer screening programmes. Full pathological details of all three

Table 1—Comparison of content of adipose tissue (expressed as percentages) in 48 subjects according to type of fat used for cooking and frying. * Figures are means (SD)

	Type of fat		P value (t test)
	Vegetable ghee (n=14)	Non-hydrogenated vegetable oil (n=21)	
Saturated fatty acids	26.89 (4.34)	26.34 (4.75)	0.73
Cis-monounsaturated fatty acids	43.99 (5.08)	40.86 (8.40)	0.22
Oleic	37.62 (3.53)	34.37 (8.66)	0.14
Cis-polyunsaturated fatty acids	16.03 (5.07)	21.61 (6.34)	0.01
Linoleic 18:2n-6	13.74 (4.90)	18.68 (5.65)	0.01
Linolenic 18:3n-3	0.60 (0.22)	1.07 (0.80)	0.02
Dihomogamma linolenic 18:3n-6	0.25 (0.08)	0.30 (0.11)	0.11
Arachidonic 20:4n-6	0.55 (0.30)	0.48 (0.19)	0.40
Long chain n-3 fatty acids	0.36 (0.11)	0.45 (0.20)	0.11
20:5	0.07 (0.06)	0.07 (0.05)	0.93
22:5	0.18 (0.07)	0.22 (0.09)	0.18
22:6	0.11 (0.06)	0.16 (0.09)	0.11
Total <i>trans</i> -fatty acids	4.99 (1.82)	3.41 (1.75)	0.01
Total 18:1 <i>trans</i>	3.92 (1.60)	2.65 (1.60)	0.03
Total 18:2 <i>trans</i>	0.96 (0.36)	0.63 (0.40)	0.02
Trans, trans 18:2n-6	0.13 (0.11)	0.13 (0.11)	0.83
Cis-9, trans-12 18:2n-6	0.59 (0.23)	0.33 (0.25)	0.005
Trans-9, cis-12 17:2n-6	0.24 (0.12)	0.17 (0.21)	0.26

*Thirteen subjects used a combination of fats.