We wrote to the cookery editor of each publication asking whether it had a policy on publishing recipes that required raw or lightly cooked eggs; three responded. One admitted that the publication did not publish warnings but intended to introduce them in future for high risk groups. The second claimed that a caption was printed next to high risk recipes. The third said that the publication printed a warning to vulnerable groups alongside recipes containing raw egg; we could find no such warning.

Clearly, many editors still do not appreciate the risk of salmonella infection from eating raw eggs. There seems to be some misapprehension that only high risk groups such as very young or elderly people may be at risk. Many of the people affected in outbreaks in which raw egg has been implicated have been young, previously fit adults.

Cookery writers are well placed to educate the public and to develop alternatives for recipes that require inadequately cooked eggs. Some alternatives, such as dried or pasteurised eggs, are not always easily available in retail outlets. If these products were widely promoted in recipes the increased demand would widen their availability and encourage safe cooking practices.

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- 1 Department of Health. *Salmonella and raw eggs*. London: DoH, 1988. (PL/CO(88)9.)
- 2 Advisory Committee on the Microbiological Safety of Food. *Report on salmonella in eggs*. London: HMSO, 1993.
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Health promotion advice in the private sector

EDITOR,—An 86 year old female patient of mine was given a cardiovascular risk assessment as a Christmas present by her family. This was done at a local private hospital and cost £50. The report does not mention her existing angina or osteoporosis as two major health problems. For her £50 she had her total cholesterol concentration measured (7.3 mmol/l, her body mass index calculated (26), and her blood pressure tested (160/90 mm Hg). She was told that she should lose 6.4 kg in weight and given detailed dietary advice on reducing her fat intake. Following this advice would not have lengthened her life but would certainly have made it more miserable. She was greatly relieved when I told her that she could ignore this and eat what she liked.

How can any sensible, coherent, and consistent health promotion advice be given to the general public when messages like this emanate from the private sector?

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Study leave difficult to fund

EDITOR,—Like many college tutors I am wrestling with the task of designing an educational scheme for my department's trainees that is compatible with time that they are available and with service demands. The senior house officers and registrars work the equivalent of a 72 hour on call rota. The mathematics of this means that there are occasions when they have complete days free of a service commitment. They may well be recovering from a busy night on call.

Senior house officers and registrars are entitled to up to 30 days' study leave each year. This, however, originated when the normal working week for trainees was frequently over 100 hours. Therefore the time that they could commit to training was considerably less than it is now. The hourly working week now is perhaps two thirds what it used to be. Has the time come to reduce the annual allocation of study leave to senior house officers and registrars to 20 days? I am sure that my department is not alone in finding it impossible to meet the financial demands of 30 days' leave with expenses.

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Failure to thrive

Define it carefully

EDITOR,—Harvey Marcovitch's review of failure to thrive was flawed in its failure to define the term satisfactorily.¹ In the wider sense failure to thrive can be defined as the failure of a child to fulfil his or her potential in terms of physical, social, and emotional growth and development. In the somatic sense, the term failure to thrive is usually applied to infants and preschool children to denote a failure to gain weight at an appropriate rate. In other words, the child is thin; typically, head growth is preserved relative to linear growth, and linear growth is preserved relative to body weight.

By contrast, short stature simply means height below the third centile and makes no assumption about the normality or otherwise of the child. Clearly, a child who is particularly short but proportionate will be below the third centile for weight as well as height without in any sense failing to thrive.

Growth failure can be defined as failure to achieve a height velocity appropriate for age and stage of development. A classic example of this is seen in acquired primary hypothyroidism (for example, Hashimoto's disease), in which initially at least the child will not necessarily be short and certainly will not be thin.

Failure to thrive, short stature, and growth failure may coexist but are separate entities that should not be confused. For example, in box 1 in Marcovitch's review (differential diagnoses in children who may be failing to thrive) a normal child with short stature cannot by definition be failing to thrive.

With regard to mid-parental heights, I agree that parents should be measured whenever possible but disagree that parents "tend to overestimate own height." Though men almost always do this, women usually underestimate it.

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- 1 Marcovitch H. Failure to thrive. *BMJ* 1994;308:35-8. (1 January.)

Persevere with breast feeding

EDITOR,—We believe that the information on managing failure to thrive in a breast fed baby given in box 6 of Harvey Marcovitch's article warrants further discussion.¹ If other causes have been excluded there is little point in test weighing the baby. This procedure is notoriously inaccurate² and will not assist in the management. It is essential to observe a breast feed.

To feed efficiently the baby needs to make a teat from both the nipple and the breast. If the baby is trying to feed from the nipple alone he or she will fail to compress the lactiferous sinuses underlying

the areola and will obtain most milk via the letdown reflex. The baby will thus fail to obtain the high fat (high energy) milk that comes at the end of an efficient feed.³ The mother's breasts may respond to inefficient use by either increasing or decreasing the volume, but unless the quality of the baby's "mouthful of breast" is improved the feeds will continue to be low in fat.

Discussion with the mother may establish that she is removing the baby from the breast after a set time rather than allowing the baby to terminate the feed by spitting out the nipple when satiated. (Until recently, mothers were told not to allow the baby to feed at one breast for longer than 10 minutes.) Such a practice can also lead to the baby failing to obtain the hind milk.⁴

In both instances the mother will indeed need "practical nursing advice"—that is advice on how to nurse her baby. Marcovitch's instruction to "discuss with the mother how important she regards breast feeding" seems to imply that she should be discouraged from continuing unless she is adamant that she wishes to do so. In view of the overwhelming benefits to the baby of receiving his or her mother's breast milk, surely the emphasis should be on helping the mother to solve her problem. The instruction shows what little confidence health care professionals now have in their ability to help a woman breast feed successfully.

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- 1 Marcovitch H. Failure to thrive. *BMJ* 1994;308:35-8. (1 January.)
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Risk factors for salmonella infection

Loss of gastric acid linked to candidiasis

EDITOR,—Keith R Neal and colleagues report that recent treatment with H₂ antagonists and gastric surgery predispose to salmonella infection, presumably as a result of reduced production of gastric acid.¹ A protective effect of gastric acid against the non-typhoid salmonellosis has been suspected.² Another potential infective complication of reduced secretion of gastric acid is candidiasis.

There have been anecdotal reports of both local and systemic candidal infections after various interventions that produce gastric hypoacidity, including partial gastrectomy, vagotomy, and treatment with H₂ antagonists^{3,4} and proton pump inhibitors.⁵ Because local candidal infections—for example, of the oesophagus—are often asymptomatic the risk of infection after inhibition of secretion of gastric acid is difficult to quantitate by case-control studies. Data from patients with systemic sclerosis suggest, however, that a combination of impaired oesophagogastric motility and reduced production of acid may particularly enhance susceptibility: candida was found in oesophageal brushings in 44% of untreated patients but in 89% of a subgroup of patients treated for oesophagitis with high dose ranitidine (> 300 mg/day) or omeprazole (40 mg/day).⁶ Such observations have prompted the suggestion that

secretion of gastric acid and physiological gastro-oesophageal reflux may protect against candidal infection.⁵

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- 1 Neal KR, Brij SO, Slack RCB, Hawkey CJ, Logan RFA. Recent treatment with H₂ antagonists and antibiotics and gastric surgery as risk factors for salmonella infection. *BMJ* 1994;308:176. (15 January.)
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- 5 Lerner AJ, Lendrum R. Oesophageal candidiasis after omeprazole therapy. *Gut* 1992;33:860-1.

Risk is higher in developing countries

EDITOR,—I agree with Keith R Neal and colleagues that treatment with H₂ receptor antagonists increases the risk of infections.¹ Colleagues and I have conducted studies indicating that people who take H₂ antagonists long term are at high risk of contracting infections, particularly with opportunistic pathogens such as *Candida albicans*² and *Strongyloides stercoralis*.³ This is probably more common in developing and underdeveloped countries because of the lack of safe drinking water; the chances of colonisation once the opportunistic organism is in the favourable environment produced by these antilulcer drugs are increased. In one study we found that in 20% of patients with duodenal ulcers receiving cimetidine treatment the ulcer did not heal and was colonised and invaded by *C. albicans*.² In our opinion this increased risk was not solely due to the hypochlorhydria or achlorhydria; these drugs also cause immune suppression through the T4 lymphocytes.² I believe that indiscriminate use of these drugs should be checked, especially in countries where safe drinking water is not commonly available.

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- 1 Neal KR, Brij SO, Slack RCB, Hawkey CJ, Logan RFA. Recent treatment with H₂ antagonists and antibiotics and gastric surgery as risk factors for salmonella infection. *BMJ* 1994;308:176. (15 January.)
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Clinical oncology information network

Population based registries remain valuable

EDITOR,—S J Karp describes initiatives by clinical oncologists to evaluate their work in cancer treatment centres in Britain.¹ This is an important step forward, but many patients with cancer are treated by general surgeons, physicians, or geriatricians in district hospitals. Sometimes cancer is diagnosed for the first time at postmortem examination. It is important to evaluate the treatment of all patients with cancer and not just those referred for specialist treatment, particularly in a system in which access to care is limited. Clinic based information systems may help to evaluate treatment provided by particular institutions but give an incomplete picture of care provided for people

with cancer in Britain. Karp is therefore incorrect to dismiss the use of data from cancer registries in the evaluation of cancer treatment. Population based registries are important sources of data for evaluating cancer care in Britain.

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- 1 Karp SJ. Clinical oncology information network. *BMJ* 1994;308:147-8. (15 January.)

Creating a database need not be slow . . .

EDITOR,—We agree with S J Karp that there is an urgent need for a national database covering the treatment of malignant diseases and their outcome for audit and research.¹ We have adopted a different approach to the development of a national audit database for malignant diseases from that adopted by the clinical oncology information network. Eighteen months ago a group of haematologists and oncologists formed a working party to create such a database to cover the range of malignant diseases treated in both haematology and oncology clinics. Money was raised through sponsorship by Schering-Plough to write the clinical case record and data collection module and the program for the central database of anonymised patient data. To ensure complete independence from sponsors and to maintain professional integrity, a charitable trust company (the Clinical Information Research Trust) has been established to raise development funds and steer the project.

After only 18 months from its inception the data collection system has been successfully piloted and is ready for distribution to hospital haematology and oncology departments. An ethics committee is being set up to monitor requests for access to data, which will be transmitted from individual clinical departments through a modem to the central database. The Information Management Group of the NHS Management Executive has agreed that this use of data is ethical so long as patients' identity is protected and patients benefit from the scheme.

The advantage of this approach has been the speed of implementation, with the additional benefit that clinicians can be introduced to the concept of computerised data collection as a part of everyday clinical work while the scope and complexity of the database continue to develop. The system has been designed with inherent flexibility so that specific studies can be supported by the addition of appropriate datafields for only a modest investment.

The independent constitution of the Clinical Information Research Trust has already attracted interest from national bodies doing research into leukaemia and is being considered as a method of collecting data for the Medical Research Council's leukaemia trials.

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. . . with investment from industry

EDITOR,—S J Karp outlines an initiative to set up a clinical oncology information network to carry out national collaborative audit.¹ Readers may be interested to learn of an initiative by the pharmaceutical company Schering-Plough: in 1990 we began to develop an audit database for haematology and oncology clinics, working closely with a small number of enthusiastic physicians. The database is administered independently of Schering-

Plough by the Clinical Information Research Trust and is overseen by an ethics committee of clinicians. Three hospitals began to use the system late last year, and 40 other centres have expressed an interest in being included in the network.

We have not seen the specifications for the clinical oncology information network, but the audit database for haematology and oncology clinics accommodates the minimum dataset specified for the network. Thus the database could serve the exact purpose described for the network but will be operational sooner.

Despite the increasing pressure under which the British pharmaceutical industry operates, much investment and innovation continue. At a time of limited resources for the NHS, academia, and the industry it does not seem wise for a competition to be taking place, the ultimate loser of which would be patients with cancer. Schering-Plough would welcome an approach from the developers of the clinical oncology information network to explore whether we can help speed up a network which we recognise is badly needed.

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Call for more confidential inquiries

EDITOR,—The confidential inquiry into perioperative deaths is proving to be one of the effective means of auditing surgical care. When is a similar system to be established for monitoring chemotherapy and radiotherapy? Most such treatment can be classified only as crude, and therefore an effective impartial overview is long overdue.

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Overruling the parents of child patients

EDITOR,—The trial of Dwight and Beverley Harris for the manslaughter by neglect of their 9 year old daughter, Nakhira,¹ should alert medical staff to the danger of failing to overrule parental decisions and the corresponding need to be fully familiar with correct legal procedure. The failure of the hospital team that diagnosed Nakhira's diabetes to shield her from parental neglect must cause concern. The legal powers available to protect her were extensive. Perhaps the time has come to rehearse them.

A doctor has a duty to provide medical care for his or her child patients. Normally, decisions about that medical care are the responsibility and right of each child's parents. As the House of Lords made clear in 1985,² however, when parents act against the interests of their child they lose the legal right to consent to or reject medical treatment. When doctors and the parents disagree about the course of action that will best serve the interests of a child "the court can decide and is not slow to act. . . . If there is no time to obtain a decision from the court, a doctor may safely carry out treatment in an emergency if the doctor believes the treatment to be vital to the survival or health of an infant."³

If there is time to involve the court, a court case in 1993 recommended application to the High Court for a "specific issue" order under section 8 of the Children Act 1989.³ The "most strenuous