cholesterolaemia is found and the decision is made to measure the low density lipoprotein cholesterol concentration. Many laboratories use an indirect measurement of this which requires knowledge of the triglyceride concentration. Consistent evidence that triglycerides have an important independent role in the prevention of coronary heart disease, however, remains elusive; calls for triglyceride testing must appeal to faith rather than established fact.

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Excessive expenditure of income on treatments in developing countries

EDITOR,—R J Hay and colleagues draw attention to an important issue for many developing countries—namely, excessive expenditure of limited disposable income on ineffective treatments.¹ Whereas in Mexico pharmacists, private doctors, and traditional healers seem to be most to blame,¹ in China the problem permeates the entire health care system.

The introduction of a market based economy into the health care system in China since the early 1980s has meant that health professionals and hospitals have to generate most of their income, including the salaries of staff in many cases. Central directives ensure that the cost of basic medical care (for example, consultation fees and bed occupancy) are kept low while profits are made almost entirely from charging for drugs and for the use of technology.

Drugs can be charged at a mark up of 15%, which leads to massive overprescription and in particular to excessive use of injections and infusions. This results in two extremes: the 15% of the population who have some health cover (mostly state employees) and rich people are showered with often useless medicines, while many poor people are afraid to seek health care because of inability to pay for the drugs that will be prescribed. In the middle are the majority, who waste limited resources on ineffective and sometimes dangerous treatments.

Our survey of village health clinics in Zhejiang province, eastern China, in 1993 showed that for upper respiratory tract infections in children an average of four drugs were prescribed at every visit. The drugs were usually a mixture of traditional Chinese and Western treatments, the Western treatments usually being antibiotics. In township hospitals an intravenous infusion is a standard treatment for upper respiratory tract infection and fever in children. The average annual per capita income in that part of China is about 750

yuan (13 yuan=£1). We estimate the drug cost per visit to be around 15-20 yuan; this increases if injectables or infusions are used.

The current funding mechanisms mean that health practitioners and hospitals cannot survive without this source of income. The problem will become intractable unless radical steps are taken to develop alternative strategies for funding health care.

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Protection afforded by cycle helmets

EDITOR,—Frank McDermott and John Lane defy engineering evidence in stating that cycle helmets reduce the risk of serious head injury in accidents involving motor vehicles.¹ Their study, however, looked only at people who had contacted health services after being injured and included no facts on the relative risk of injury with and without a helmet. Their data do not form a valid basis for their assertion.² They fail to mention the work of Spaite *et al.*, who studied cyclists attending a university trauma centre after being hit by cars. Both head and non-head injuries of people who had voluntarily been wearing helmets were less severe than those of people who had not been wearing helmets. Presumably people who voluntarily wore helmets behaved more cautiously in general, perhaps riding more carefully or being more likely to attend hospital after an accident.³ This sort of confounding means that studies of voluntary helmet wearing cannot test the hypothesis of protection conferred by helmets.

McDermott and Lane argue that the results of mandatory use of helmets in Victoria, Australia, support the suggestion that helmets have a protective effect against impact from cars. In the first year of compulsory use of helmets, however, cycle use decreased by about 40% while overall deaths of non-cyclists on the roads decreased by 25%.⁴ Both head and non-head injuries to cyclists decreased. We suggest that the information from Victoria is not adequate to indicate what, if any, effect compulsory use of helmets is likely to have on injury rates. Human behaviour is too confusing and complex for valid analysis in the face of insufficient numbers, inadequate information, inconstant underlying trends, and a poor scientific approach to data that are selectively quoted and potentially biased from the point of collection.⁵ The published work on Victoria displays all of these problems.

Many people find cycle helmets uncomfortable and expensive. Such helmets were never designed to give adequate protection against impact with a motor vehicle. Evidence suggests that compulsory use of cycle helmets would harm health by stopping people from cycling without affecting injury rates. Cycle helmets should remain a matter for free individual choice. Roads safe for everyone are the only real solution.

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Effects of health publicity on prevalence of smoking

EDITOR,—Joy Townsend and colleagues' study of the effects of price and health publicity on cigarette smoking used a broad definition of publicity, which may lead to misunderstandings.¹ The definition was, in effect, a measure of "everything else except price"—which, as the authors acknowledge, comprises a much wider range of influences than publicity alone.

The authors found that health publicity, as they defined it, had had relatively less influence on the smoking habits of more disadvantaged socioeconomic groups, so adding to inequality. The effect of mass communications—that is, health publicity as it is usually defined—seems, however, to depend on the medium used. For example, studies of rates of stopping smoking between 1950 and 1980 in the United States suggest that health scares in the 1950s, which were largely carried by the print media, had relatively little influence on the prevalence of smoking in more deprived groups relative to the population as a whole. These groups were much more responsive, however, to later publicity in the electronic media—especially the "fairness doctrine" antismoking campaign on television between 1967 and 1970.² Smokers in all social classes responded equally to Sydney's "quit for life" campaign on television in 1983.³

Television, which is generally watched more by members of social classes C, D, and E, is therefore a potentially class free medium for health promotion in comparison with the print media, though these probably have a correspondingly greater influence on decision makers.

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Vitamin K for neonates

EDITOR,—Mary Newburn and Rosemary Dodds discuss administration of vitamin K in relation to breast feeding.¹ Von Kries and Göbel have raised concerns about the efficacy of prophylaxis with oral vitamin K.² Oral administration is recommended because of the potential carcinogenic risk of parenteral administration in neonates. Surveillance data on late haemorrhagic disease of the newborn in Germany, however, suggested that the incidence of the disease increased after a switch from parenteral to oral prophylaxis. This is in sharp contrast to our data.

In the Netherlands it is recommended that all babies should be given 1 mg vitamin K orally or intramuscularly after birth and that breastfed

babies should thereafter be given either 25 µg daily or 1 mg weekly orally from 1 week until 3 months of age. All suspected cases of haemorrhagic disease of the newborn were collected by a surveillance system similar to that in Germany and Britain and based on active monthly reporting by all paediatric departments. From 1 October 1992 until 31 August 1994 no cases of serious bleeding or intracranial haemorrhage were reported. Only one case could be validated as idiopathic late haemorrhagic disease of the newborn.³ This was in a healthy 8 week old Turkish boy who was admitted with persistent nasal bleeding. He had been exclusively breast fed and had never received extra vitamin K.

Thus over 23 months only one case of idiopathic late haemorrhagic disease of the newborn was reported, in a boy who had not received prophylaxis. In the Netherlands an incidence of 7/100 000 was found before prophylaxis was introduced⁴; this is comparable to the incidence in Britain⁵ and Germany.⁶ As about 200 000 babies are born in the Netherlands each year and about 70% are breast fed it is striking that we did not encounter a single case in which prophylaxis failed; the surveillance system obtained a mean response rate of 90% (range 87-93%). In contrast, many cases of failure of oral prophylaxis were found in Germany, where a response rate of 77-88% was achieved.² We assume that this is because only two or three doses are given in Germany. In accordance with our data, the British Paediatric Surveillance Unit stated in 1993 that a considerable proportion of babies in Britain probably received repeated oral doses and that it had not been notified of any failure (unpublished report).

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Should obesity be treated?

Patients with sleep apnoea should be treated

EDITOR,—We believe that there are two further aspects to the problem of whether obesity should be treated.¹ Firstly, conditions in which obesity is life threatening and not just a marginal statistical risk must be considered. We frequently see patients with the obesity hypoventilation syndrome and respiratory failure. In these dangerously obese patients weight loss is critical if life expectancy is to be greater than just a few months. We take an aggressive approach to dieting in this condition and generally achieve a good response.

Secondly, obese patients who are a potential hazard to others should be treated. An appreciable number have the sleep apnoea syndrome, in which an excess of road traffic accidents occur because

patients fall asleep at the wheel. The driving authorities in Britain ban people with this condition from driving public service or heavy goods vehicles until they have received 12 months of effective treatment. We have seen more than 20 professional drivers (of buses, taxis, and heavy goods vehicles) who are unwilling to accept investigation or effective treatment for sleep apnoea because of the potential effect on their ability to drive and hence their standard of living. We have a major moral dilemma here. Should we inform the driving authorities about these patients or should patient confidentiality come first? It is difficult to resist the temptation to blackmail patients into losing weight with threats of driving bans.

We are faced daily with the problems of managing obesity in patients with disordered breathing during sleep. We feel duty bound to take an active approach to weight loss in view of the adverse effects of obesity on the patients and the community. We strongly support J S Garrow's proposal for community based slimming clinics, although, while women find these useful, our predominantly male patients with sleep apnoea decline to attend them.

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Amniotic band sequence in child of thalidomide victim

EDITOR,—Andrew P Read¹ and Richard W Smithells² dismiss W G McBride's hypothesis that thalidomide might be a mutagen.³ After this correspondence was published we saw a child with limb reduction defects born to a thalidomide victim.

The baby had the following isolated anomalies of the left hand: almost complete absence of the third and fourth fingers, with necrotic tissue attached to the tip, while the second finger had a deep constriction ring at the proximal phalanx with a hypertrophic distal segment and hypoplastic nail. Annular constriction was also present between the first and second phalanges of the thumb and was associated with a fibrous remnant; the fifth finger was normal (figure).

Pregnancy had been uneventful; ultrasound examinations did not show any limb defect, but a probable amniotic band was noted at the 22nd week of gestation. The mother, who was 34, had first been seen in 1986 when she received genetic counselling; her history showed maternal intake of thalidomide during the first trimester of pregnancy in 1959. Physical examination showed defects typical of thalidomide victims: bilateral symmetrical reduction defects of the arms (complete absence of the left forearm and hand with severe hypoplasia of the distal segment of the left

Limb reduction defect in baby born to thalidomide victim

humerus; absence of the right forearm with fusion of the hypoplastic humerus with a bony stump, possibly the radius, and the presence of only one finger) and shortening of the left femur, the rest of the legs being normal.

The birth prevalence of limb reduction defects in our region (north east Italy malformation registry, a EUROCAT local registry—EUROCAT is a European network for epidemiological surveillance of congenital anomalies) was 5.3/10 000 newborn babies during 1981-93, when 570 872 live births and stillbirths occurred. Three of the 304 cases were familial: two babies had a split hand or split foot malformation and one had a defect not due to thalidomide. In the same period only 10 cases due to amniotic bands, all sporadic, were registered. These data are not significantly different from those reported by other registries.^{4,5}

This is the third report of limb reduction defects in children of thalidomide victims; to our knowledge no anomalies other than limb reduction defects have been noted. These three reports raise the possibility that thalidomide could be involved in the cases. Read pointed out that thalidomide is unlikely to be a mutagen because a mutagen is not specific and thus malformations other than limb reduction defects should also be expected. Limb reduction defects could, however, be more easily reported than other defects because they are evident to the doctor, especially when a parent has a limb reduction defect. Furthermore, the hypothesised split hand or split foot deformity and Holt-Oram syndrome in the two cases reported by McBride could be the result of a new mutation.

Finally, although these three cases might have arisen by chance, a causal relation between limb reduction defects in the offspring of thalidomide victims and parental exposure to thalidomide cannot be excluded because the three cases are statistically unexpected on the basis of available epidemiological data and because the offspring of thalidomide victims are few (owing to the limited number of the victims and their presumed reduced fitness).

Thus retrospective and prospective studies should be carried out, especially because thalidomide is still used to treat leprosy.

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Resuscitation and patients' views

EDITOR,—N J Dudley suggests that the Medical Defence Union and the Medical Protection Society should re-evaluate their advice on cardiopulmonary resuscitation and expresses the view that our advice is "both ill considered and . . . incorrect."¹ If our advice had been quoted correctly we would accept his objection, but unfortunately it was not.