Pregnant women should wear seat belts

EDITOR,—Colleagues and I have previously highlighted the dangers of pregnant women failing to wear seat belts (or failing to wear them correctly) when travelling by car.¹⁻² In addition, we have shown that incorrect advice may be given by professionals.³ Our advice, which is supported by the Royal Society for the Prevention of Accidents, is still not being universally acted on by practitioners, some of whom still issue certificates that exempt pregnant women from wearing seat belts.

I have recently become aware of section 2 of the Congenital Disabilities (Civil Liability) Act 1976, which states:

A woman driving a motor vehicle when she knows (or ought reasonably to know) herself to be pregnant is to be regarded as being under the same duty of care for the safety of her unborn child as the law imposed on her with respect to other people; and if in consequence of her breach of that duty her child is born with disabilities which would otherwise not have been present, those disabilities are to be regarded as damage resulting from her wrongful act and actionable accordingly at the suit of her child.

This legislation—possibly uniquely—places a responsibility on the mother for the wellbeing of her unborn child. Any professional who wrongly advises a pregnant woman or issues a certificate that exempts a pregnant woman from wearing a seat belt may also be open to litigation. This may also be an issue for the woman's motor insurers. Professionals should encourage all pregnant women to wear correctly fitting seat belts; no one should encourage women not to do so.

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- 1 Griffiths M, Hillman G, Usherwood MMCD. Seat belt injury in pregnancy resulting in fetal death: two case reports. *Br J Obstet Gynaecol* 1991;98:320-1.
- 2 Griffiths M, Siddall-Allum J, Reginald PW, Usherwood MMCD. Road traffic accidents in pregnancy. Trauma-management and prevention. In: Studd J, ed. *Progress in obstetrics and gynaecology*. Vol 10. Edinburgh: Churchill-Livingstone, 1993: 87-100.
- 3 Griffiths M, Usherwood MMCD, Reginald PW. The use of seat-belts in pregnancy: the role of antenatal teaching. *BMJ* 1992;304:614.

Tobacco companies violated advertising restriction

EDITOR,—Despite its being a specific target in the Health of the Nation strategy, the prevalence of smoking among teenagers has risen in the past two years.¹ Three years ago the chief economic adviser to the Department of Health concluded that tobacco advertising increased tobacco consumption.² The government's response was to renegotiate the voluntary agreement limiting the advertising and promotion of tobacco.³ Assessment of whether advertisements "play on the susceptibilities of . . . the young and immature" or "incite people to start smoking" is difficult, but compliance with other, more easily measurable parts of the voluntary agreement can be used as an indirect measure of the industry's commitment to the code as a whole.

The revised agreement states that poster advertisements for tobacco will not be placed within 200 m of the main entrance to a school or be clearly visible from within the grounds of a school.³ A survey was carried out to assess compliance with this section of the voluntary agreement. The method used was the same as that used in a similar survey in 1993.⁴

One hundred and thirteen schools in Newcastle upon Tyne were identified from the local authority's listing in the telephone directory and were visited in a three week period in February-

March 1995. Poster sites were found to be within 200 m of the main entrance or clearly visible from the grounds of 20 of the schools, and these schools were visited monthly for a total of six visits (March-August). Any tobacco advertisements identified were photographed. By the end of the survey tobacco advertisements had been placed outside eight (40%) of the schools in violation of the ban. This compares with nearly two thirds of schools in 1993 but was at a time of rapidly falling spending on poster advertisements (by one third between April 1994 and March 1995 alone). It therefore seems unlikely that the tobacco industry is any more committed to the voluntary agreement now than it was then.

One high profile advertising campaign (the "Reg" advertisements) was shown to appeal almost exclusively to teenagers and was subsequently withdrawn,⁵ but it is only one of a series of humorous, cartoon-like advertisements for tobacco. Given the cost involved, it is unlikely that any other advertisements will be subjected to similar scrutiny. The public has to trust the tobacco industry not to produce advertisements that appeal to children and teenagers. If the industry fails to comply with easily measurable sections of the voluntary agreement how can we trust it not to try to persuade teenagers to start smoking? If the government is serious about reducing smoking it should ban tobacco advertising.

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- 1 Department of Health. *Fit for the future: second progress report on the health of the nation*. London: Department of Health, 1995.
- 2 Smeed C. *Effect of tobacco advertising on tobacco consumption: a discussion document reviewing the evidence*. London: Economics and Operational Research Division, Department of Health, 1992.
- 3 Department of Health. *Voluntary agreement on tobacco products' advertising and promotion*. London: Department of Health, 1994.
- 4 Guthrie B. Tobacco advertising near schools. *BMJ* 1994;308:658.
- 5 Hastings GB, Ryan H, Teer P, Mackintosh AM. Cigarette advertising and children's smoking: why Reg was withdrawn. *BMJ* 1994;309:933-7.

Hazards of β blockade

Pressor effects may be important

EDITOR,—If doctors follow Morris J Brown's recommendation that "until current trials tell us otherwise . . . doctors can be encouraged to use either type of β blocker"¹ then probably many more patients will be killed than the one described in the case report to which the final sentence of Brown's editorial ("One drop of timolol down the lacrimal duct can kill") refers.

For more than 10 years non-selective β blockers have been absolutely contraindicated in patients with chronic obstructive pulmonary disease, delayed hypoglycaemia, and severe triglyceridaemia. *Goodman and Gilman's Pharmacological Basis of Therapeutics* recommends that in pheochromocytoma non-selective β blockers should be used only after adequate α blockade has been established, to avoid an augmented pressor response to epinephrine; it adds that such effects can also occur in other situations that involve increased

sympathetic activity, such as hypoglycaemic reactions in patients with unstable diabetes or who smoke a lot.² In the past five years we have shown such pressor effects in prospective randomised double blind trials performed under stressful conditions, such as acute admission to hospital,³ surgery,⁴ and unstable angina⁵ (table). The pressor effect is not only reproducible in everyday practice but also greater than Brown suggests. In addition, β_2 blockade seems not to reduce blood pressure.⁶

We therefore think that it is justifiable to ask whether non-selective β blockers should be replaced by selective β blockers in patients with hypertension.⁷ In patients with angina things are more complex. On the one hand, non-selective β blockers may be better than selective ones at preventing cardiac arrhythmias. On the other hand, a pressor effect is disadvantageous because it raises the pressure-heart rate product, which is a direct estimate of myocardial oxygen demand. This might explain why, in secondary prevention studies, not only were non-selective β blockers slightly better than selective β blockers but this advantage was lost in smokers, since nicotine augments sympathetic activity.

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- 1 Brown MJ. To β block or better block? *BMJ* 1995;311:701-2. (16 September.)
- 2 Hofman BB, Lefkowitz RJ. Adrenergic receptor antagonists. In: Gilman AG, Rall TW, Nies AS, Taylor P, eds. *Goodman and Gilman's pharmacological basis of therapeutics*. 8th ed. New York: Pergamon Press, 1990:221-43.
- 3 Cleophas TJM, Stapper GJ. A pressor effect of noncardioselective beta-blockers in mildly hypertensive patients during acute hospitalization. *Angiology* 1990;41:124-32.
- 4 Cleophas TJM, van Asselt L, Oudshoorn N, Quadri S. A pressor effect of noncardioselective beta-blockers in mildly hypertensive patients during surgery under anaesthesia. *Angiology* 1991;42:805-11.
- 5 Cleophas TJM, van 't Leven M, Kaur FHW, Remmert HP, Kuiper A, Zwinderman K. Celiprolol versus propranolol in unstable angina pectoris. *Clin Pharmacol Ther* 1995;57:50-6.
- 6 Dahlöf B, Andren L, Svensson A, Hansson L. Antihypertensive mechanisms of beta-adrenoceptor antagonism: the role of beta-2-blockade. *J Hypertens* 1983;1 (suppl 2):112-5.
- 7 Cleophas TJM, Kalmansohn R. New arguments in favour of cardioselective beta-blockers. *Neth J Med* (in press).

Author's reply

EDITOR,—Ton J M Cleophas and Robert B Kalmansohn's letter is misleading. There is a twofold difference between the undisputed and sometimes fatal risk of asthma in patients taking a β blocker and the risks (if any) of the transiently higher blood pressure observed by the authors in a few patients admitted to hospital or undergoing anaesthesia. My editorial otherwise agreed with everything in the first half of their letter except for the implication that β_1 selective blockade does not cause asthma.

The second half of the letter also agrees with the editorial about the theoretical risks of β_1 selective blockade in angina and gives one of the theoretical reasons for preferring this in hypertensive patients.

Exaggerated pressor effect of non-selective β blockers (difference between effect of non-selective and selective β blockade) in patients under stressful conditions

	Systolic		Diastolic	
	Difference (range) (mm Hg)	P value	Difference (range) (mm Hg)	P value
Acute admission to hospital	27 (11-74)	<0.001	18 (8-62)	<0.001
Surgery	15 (12-43)	<0.05	9 (3-24)	<0.05
Unstable angina pectoris	10 (4-38)	<0.01	2 (0-15)	NS