elderly people may be the unrepresentativeness of patients enrolled in the major trials.

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Secondary prophylaxis after myocardial infarction

EDITOR.—In writing about secondary prophylaxis after myocardial infarction D L Whitford and A J Southern state that "β blockers should be given to all patients except those with active reversible airways disease, heart block, or heart failure, and treatment should be continued for at least one year and up to six years in the community."¹ Such dogmatism is not justified, and it would be alarming if such authoritarian statements were used as a criterion on which to evaluate the quality of care given by physicians. The opinions expressed are based on the interpretation of clinical trials. While these trials have clearly shown the prophylactic benefit of this treatment in the subjects recruited, they have included only a minority of the potential patients after infarction. Furthermore, many of those included in the trials had such a good prognosis that one can question the need for β blockade in similar cases.² As Chamberlain wrote recently, "In addition to the 30% of patients after infarction who may not tolerate β blockade, it may be reasonable to define another group of approximately similar size for whom β blockade is not indicated on grounds of good prognosis."³

Practice should certainly be based, when possible, on the results of good clinical trials. Interpretations, however, are not straightforward. One should be cautious about elaborating rigid rules on treatment and incorporating them into local protocols. It would be unfortunate if those physicians who believe that one can be selective about the use of β blockade after infarction were criticised or even penalised for not having achieved a questionable standard.

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Smoking in China

EDITOR.—I was heartened by the titles of the Editor's Choice and Ronald M Davis's editorial¹ in the issue of 8 October, which is dominated by articles on smoking. I wish to point out, however, that it is not enough just to slow the march of the Marlboro man; we should eliminate him

Antismoking slogan on packet of cigarettes

altogether. After a letter that I wrote, entitled "Marlboro man,"² was published in the *Medical Journal of Australia*³ I received quite a bit of hate mail.

During my latest visit to China, last June, I saw a photograph on the wall of the observatory opposite the tall television tower in Wuhan of the tower with a conspicuous sign advertising KENT painted on it. But when I looked at the tower itself the sign had disappeared. Apparently, a month earlier Dr M Z Chen, minister of public health in China, had visited Wuhan, seen the sign, and ordered its immediate removal.

Although we bemoan the deplorable statistics cited by Peto that one of every three cigarettes manufactured in the world is consumed by people in China,⁴ we can take pride in the strong antismoking campaign that Minister Chen has been waging.⁴ He is, however, fighting an uphill battle, because Mao Zedong was, and Deng Xiaoping is, a heavy cigarette smoker. But I was interested to note that in a newspaper that published a photograph of Deng smoking there was an equally prominent antismoking slogan printed on the next page, which said in Chinese, "Every time you smoke a cigarette you shorten your life by five minutes." Nowadays, all the cigarettes in China have to carry the same health hazard warning, whether in English or in Chinese, on their packaging (figure). So there is hope that "a smoke-free hospital can be achieved in China by year 2000."⁵

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Vaccination against hepatitis A for travellers

Will alter the dynamics of transmission in Britain

EDITOR.—R H Behrens and J A Roberts suggest that vaccination against hepatitis A is not cost effective and recommend that travellers should contribute more to the true cost.¹ This requires debate, but their work also raises several public health issues. Hepatitis A is endemic in Britain,^{2,3} and on average each case of infection results in one secondary case⁴; this is a feature common to infectious diseases, which allows them to persist. Hepatitis A associated with travel may cause few outbreaks because those most at risk (family and household members⁵) may have been protected against hepatitis A as they travelled at the same time. Not preventing hepatitis A would lead to an increase in secondary cases.

Mortality from hepatitis A increases with age,⁶ with the death rate per notified case in 55-64 year olds being 30 times higher than that in 15-34 year olds. Vaccination of susceptible elderly people is particularly important, and prior antibody screening makes this cost effective. Although nearly all elderly people were immune to hepatitis A some years ago, for new cohorts of this age group this will not be the case: 20-25% of 50-60 year olds are currently at risk of infection.⁷

Two and a half million people—more than 4% of the total British population—travel annually to areas where protection against hepatitis A could be warranted.⁸ Over five years this percentage would be greater. If large numbers of the population were vaccinated herd immunity would increase, with a subsequent reduction in the transmission of hepatitis A virus in Britain⁹; there would also, however, be an increase in the average age at infection and, more importantly, in the number of elderly people becoming infected, with a worse prognosis.¹⁰ Because of the low basic reproductive rate of hepatitis A⁴ (about 2¹¹) herd immunity needs to be increased by only a small amount to reduce endemic transmission in Britain appreciably. Because hepatitis A virus is commonly spread from child to child¹² protection of adults by vaccination as the only measure would not eliminate transmission.

Protection for foreign travel is unlikely to be withdrawn because the government could be accused of privatising the NHS. Whatever funding arrangements exist, vaccination will increase immunity to hepatitis A, which will alter the dynamics of transmission. The current policy has the potential to increase mortality and morbidity, and a full assessment of the implications of measures to control hepatitis A is required.

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All relevant costs and consequences should be measured

EDITOR.—On the basis of a comprehensive economic evaluation R H Behrens and J A Roberts conclude that "a national policy of immunising all travellers against typhoid and hepatitis A does not seem to be cost beneficial to the community."¹ While in principle such evaluations should help guide public health policy, considerable uncertainty surrounds many of the estimates used, and their conclusion should not compromise public health advice on the need for vaccination for certain categories of travellers.

Certain costs and consequences were not identified in the evaluation. The authors acknowledge the potential for outbreaks of typhoid and hepatitis A to occur but state that, on the basis of published data, there is no evidence to suggest that either infection is transmitted from returning travellers to the community. A lack of published evidence for such transmission does not, however, exclude its occurrence. Furthermore, many potential out-