Changes in the Health Education Authority

EDITOR,—Jack Warden chronicles the government's relation to the Health Education Authority and refers to the report produced under the chairmanship of John Lee, which was submitted to the government in November 1993.¹ He states that this report is thought to have advised drastic reform of the authority, if not abolition.

I was a member of the committee that produced the report; I have experience in health promotion as I was a director of public health at the time. While it is not appropriate to break the confidentiality of a report to ministers, some things should be put on record. The first is that the Lee report supported having a national agency in this field. This was also the view that emerged in evidence to us, notwithstanding criticisms of the Health Education Authority in some quarters. Another theme concerned the need to clarify the relation between the centre and the authority, which was widely seen as unsatisfactory. We hoped we could achieve the stable configuration that had eluded previous "reforms." A key goal was to ensure that a reconstituted agency would enjoy a productive partnership with those working in health promotion. We sought a clearer definition of its central role and a more sharply focused sense of its value in relation to the field. This was one of the areas in which the authority had been most criticised. The final aspects concerned the way in which the authority should deliver its functions. We tried to provide a more contemporary approach.

The delay between the submission of our report and the response by government is obviously unsatisfactory for the authority and was unexpected. The conclusion to be drawn from both the delay and the fact that what has emerged differs from that recommended is that the government has appraised these issues afresh.

With the changing roles of the regions, the executive, and the Department of Health after the functions and manpower review, there is cause for concern over whether the arrangements now proposed will achieve one of the Lee committee's goals—namely, the support and encouragement of effective health promotion. Collaboration is important. The revised Health Education Authority, as the Lee report envisaged it, was intended to have a constructive role. It is questionable whether an agency, relying on external funding to the extent that the new Health Education Authority must apparently do, can achieve that goal successfully.

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1 Warden J. Health education funding to go private. *BMJ* 1995;310:10-1. (7 January.)

Severe chickenpox during treatment with corticosteroids

At what age should varicella-zoster immunoglobulin be given?

EDITOR,—Philip Rice and colleagues state that "varicella zoster" immunoglobulin should be given to any patient in contact with varicella who has been treated with supraphysiological doses of corticosteroids, regardless of the duration of treatment, within the previous three months.¹ The authors recognise that children usually suffer relatively few problems from chickenpox (although that is not always the case, in particular among adolescents). Nevertheless, general practitioners and paediatricians now commonly prescribe prednisolone 1-2 mg/kg/day, for only a

few days, for acute exacerbations of asthma. Surely the authors are not advocating giving varicella-zoster immunoglobulin to children who have received such steroids in the preceding three months? The resource implications of this would be enormous with little cost benefit.

Paediatricians require clarification on this point. If Rice and colleagues do not advocate this as routine practice in children, at what age do they recommend its implementation?

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1 Rice P, Simmons K, Carr R, Banatvala J. Near fatal chickenpox during prednisolone treatment. *BMJ* 1994;309:1069-70. (22 October.)

Immunoglobulin should be given if steroid dosage was ≥ 0.15 mg/kg/day in preceding three months

EDITOR,—The report on near fatal chickenpox in a steroid user raises the importance of defining clearly, in mg/kg/day, the dosage of systemic steroid at which the scarce and costly varicella-zoster immunoglobulin should be given to non-immune steroid users in contact with people with chickenpox.¹ The authors of the report suggest prophylaxis for users of "supraphysiological" dosages of steroids but do not define these. The booklet *Immunisation Against Infectious Disease*² states clearly that immunoglobulin is deemed necessary at 2 mg/kg/day, but this may be pitched too high.³

Reports of fatal or severe chickenpox in steroid users⁴ have led the Committee on Safety of Medicines to advocate immunoglobulin for all non-immune patients taking systemic steroids "other than replacement" within the three months before exposure. The committee was unable, however, to state a cut off steroid dose at which prophylaxis becomes necessary.

The resource implications of treating every non-immune person who has taken any systemic steroids within three months are enormous. The current supply of varicella-zoster immunoglobulin may not suffice to meet such a demand. Furthermore, the time expended by health care staff in following up every non-immune contact who has taken any systemic steroid in the preceding three months is probably not justifiable in most cases and could cause much undue anxiety.

In cases of fatal or near fatal chickenpox of which I am aware and in which the dosage is recorded, a dosage ≥ 0.5 mg/kg/day has been given; these include the near fatality reported by Philip Rice and colleagues.¹ I therefore suggest, as a workable solution and until a more definitive dosage can be proposed, that we pitch the cut off point at 0.5 mg/kg/day within the previous three months.

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- 1 Rice P, Simmons K, Carr R, Banatvala J. Near fatal chickenpox during prednisolone treatment. *BMJ* 1994;309:1069-70. (22 October.)
- 2 Department of Health, Welsh Office, Scottish Office Home and Health Department, Department of Health and Social Services (Northern Ireland). *Immunisation against infectious disease*. London: HMSO, 1992.
- 3 Committee on Safety of Medicines and Medicines Control Agency. Severe chickenpox associated with systemic corticosteroids. *Current Problems in Pharmacovigilance* 1994;20:1-2.
- 4 Dowell SF, Bressee JS. Severe varicella associated with steroid use. *Pediatrics* 1993;92:223-8.

National guidelines exist

EDITOR,—Philip Rice and colleagues draw attention to the problem of severe chickenpox during treatment with corticosteroids and the need for

effective preventive measures.¹ We have addressed this issue in several ways.

The authors proposed recommendations to reduce the risk of further cases. National guidelines regarding the management of such patients were published in February 1994 in a bulletin sent to all British doctors and pharmacists.² The issue was also drawn to the attention of all doctors in the chief medical officer's update last May.³ These guidelines stated that all patients taking systemic corticosteroids for purposes other than replacement and who have not had chickenpox should be regarded as being at risk, irrespective of the dose or duration of treatment. The authors' statement referring to the national guidelines is misleading since it fails to make clear that patients who have had chickenpox are not at risk and therefore do not need varicella-zoster immunoglobulin. When this is indicated it should preferably be given within three days of suspected exposure, but it may be useful for up to 10 days. We do not recommend prophylactic acyclovir as an alternative to varicella-zoster immunoglobulin. The guidelines referred to in the handbook *Immunisation Against Infectious Disease*⁴ are being revised and will reflect the new recommendations. Subsequently, the handbook will be issued to all doctors in Britain.

A warning regarding chickenpox and other infectious diseases is among proposed changes to the patient held steroid card currently being considered by the Department of Health. Any proposals for change will be subject to consultation. Information for patients will also become available in leaflets provided with the medicine. The Medicines Control Agency has asked all pharmaceutical companies producing corticosteroids that are to be administered systemically to revise their product information to reflect the new recommendations and to introduce information leaflets for patients. Leaflets will include advice for patients on what to do if they have been in contact with people with chickenpox.

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- 1 Rice P, Simmons K, Carr R, Banatvala J. Near fatal chickenpox during prednisolone treatment. *BMJ* 1994;309:1069-70. (22 October.)
- 2 Committee on Safety of Medicines and Medicines Control Agency. Severe chickenpox associated with systemic corticosteroids. *Current Problems in Pharmacovigilance* 1994;20:1-2.
- 3 Department of Health. Corticosteroids and varicella-zoster virus. *Chief Medical Officer's Update* 1994 May:3.
- 4 Department of Health, Welsh Office, Scottish Office Home and Health Department, Department of Health and Social Services (Northern Ireland). *Immunisation against infectious disease*. London: HMSO, 1992.

Commercial assays have high false positive rate

EDITOR,—We agree with Philip Rice and colleagues' advice that immunocompromised patients (including all patients taking steroids) who claim not to have had chickenpox previously or are uncertain whether they have had it should be tested for antibodies to varicella zoster virus.¹ We advise caution, however, with regard to use of the latex agglutination assay.

Over the past 19 months we received 32 serum