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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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

samples from various laboratories in the south east that used a commercial latex agglutination assay. These were referred to us for confirmatory testing by indirect enzyme linked immunosorbent assay (ELISA)²; 11 gave discrepant results (table). If equivocal results are treated as negative then seven patients (four with negative and three equivocal results in the latex assay) would have been wrongly considered to be negative for the antibody if confirmation had not been sought (a false negative rate of 7/32 (22%). Only five serum samples that yielded a positive result in the latex assay were referred to us, and these were all positive on ELISA.

Comparison of results obtained with latex test and ELISA for antibodies for varicella zoster virus

	Result of ELISA			Total
	Negative	Equivocal*	Positive	
Result of latex test:				
Negative	16	1	4	21
Equivocal	3	0	3	6
Positive	0	0	5	5
Total	19	1	12	32

*Equivalent results of ELISA should be regarded as negative for clinical purposes.

A working party of the Public Health Laboratory Service is currently assessing commercial assays to detect IgG antibody to varicella zoster virus. Although latex agglutination has compared well with immunofluorescence in the United States,³ we recommend that, until the results of the working party's study are available, all serum samples that yield negative results on latex testing should be retested with more sensitive assays. This will save unnecessary use of zoster immunoglobulin and acyclovir in the event of exposure. Even in urgent cases—that is, those in which testing is done after exposure—there is usually sufficient time to refer serum samples to laboratories that can offer rapid confirmatory assays since zoster immunoglobulin can be given up to 10 days after exposure,⁴ not 72 hours as stated by Rice and colleagues.

We question the acceptability of a 1-2% false positive rate when better tests are available. A false positive result may have serious consequences for an immunocompromised patient. Health care workers are also a large group screened for immunity to chickenpox; unexpected chickenpox in a health care worker can cause considerable problems of infection control.⁵

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Authors' reply

EDITOR,—Paul Buss and Isobel Burnett express concern about our recommendation that varicella-zoster immunoglobulin should be given to non-

immune patients exposed to chickenpox who have received systemic steroids within the previous three months, a recommendation made by the Committee on Safety of Medicines earlier last year.¹ Depression of cell mediated immune responses occurs within four to six hours of administration of steroids. Therefore a short course of steroids given within the incubation period of chickenpox might impair host responses.² Even if short courses of steroids (less than five days) are given during the incubation period of chickenpox, severe and sometimes fatal infection occurs more commonly.³

We are therefore reluctant to alter our recommendations, although we accept Buss's and Burnett's point that the recommendations by the Committee on Safety of Medicines are likely to have considerable implications for supplies of varicella-zoster immunoglobulin. Although a history of chickenpox or detection of antibody will allow prophylaxis to be targeted more effectively, augmentation of these supplies should be considered. Blood donors are altruistic and could be reminded to donate blood if they have recently had chickenpox or shingles, thereby increasing supplies of varicella-zoster immunoglobulin. Alternatively, if the varicella vaccine now under review by the Food and Drug Administration in the United States was licensed in Britain the incidence of chickenpox would decline.⁴ This vaccine would also protect susceptible health care workers, who might otherwise transmit infection to others, including those receiving corticosteroids.

Donna Ellender and colleagues state that we failed to emphasise that patients who have had chickenpox are not at risk and therefore do not require prophylaxis with varicella-zoster immunoglobulin. We not only stated that a history of chickenpox should be ascertained, as this correlates reliably with past infection and immunity, but also emphasised this by stating that patients shown to be seronegative must be told that they are at risk of serious complications of chickenpox. This point was reiterated in the lesson. The Medicines Control Agency and Department of Health propose to issue a warning regarding chickenpox and other infections in a new patient held steroid card; serious complications of chickenpox have been known for a long time, and the recommendations are long overdue.

Cost-benefit analyses seem to have convinced the American Academy of Pediatrics and the Advisory Committee for Immunisation Practices to recommend vaccination of susceptible children, adolescents, and adults if the vaccine is licensed.⁵ This would overcome the increased morbidity and mortality associated with chickenpox among children receiving only modest doses of corticosteroids for asthma.

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Managing ulceration of the breast

EDITOR,—The article on the management of breast infection includes, under the heading "skin associated infection," a photograph of a previously irradiated breast showing longstanding telangiectasia within the radiotherapy field and a central area of ulceration of the skin.¹ Although this is described as cellulitis, the features are typically those of cutaneous radionecrosis,² which may be further complicated by an underlying osteoradionecrosis. We are concerned that the article is misleading as management with antibiotics and dressings would rarely produce a stable wound. We suggest that consideration should therefore be given to excision of the area affected and reconstruction with a local or distant flap.³

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2 Lipsztein R, Dalton JF, Bloomer WD. Sequelae of breast irradiation. *JAMA* 1985;253:3582-4.

3 Slavin SA, Love SM, Sadowsky NL. Reconstruction of the radiated partial mastectomy defect with autogenous tissues. *Plast Reconstr Surg* 1992;90:854-65.

Author's reply

EDITOR,—The example of cellulitis after radiotherapy in my article (reproduced in the figure (top)) was from a patient who in 1983 was treated for a cancer of the right breast by mastectomy, immediate reconstruction with a subpectoral prosthesis, and postoperative radiotherapy. In 1993 she presented with three areas of ulceration over the implant; the prosthesis was protruding through one of these areas and was removed in the outpatient clinic. The figure (top) shows cellulitis affecting the chest wall after the prosthesis was removed. Treatment with co-amoxiclav produced resolution of the cellulitis within two weeks (figure (bottom)).

Culture of material from the ulcerated areas yielded *Staphylococcus aureus*, which confirmed the clinical impression that infection was present. Although excision of the damaged area was

Cellulitis of right breast before (top) and after (bottom) a course of co-amoxiclav. Note resolution of erythema. Areas of ulceration healed after resolution of infection