- 1 Hatton MQF, Allen MB, Vathenen AS, Mellor E, Cooke NJ. Does sedation help in fiberoptic bronchoscopy? *BMJ* 1994; 309:1206-7. (5 November.)
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No grounds for abandoning sedation

EDITOR,—M Q F Hatton and colleagues suggest that in the case of fiberoptic bronchoscopy "routine sedation has little part to play in patients undergoing a single diagnostic procedure."¹ The patients in their study received both lignocaine and intravenous atropine before placebo or a sedative agent if the order reported was the order of administration. The taste of lignocaine and the side effects of atropine, the administration of which is questionable, are themselves distressing to some patients. It would have been more appropriate to give the sedative before these drugs, thus allowing the sedation to encompass the whole procedure. In addition, the operators found the procedure easier with sedation. Might this not have resulted in improved biopsy technique and yield?

There are no grounds for abandoning sedation on the basis of the findings of this study.

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Immunisation against chickenpox

Pregnant women should be screened

EDITOR,—Lainie Friedman Ross and John D Lantos recommend that immunisation against chickenpox should be confined to those at high risk.¹ While they acknowledge the risk to susceptible pregnant women and their fetuses, however, they seem to include only immunocompromised children in their high risk category.

Even without the possible effects of a universal immunisation programme the average age at infection is showing a natural shift upwards,² and significant numbers of females of childbearing age are being infected.³ Antenatal patients are already screened for syphilis and for antibody to rubella. Would it not be prudent to screen those without a definite history of chickenpox for immunity and to offer immunisation to susceptible mothers postnatally?

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Good argument exists for universal vaccination

EDITOR,—We wish to make three comments in response to Lainie Friedman Ross and John D Lantos's editorial on immunisation against chickenpox.¹ Firstly, the implicit general proposition that a disease must be potentially fatal or at least a source of serious morbidity to justify prevention by vaccination is hardly tenable in a profession whose objective is to improve quality of

life. If a vaccine has been proved to be safe the ideal circumstances is for it to be available to all citizens at possible risk of the disease.

Secondly, the posited detrimental outcome of the possible waning of the effect of childhood vaccination is based on an assumption that "illness and teratogenicity" will be more common and more severe in vaccinated patients than unvaccinated or previously infected patients. There is no evidence to support this view from studies of live attenuated varicella zoster vaccines.^{2,3}

Finally, one of the main consequential problems of chickenpox is herpes zoster in adults and particularly neuralgia after herpes zoster. In the experience of one of us (GRBS) this is one of the most intractable problems not related to cancer that arises in clinical practice; it seriously prejudices the last years of elderly—usually quite elderly—patients: GRBS has failed to find a therapeutic strategy that appreciably relieves neuralgic symptoms. Present thinking would argue that if chickenpox was prevented then herpes zoster would not occur. We contend that an effective inactivated varicella zoster vaccine might be preferred to a live vaccine, and as there is already one report of herpes zoster after vaccination⁴ it is difficult to exclude the possibility that the vaccine virus or a recombinant vaccine field virus might result in herpes zoster in later later life. A mixed regimen with a primary inactivated vaccine—to prevent colonisation of the ganglia by live attenuated virus—followed by a live attenuated virus vaccine might be a useful compromise.⁵

On these grounds we believe that there is a good argument for universal vaccination against chickenpox and that until further evidence is available, inactivated vaccines may be the safer option.

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- 1 Friedman Ross L, Lantos JD. Immunisation against chickenpox. *BMJ* 1995;310:2-3. (7 January.)
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Authors' reply

EDITOR,—We agree with D S G Sloan that women of childbearing age are at high risk of serious chickenpox. In fact, both male and female adolescents and young adults who are not immune are at high risk. We question, however, whether the upward shift in the average age at infection is a true trend. Although epidemiological studies of military recruits in the United States have found a rising rate of seronegativity for varicella zoster virus,¹ this can be explained both by the increased number of recruits from island nations or territories where chickenpox has always occurred at older ages^{2,3} and by known associations between seronegativity for the virus and race and sex.⁴ Sloan's citation of the advancing age at infection in the British population⁵ does not address the question of whether it is more than a reflection of the increasing number of immigrants from tropical countries or other changing demographic features.

We also agree with Sloan's recommendation that voluntary immunisation should be offered to susceptible mothers postnatally. We would go one step further and recommend that varicella vaccine

should be given to all susceptible people at high risk, including (but not limited to) immunocompromised people and their families, health care workers, those taking care of small children, women of childbearing age before pregnancy, military recruits, and college students. Our recommendation is not, as Gordon R B Skinner and Judith Davies suggest, to deny varicella vaccine to any group, only to reject routine immunisation of healthy young children at low risk.

Finally, Skinner and Davies's concern about neuralgia after herpes zoster in elderly people is valid, but the commercial vaccines that are available do not prevent herpes zoster.⁶ If a varicella vaccine offering lifelong immunity and preventing herpes zoster becomes available then we will reconsider our recommendations against universal vaccination.

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Spontaneous fractures in cerebral palsy

EDITOR,—Last year a patient of ours presented to hospital with a chest infection. She was 19 years old, had cerebral palsy, and at the time was chronically malnourished because of feeding difficulties. On the day after the girl's admission her mother noticed a change in her behaviour and that she was sitting on a bean bag in a position that her mother thought was uncomfortable. Later it was realised that her thighs were swollen. Subsequent x ray films showed an oblique fracture of the left femur and a greenstick fracture of the right femur. The fractures were recent and the bones demineralised and thinned.

Had this child had only one fracture we might have considered that it was a spontaneous fracture. Probably, however, she had been put on the bean bag by a member of staff who did not appreciate her physical deformity and tried to put her in a "good" position. Her mother, visiting shortly afterwards, was aware of her daughter's mood change—something difficult for staff meeting the child for the first time to appreciate.

Given the history of this case, we suggest that S Lingam and Jane Joester may be incorrect in describing as spontaneous the fractures that they report.¹ Our patient was cared for at home, and her father commented that she liked her legs to be passively moved, flexed, and extended. Forced abduction and external rotation to achieve a "good" sitting position probably caused the fractures.

We have previously seen a 12 year old boy with microcephaly and spina bifida and an unexplained fracture of the femur; he was malnourished and had thin bones. His fracture occurred while his