wellbeing but is potentially counterproductive to promotion of breast feeding.

I suggest the following amendments to the author's key messages:

- First assess whether the heel prick is really necessary
- Minimise the discomfort of the procedure by asking the parent (or member of staff) to cuddle and soothe the baby
- If the mother is breastfeeding encourage her to put the baby to the breast before the procedure starts and allow the baby to suckle during the procedure

Lastly, before drug manufacturers seize a new opportunity to market prepacked phials of sterile sucrose solution, complete with dropper, could I urge the authors to consider mounting a study to answer their own query—namely, “whether simply cuddling a crying infant after heel prick is as effective in reducing crying as 50% sucrose.” It may be that going back to the basics is all that is needed.

CORAL JEPSON
Primary health care information officer

Appropriate Health Resources and
Technologies Action Group,
London EC1M 3JB

- 1 Haouari N, Wood C, Griffiths G, Levene M. The analgesic effect of sucrose in full term infants: a randomised controlled trial. *BMJ* 1995;310:1498-500. (10 June.)
- 2 WHO/Unicef. *Protecting, promoting and supporting breast-feeding: the special role of maternity services. A joint WHO/Unicef statement.* Geneva: WHO, 1989.
- 3 Woolridge M. The baby friendly initiative UK. *Modern Midwife* 1994;15(5):32-3.

Are sugar pills unsuitable placebos?

EDITOR,—Now that a solution of 50% sucrose has been shown to have analgesic properties in babies,¹ I believe it is time to discard all those trials where lactose has been used as a placebo.

A FERRIS
General practitioner

Potter's Bar,
Hertfordshire EN6 2RG

- 1 Haouari N, Wood G, Griffiths G, Levene M. The analgesic effect of sucrose in full term infants: a randomised controlled trial. *BMJ* 1995;310:1498-500. (10 June.)

Adult survivors of child sex abuse

Group therapies are also effective

EDITOR,—In their paper on the pilot service, Breakfree, for adult survivors (both men and women) of childhood sexual abuse David Smith and colleagues leave some points unclear.¹ How many support workers were there, and how professionally trained were they? They were “initially supervised,” but by whom and for how long? The average duration of a counselling session was 1.8 hours (no range was given), sometimes twice weekly. This seems a lavish use of resources. The scheme was found to be successful in this study, but care would have to be taken in replication to ensure the quality of supervision and counselling.

In testing the differences between scores at the start and end of treatment the authors have emphasised hypothesis testing by quoting *z* and *P* values. It would have been helpful, however, if they had given summary statistics, such as the median scores and percentile ranges, and indicated the magnitude of the differences by calculating confidence intervals for the differences.² Finally, we are not told how the sum of £70 000 was arrived at as the cost of the year's pilot scheme.

In the psychological therapies service in Southampton we have been treating women

survivors of childhood sexual abuse in a weekly analytic group of one and a half hours' duration since January 1986. The learning from group therapy for these patients is particularly rapid, probably because they find that their experiences are not unique and they therefore feel less isolated. A clinical account of the first 94 patients admitted to the group from the 235 referred up until August 1990 has been published.³ Their depressive inventory score fell during their time in the group, and the fall was maintained for between two and seven years afterwards and was independent of treatment with antidepressants. Their use of psychiatric hospital and primary care services was also reduced over five years' follow up.⁴

It will be interesting to know if the improvement during the Breakfree programme is maintained at follow up and whether it depends on continued contact with the service. If so, the cost will increase with time.

We are now estimating the cost of our method of treating women survivors. It would be useful to be able to compare the cost and effectiveness of the two methods of dealing with this vast source of psychological distress.

ZAIDA HALL
Honorary research fellow

Department of Psychiatry,
University of Southampton,
Royal South Hampshire Hospital,
Southampton SO9 9PE

MARK A MULLEE
Senior statistical programmer

Medical Statistics and Computing,
University of Southampton,
Southampton SO9 4XY

CHRIS THOMPSON
Professor of psychiatry

University of Southampton,
Royal South Hampshire Hospital,

- 1 Smith D, Pearce L, Pringle M, Caplan R. Adults with a history of child sexual abuse: evaluation of a pilot therapy service. *BMJ* 1995;310:1175-8. (6 May.)
- 2 Gardner MJ, Altman DG. Confidence intervals rather than *P* values: estimation rather than hypothesis testing. *BMJ* 1986;292:746-50.
- 3 Hall Z. Group therapy for women survivors of childhood sexual abuse. *Group Analysis* 1992;25:463-75.
- 4 Hall Z, Mullee M, Thompson CA. A clinical and service evaluation of group therapy for women survivors of childhood sexual abuse. In: Aveline M, Shapiro D, eds. *Research foundation for psychotherapy practice.* Chichester: Wiley, 1995:263-79.

Authors' reply

EDITOR,—Our study was an audit of a pilot scheme set up in response to identified needs of adult survivors requesting one to one “abuse focused” therapy in a community setting. Because of the diversity of long term effects of child sexual abuse, survivors will require and request therapy to suit their individual needs at a particular stage of their healing process. Our “imaginative” client led, community based, interagency pilot scheme reflects one sensitive and appropriate approach that clients found to be successful.

The pilot scheme had 12 sessional support workers, all of whom received training from specialists in treating adult survivors, such as Dr Liz Hall, a consultant clinical psychologist; training in issues concerning child protection and offenders' behaviour, provided by Lincoln social services' training department; and training in humanistic counselling. All staff initially received frequent debriefing by peers in addition to regular supervision (conforming to the guidelines of the British Association for Counselling) from fully qualified psychotherapists and psychologists.

Contracts for therapy were negotiated to meet individual need and ranged from half an hour a week to two two-hour sessions a week. Such flexibility of approach facilitated disclosure and allowed the clients to regain their composure before leaving the building.

The year's budget for the pilot scheme was £70 000, but this did not include any costs for the

infrastructure. The Breakfree Service for Adult Survivors is now operating as an independent service but still maintains a competitive costing structure. The pilot scheme was funded for only a year, and no provision was made for long term follow up. We now intend to continue evaluating the approach and to monitor long term outcome, perhaps with comparative studies.

DAVID SMITH
Director

LINDA PEARCE
Coordinator

Breakfree Service for Adult Survivors,
Lincoln LN2 2JP

MIKE PRINGLE
Professor

Department of General Practice,
Queen's Medical Centre,
Nottingham NG7 2UH

RICHARD CAPLAN
Consultant

Department of Psychiatry,
Southern General Hospital,
Glasgow G51 4TF

Protecting adolescent girls against tetanus

Targeting both sexes may avoid misunderstandings

EDITOR,—As a surgeon working in the developing world, but home on leave, I would like to comment on the editorial by Loretta Brabin and colleagues.¹ In our rural area in Cameroon we see at least as many teenage boys with tetanus as we see girls, possibly because of their hunting and outer outdoor pursuits. The incidence in men is certainly higher than in women, because of the number of women protected through antenatal care.

A few years ago a campaign to protect teenage girls went sadly wrong due to insufficient education of the community before the campaign. Because the campaign was aimed only at girls, a rumour started that these injections were of a long term contraceptive. The rumour was taken up by some religious leaders and believed by the girls and resulted in a sharp increase in pregnancies among school students.

For both these reasons it is preferable to target primary school leavers of both sexes. I know more toxoid would be needed, but the cold chain and staff could deal with both groups as many primary schools are coeducational. Those not attending school at all should also be targeted as they usually drop out after the infant course and do not come for the booster dose five years later. Since the cold chain is of variable efficiency some of the doses given may have been ineffective and an extra dose is therefore better than one dose too few.

ANNE SEYMOUR
Medical officer in charge,
St Martin de Porres Hospital

144 Harton House Road,
South Shields NE34 6EA

- 1 Brabin L, Kemp J, Maxwell S, Ikimalo J, Obunge O, Briggs N. Protecting adolescent girls against tetanus. *BMJ* 1995;311:73-4. (8 July.)

Induced abortion can predispose to tetanus

EDITOR,—As participants in the course for the diploma of reproductive health for developing countries at the Liverpool School of Tropical Medicine, we read with interest the article by Loretta Brabin and colleagues.¹ Four of the six participants on the course have had experience in managing a total of seven patients with post-abortion tetanus in three countries (table).

These seven women were admitted with tetanus following induced abortions, usually undertaken by a traditional abortionist. These cases illustrate that antenatal vaccination alone misses women

Outcome in women with tetanus after induced abortions

Country	Year	Age	Gravidity	Outcome
Bangladesh	1982	18	Primipara	Died
	1988	28?	Multipara	Died
	1991	32?	Multipara	Died
	1994	36	Multipara	Died
Nigeria	1986	19	Primipara	Survived
	1988	24	Multipara	Died
Pakistan	1989	19	Primipara	Died

who are at high risk of developing maternal tetanus. This is because women (especially teenagers) with unwanted pregnancies often do not attend for antenatal care and may resort to unsafe abortion.

On the basis of our personal experience we support the authors' proposal to include adolescent girls as a target for vaccination for tetanus toxoid. This strategy would substantially reduce the rates of maternal mortality in young women from maternal tetanus secondary to induced abortion.

SAYEBA AKHTER
Consultant obstetrician and gynaecologist

Mymensingh Medical College,
Mymensingh,
Bangladesh

CHRISTINE EDWARDS
Obstetrician

LAMB Hospital,
DT Dinajpur,
Bangladesh

JOHN IKIMALO
Consultant obstetrician

University of Port Harcourt,
Port Harcourt,
Nigeria

SHANI PANEZAI
Demonstrator in community medicine

Quetta Bolan Medical College,
Pakistan

1 Brabin L, Kemp J, Maxwell S, Ikimalo J, Obunge O, Briggs N.
Protecting adolescent girls against tetanus. *BMJ* 1995;311:
73-4. (8 July.)

Nestlé obeys Indian label laws

EDITOR,—It is disappointing that a professional journal like the *BMJ* should print stories in an obviously slanted way, and the inaccuracies of Claire Lockwood's news report¹ need to be corrected.

The Indian court case is a direct result of a conflict between two laws which will have to be determined by the government or by the courts. One law requires the labels to contain the statement, "Breast milk is best for your baby," while the other requires "Mother's milk is best for your baby." It is clearly right that the law should be observed, and either is equally acceptable to Nestlé. The issue is of no significance to the health of infants, which is presumably everyone's prime concern.

Similarly, your reporter misrepresents the issue of language. The Indian government determines the language of the labels and these laws are adhered to by Nestlé. Although this is not a legal obligation, almost all Nestlé labels for products dealing with infant feeding are printed in both English and Hindi, and they include pictorial instructions for those who cannot read. Some other infant formula products in India have until recently had labels in English only, and we are aware of no court action against these manufacturers. The language "problem" is not about instructions or warnings, as your readers may expect, but only concerns the one phrase about which there remains doubt within the law—which Nestlé prints in both English and Hindi.

Lockwood does not identify the "potentially misleading instructions" mentioned. There are none.

Nestlé adheres fully to the WHO International

Code and to Indian law. We fully investigate all allegations and guarantee swift response and action if required. It is noteworthy that none of the complaints against Nestlé are made by the Indian government or regulatory bodies of the health and paediatric services. Nestlé's reputation in this field is the highest in India. It is sad that the *BMJ* does not pursue balanced reporting on this as in other matters.

DENISE BRIGGS
Specialist in dietetics

Corporate Affairs Department,
Nestlé UK Ltd,
Croydon,
Surrey CR9 1NR

1 Lockwood C. Nestlé appears in court in India. *BMJ* 1995;311:
348. (5 August.)

Non-Hodgkin's lymphoma and skin cancer

Ultraviolet light is unlikely explanation for association

EDITOR,—Johanna Adami and colleagues provide data showing a greatly increased risk of melanoma and squamous cell skin cancer after non-Hodgkin's lymphoma and chronic lymphocytic leukaemia.¹ They also show a smaller but significantly increased risk for the reverse (non-Hodgkin's lymphoma and chronic lymphocytic leukaemia after skin cancer). They conclude that "this supports the hypothesis of a role for ultraviolet light in the increasing incidence of non-Hodgkin's lymphoma." We believe that this inference lacks justification, particularly since the relative risk of non-Hodgkin's lymphoma and chronic lymphocytic leukaemia associated with ultraviolet light would have to be of similar magnitude to that of melanoma to explain the substantial increase in the incidence of non-Hodgkin's lymphoma and chronic lymphocytic leukaemia (even after correction for changes in diagnosis).²

Geographical correlations of rates of melanoma (*International Classification of Diseases, Ninth Revision* (ICD-9) code 172) and non-Hodgkin's lymphoma and chronic lymphocytic leukaemia (ICD-9 codes 200, 202) in white populations do not support the role of ultraviolet light (table). The most likely explanation for the increased risk of skin cancer after non-Hodgkin's lymphoma and chronic lymphocytic leukaemia is immunodeficiency from non-Hodgkin's lymphoma and chronic lymphocytic leukaemia themselves and from the immunosuppressive treatments given. It is well documented that recipients of renal transplants are at greatly increased risk of squamous cell skin cancer and, to a lesser extent, malignant melanoma.³

We do not have an explanation for the smaller increased risk of non-Hodgkin's lymphoma and

chronic lymphocytic leukaemia after squamous cell skin cancer other than the possibility that both cancers were caused by immunodeficiency predating the squamous cell skin cancer. The risk of non-Hodgkin's lymphoma and chronic lymphocytic leukaemia after melanoma was only marginally significant ($P=0.05$ for ICD-9 codes 200, 202, and 204.0 combined).

We believe that simpler explanations for the association between these cancers, such as that skin cancers are caused by immunosuppression, are more plausible than the claim that ultraviolet light could be responsible for the rapid increase in rates of non-Hodgkin's lymphoma and chronic lymphocytic leukaemia.

PETER SASIENI
Research scientist

Department of Mathematics, Statistics, and Epidemiology,
Imperial Cancer Research Fund,
PO Box 123,
London WC2A 3PX

VERONIQUE BATAILLE
Senior registrar

Department of Dermatology,
St George's Hospital,
London SW17 0RE

- Adami J, Frisch M, Yuen J, Glimelius B, Melbye M. Evidence of an association between non-Hodgkin's lymphoma and skin cancer. *BMJ* 1995;310:1491-5. (10 June.)
- Hartge P, Devesa SS, Fraumeni JF Jr. Hodgkin's and non-Hodgkin's lymphomas. *Cancer Surv* 1994;19/20:423-53.
- Parkin DM, Muir CS, Whelan SL, Gao Y-T, Ferlay J, Powell J, eds. *Cancer incidence in five continents*. Vol 6. Lyons: International Agency for Research on Cancer, 1992. (IARC scientific publication No 120.)
- Birkeland SA, Storm HH, Lamm LU, Barlow L, Blohne I, Forsberg B, et al. Cancer risk after renal transplantation in the Nordic countries, 1964-1986. *Int J Cancer* 1995;60:183-9.

Pathogenesis is multifactorial

EDITOR,—Johanna Adami and colleagues present evidence of an association between lymphoma and skin cancer, interpreting their findings as evidence of the role of immunosuppression induced by ultraviolet light in the pathogenesis of non-Hodgkin's lymphoma and leukaemia.¹ There are, however, several reasons for believing that this conclusion may not be valid. According to the authors' line of reasoning, the incidence of lymphoma in countries where people are exposed to high doses of ultraviolet radiation should be considerably higher than that in countries with more temperate climates. Such a difference has never been reported. In contrast, the incidence of skin cancer in sunny countries is strictly related to exposure to ultraviolet radiation—for example, the incidence of malignant melanoma is 20.5/100 000 person years in Hawaii compared with 8.8 in Detroit.²

Melanin in people with dark skin serves as a filter for ultraviolet radiation, and thus local and systemic effects of such radiation are much less pronounced in these people. This difference is shown by the incidence of skin cancer: the

Age standardised incidences* of malignant melanoma and non-Hodgkin's lymphoma from selected cancer registries.³
Figures are per 100 000

Registry	Male		Female	
	Melanoma (ICD-9 code 172)	Non-Hodgkin's lymphoma and chronic lymphocytic leukaemia (ICD-9 codes 200, 202)	Melanoma (ICD-9 code 172)	Non-Hodgkin's lymphoma and chronic lymphocytic leukaemia (ICD-9 codes 200, 202)
Australia (New South Wales)	25.9	10.2	23.8	7.6
Hawaii (white)	22.2	11.3	14.9	8.1
New Zealand (non-Maori)	18.6	8.6	23.0	5.9
Australia (Victoria)	16.4	11.9	18.0	8.0
Los Angeles (white)	14.6	13.0	11.6	8.1
Ontario	9.0	12.5	8.9	8.8
Detroit (white)	9.0	13.9	7.2	9.6
Denmark	7.7	8.0	9.8	5.6
England and Wales	3.0	7.1	5.0	4.8
Quebec	3.0	12.5	3.2	9.6

*World standard population.