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

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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.