

South-Asian tsunami

"Chance favours the prepared mind."

Louis Pasteur (1822–95)

We agree with your proposal for an International Commission on Global Responses to Complex Emergencies to plan and coordinate evidence-based emergency responses (Jan 8, p 95).¹ Communicable diseases such as cholera, dysentery, malaria, and dengue can be expected after crises like the tsunami of Dec 26, 2004, which destroyed much of the public-health infrastructure in the affected areas.² Malnourishment can also increase susceptibility to infections such as tuberculosis.³ Furthermore, not all relief workers may have received the necessary vaccination or chemoprophylaxis. A microbiology laboratory thus has an important role in detecting these infectious pathogens, and in triggering appropriate disease control responses. We set up a field microbiology laboratory in the week following the southeast Asian tsunami in the northern province of Sumatra, Indonesia.

Our ability to establish a field laboratory reflected our preparedness to deal with outbreaks of infectious diseases in modern Singapore, not in a disaster area. Diseases such as cholera are rare in Singapore. With the exception of dengue, procurement of simple and rapid diagnostic assays for the pathogens of concern, particularly in lateral-flow chromatography format, was slow owing to the limited supplies in stock within Singapore. Most such tests had to be purchased from abroad. Hence, our field laboratory had to start off with a small number of simple, rapid tests supplemented with real-time polymerase chain reaction (PCR) assays for diseases such as malaria.⁴ We were able to deploy these tests rapidly, given our role as the national laboratories for Singapore.

Although some may argue that real-time PCR with a Lightcycler (Roche Diagnostics, Mannheim, Germany) is costly and its performance in a hot and humid field laboratory untested, it does

offer advantages over conventional microbiological assays. Minimal handling of clinical specimens is required and pathogens are inactivated through nucleic acid extraction, thereby reducing the risk of laboratory-acquired infection. The amount of biohazardous waste generated is also less than with culture-based methods. We will be assessing how well real-time PCR performs in our field laboratory, and hope that our findings provide data on its usefulness for future emergency operations.

Apart from rapid diagnosis, microbiology laboratories can also help in re-establishment of the public-health infrastructure. Seroepidemiological studies could determine the levels of herd immunity to various diseases, which could be critical, particularly if local epidemiological records are destroyed. Public-health programmes could thus be rebuilt on the basis of real, rather than perceived, needs. A coordinated response between primary-care physicians and nurses, epidemiologists, and microbiologists would be essential for the success of such studies.

Perhaps an international commission could heed Louis Pasteur's observation, and prepare and coordinate future efforts so that the people who suffer natural disasters have a favourable chance of overcoming outbreaks of infectious disease that follow their heels.

We declare that we have no conflict of interest. We thank our many colleagues who aided, in one way or another, the setting up of this field microbiology laboratory.

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- 1 The Lancet. One world, one response—needed, but not yet forthcoming. *Lancet* 2005; **365**: 95–96.
- 2 World Health Organization. Health action in crises. http://www.who.int/hac/crises/international/asia_tsunami/en/ (accessed Feb 11, 2005).

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- 3 Chelala C. Fighting for survival. *BMJ* 1994; **309**: 525–26.
- 4 Lee MA, Tan CH, Aw LT, et al. Real-time fluorescence-based PCR for detection of malaria parasites. *J Clin Microbiol* 2002; **40**: 4343–45.

Your Jan 8 Editorial¹ states that "mortality is an insensitive measure of health risk", but it is a sensitive issue for some. In *The Nation*, Bangkok's independent English newspaper, on Jan 5, the tsunami-related fatalities in Thailand were reported as 5246 Thai nationals and 90 Burmese nationals. However, in the same newspaper, there was an article entitled "Hundreds of Burmese dead", which was based on information collected from the Human Rights Education Institution of Burma.² According to the article, more than 500 Burmese migrant workers died and at least 2500 went missing in the tsunami. However, most went unrecorded and unreported in Thailand's official death toll. The Burmese embassy also seemed to be indifferent to these workers, since most of them migrated into Thailand illegally.

Neglected by the country in which they work and the country from which they came, it is as if these people belong nowhere, and thus have no right to be counted, even as their bodies pile up. In addition to the dead, the same article reported that "about 3,000 Burmese workers are taking shelter around the area. . . but they are not on the list of locals as they are foreign workers. . . and that they cannot get emergency supplies from the already limited supplies."

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A disaster of this magnitude reflects how the value of one human being varies throughout the world. All are not equal. In the case of these "lost" Burmese, we can see how tsunami-linked death and poverty are directly linked.³ Poverty is one of the major reasons for migration. Human rights violations against migrant workers take place daily in many parts of the world, but now, in the midst of this huge disaster, it is time for all of us to learn a lesson about the value of human life.

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- 1 The Lancet. One world, one response—needed, but not yet forthcoming. *Lancet* 2005; **365**: 95–96.
- 2 Bhumiprabhas S. Hundreds of Burmese dead. *The Nation* Jan 5, 2005. <http://www.nationmultimedia.com/search/page.arcview.php?clid=3&id=110715&usrsess> (accessed Jan 5, 2005).
- 3 Abbasi K. Death by tsunami and poverty. *BMJ* 2005; **330**: 0.

Assessing the vital needs of disaster-stricken populations is essential to determine major health problems and priorities for aid interventions.^{1,2} Lamno town (4000 inhabitants) is located 40 km south of Banda Aceh on the

western coast of Sumatra, Indonesia. After the tsunami struck on Dec 26, 2004, about 8000 people from surrounding villages found shelter in 11 sites (tents, schools, and mosques) located throughout the town.

Médecins Sans Frontières (MSF) accessed Lamno on Jan 6, 2005, to provide medical care and safe drinking water to the displaced. On Jan 15 and 16, 2005, an epidemiologist did an assessment in a school where 2014 displaced people from nine villages received medical assistance from MSF. This assessment included a survey and general observations. The sample size was chosen to represent 20% of this population. In each of the 15 classrooms of the school, six heads of family were randomly selected by systematic sampling, and interviewed with a pretested questionnaire. Interviews were done in Indonesian or Achanese and translated into English.

The 90 families surveyed included 376 individuals, who represented 18.6% of those living in the school (table). Most families had access to running water piped from a nearby spring, but lacked enough wood to boil it every day. A large proportion of families lacked basic items such as a *tikar* (mat), underwear, soap, or water containers. Diarrhoea and wounds were rare and all six children younger than 5 years with reported fever tested negative to a rapid malaria test (Paracheck-Pf). Only 113 individuals had been vaccinated against tetanus, and only seven of the 34 children younger than 5 years had been vaccinated against measles. Most people responded positively to the question: "Do you wish to talk to someone about what has happened?"

Total shelter space was estimated at 1116 m², yielding a shelter space per person of 0.55 m²—less than a sixth of the recommended 3.5 m².³ There were no latrines on site, nor any special place for bathing, and the population was totally dependent on external food aid. According to five village chiefs interviewed separately, 40–70% of the pop-

ulation of their villages were unaccounted for.

In response to the overcrowding and lack of latrines and soap in the school, MSF distributed soap and other basic items, set up latrines, and implemented a surveillance system for the early detection of outbreaks which may occur in such contexts.⁴ A measles vaccination campaign was programmed to respond to the extremely low vaccine coverage that our survey, even with its methodological limitations, highlighted. Finally, a team of mental health specialists was sent to Lamno to try to alleviate the immense psychological distress of this population, as underscored by the need for individuals to communicate their experience.

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- 1 Noji EK. The public health consequences of disasters. *Prehospital Disaster Med* 2000; **15**: 147–57.
- 2 Médecins Sans Frontières. Refugee health: an approach to emergency situations. Paris: Médecins Sans Frontières, 1997.
- 3 Sphere Project. Minimum standards in shelter, settlement and non-food items. In: *The Sphere Handbook*. http://www.sphereproject.org/handbook/hdbkpdf/hdbk_c4.pdf (accessed Jan 31, 2005).
- 4 Toole MJ. Mass population displacement: a global public health challenge. *Infect Dis Clin North Am* 1995; **9**: 353–66.

The tsunami coverage in *The Lancet* was timely. The Sri Lankan¹ and Indian² cases poignantly illustrate the miseries of the people and the role played by doctors and health services in alleviating suffering. However, a clinical response such as treating the injured and burying the dead³ is an extremely complex issue linked to the overall sociological and cultural context. A few socioepidemiological issues need to be considered, especially in the case of India.

The first issue is the mindless and disrespectful disposal of dead bodies

| | Number of families/ individuals |
|--|------------------------------------|
| Water and fuel (n=90 families) | |
| Source of drinking water | |
| Running water | 85 (94%) |
| Commercial plastic bottles | 2 (2%) |
| Other | 3 (3%) |
| Drank non-boiled water at least once since arrival in school | 27 (30%) |
| Lacked wood at least once since arrival in school | 81 (90%) |
| Materials (n=90 families) | |
| Families with no <i>tikar</i> (mat) | 73 (81%) |
| Families with only one set of underwear | 84 (93%) |
| Families with no soap | 60 (67%) |
| Families with no water container of 10 L | 79 (88%) |
| Health (n=376 individuals) | |
| Diarrhoea in previous week | 30 (8%) |
| Observed wounds | 9 (2%) |
| Reported fever in past 48 h in children <5 years* | 6 (18%) |
| Vaccination against tetanus | 113 (30%) |
| Vaccination against measles in children <5 years* | 7 (20%) |
| Wished to talk to someone about what happened | 81 (90%) |

*n=34.

Table: Main results of health assessment, Lamno, Indonesia, Jan 15–16, 2005

in India. Many dead bodies were thrown into pits without proper identification. This was done for fear of epidemics, despite evidence to the contrary,⁴ and will result in long-term miseries and legal tangles for the surviving families. In the age of digital technology and high-tech laboratory facilities, an effort should have been made to take digital photos and tissues for DNA analysis. To decrease further legal hardships for survivors, reinstatement of lost identity documents such as cheque books, ration cards, etc, should also be instigated. In the present world, much of our existence depends on these pieces of paper. Partly as a result of the rapid disposal of bodies, many family members will forever be termed missing. The mental trauma associated with this situation will need to be dealt with⁵ and sustained for a substantial period.

Second, there is a subtle difference between this disaster and the annual cyclone and flood disasters that occur in most of the Indian states around the rim of the Bay of Bengal. The flooding caused by the tsunami was from salt water, and as a result most of the drinking-water sources were affected and could remain so for months. The probability of waterborne diseases breaking out in these areas could therefore be a little lower than that seen after ordinary floods due to rain water. This point is important for post-tsunami public-health strategies.

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- 1 Brown H. Sri Lanka banks on sustaining initial success. *Lancet* 2005; **365**: 282.
- 2 Chatterjee P. India's health workers rise to the occasion. *Lancet* 2005; **365**: 283.
- 3 Brown H. Treating the injured and burying the dead. *Lancet* 2005; **365**: 204–05.
- 4 Morgan O. Infectious disease risks from dead bodies following natural disasters. *Rev Panam Salud Publica* 2004; **15**: 307–12.
- 5 Ghosh A. Overlapping faults. *The Hindu* Jan 11, 2005.

Just a few days before the tsunami disaster of Dec 26, 2004, the United Nations Food and Agriculture Organisation (FAO) published a document on the state of food insecurity in the world.¹ In this document, FAO's Director-General, Jacques Diouf, stated that 5 million children die every year because of lack of food. This means more than 400 000 deaths every month. In other words, since the tsunami tragedy, the world has silently witnessed a number of deaths which is nearly three times that seen on Dec 26, and which continues to increase at a rate of more than 13 000 each day.

Now the risk is that the absolutely necessary and indispensable financial assistance for the victims of the tsunami tragedy will come at the expense of other funds set aside for assistance to countries affected by famine.² If this happens, poor people in less developed countries may end up paying for much of the financial relief sent to southeast Asia. So the number of children silently dying of hunger in the world will increase.

We must do our utmost in times of acute catastrophe such as the tsunami disaster. At the same time, we must ensure that these crises do not diminish our concern about ongoing tragedies that affect the rest of humanity and whose daily occurrence should never lead us to believe that their are just part of life. As Diouf's appeal stated, "We must do better, we can do better, we cannot afford not to do better".

In the short term, we believe that leaders of the developed world should formally declare that any financial support offered to tsunami victims will not in any way affect their plans for assistance to poor countries for the future. In the long term, a coordinated global political approach is needed to systematically decrease hunger, poverty, and lack of education. What we have now are ad-hoc responses that seem more frequently aimed at assuaging the conscience of an

overfed public than at achieving long-lasting change.

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- 2 Butcher J. Financing the relief effort. *Lancet* 2005; **365**: 206.

We appreciate your decision to publicise the ongoing tsunami relief campaign in Sri Lanka (Jan 15, p 204).¹ We want the world to know what we are doing for our people. The students of the Faculty of Medicine, University of Kelaniya, participated in the campaign in the immediate aftermath of the disaster. With help from the media and military, which helped us identify areas which were the worst hit and provided logistical support to get us into those areas, we set up nine health camps in Galle, Matara, Tangalle, Hambantota, and Kalmunai. The people who attended the initial camps had lost everything, including long-term medication. Several had multiple injuries and were in a state of numb disbelief about what had happened to them. Many were inconsolable over the loss of loved ones, and we felt helpless to deal with the psychological trauma.

The number of bodies lying around was frightening and the stench almost unbearable. Over the next few days, although the psychological trauma worsened, the pattern of physical ailments changed and we had to deal with people who had fever, diarrhoea, and chest infections. We did not encounter a significant shortage of antibiotics.

The present situation, as we see it, is one that should mainly concentrate on social and psychological rehabilitation. For example we feel that children

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Still Pictures

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should be sent back to school as soon as possible. We are at present collecting funds to buy books and school uniforms for children in the Galle and Matara areas, and the Teachers Association of our faculty has collected funds to rebuild a primary school in Matara.

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I would like to echo your view¹ that the primary problem with tsunami relief is lack of central coordination. I witnessed a case in point as a British Sri Lankan. The community is largely an organised one, with multiple agencies catering for many niches in our society (eg, health, land mines, rehabilitation). The aftermath of the tsunami found some of these organisations responding quickly. Some, for example, set up call centres to harness the empathy and offers of help.

Two problems emerged, however. First, no organisation had the infrastructure to cope with the scale of this disaster or the community's response. Second, without a history of cooperating with each other, some found it hard to work together, even though the situation called for it. In this context, it was reassuring to see the US and their "core countries" cede control of the response to the UN. Perhaps if large agencies and countries can work together towards a common goal, then we, who are involved in organisations of a much smaller scale, can mirror them.

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Evidenced-based decision making about Hib vaccination

In response to the results of the Lombok *Haemophilus influenzae* type b (Hib) vaccine probe trial (Jan 1, p 43),¹ Ana Lucia Sgambatti de Andrade and Celina Turchi Martelli (p 5)² ask "How much evidence is sufficient for policy makers?" In July, 2004, the Global Alliance for Vaccines and Immunization (GAVI) established a Task Force to explore how countries can be supported to make evidence-based decisions on the introduction and continued use of Hib-containing vaccines. Since then, the Task Force has undertaken a country consultation process, and explored issues related to programmes, supply, and financing associated with Hib vaccination in three groups of countries: those that have or are about to introduce Hib vaccine (Kenya, Ghana, Malaysia, Mongolia); those that are eligible for Hib but have not applied (Cameroon, Mozambique); and those considered to have an unclear disease burden (Bangladesh, Uzbekistan).

This work showed that most countries lack the information to make evidence-based decisions about whether to introduce or sustain Hib vaccine in their immunisation programmes. For countries that have not introduced Hib-containing vaccines, we believe that the core issues are to obtain data on disease burden and cost-effectiveness. Countries that have introduced Hib vaccination need to assess long-term financing issues and document whether the vaccine has reduced Hib disease.

In most Asian countries, classic studies of Hib disease incidence tend to measure very low disease burden. A WHO-convened panel recently reviewed existing evidence, including data from the Lombok study, and concluded that several factors could affect the sensitivity of incidence studies and therefore lead to underestimates. Although the panel concluded that vac-

cine probe studies are robust approaches to the documentation of Hib disease burden, it did not consider vaccine probe studies to be appropriate for most countries because there are other less costly options. These include Hib Rapid Assessments, enhanced surveillance, and case-control studies.³ However, the panel recognised that, despite the high cost of vaccine probe trials, one or two such studies would be appropriate and essential for the documentation of Hib disease in Asia and for lending support to assumptions used to assess burden in other countries.

Documentation of disease burden and cost-effectiveness are key stages in the decision-making process. However, given the high price of Hib-containing vaccines, the financial sustainability of a decision to introduce or sustain must also be considered. Among countries eligible for GAVI or the Vaccine Fund that have already introduced Hib vaccination, the country consultation process illustrated that this decision was made without detailed analyses of future costs. Although there was general consensus that the GAVI financial sustainability planning process⁴ is largely valuable, it came too late in the process to inform decision making. As a result, future financing for Hib vaccine is extremely vulnerable in these countries. GAVI and the Vaccine Fund are currently exploring bridge financing options to support countries that have adopted Hib-containing products.

The GAVI Hib Task Force considers that efforts must be mobilised immediately to help countries make evidence-based decisions about the introduction or continuation of Hib vaccine. The overall goal is not to convince countries to adopt or sustain Hib vaccination, but to ensure that countries have the information to make evidence-based decisions about whether to introduce or sustain Hib vaccination in their country.

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- 1 Gessner BD, Sutanto A, Linehan M, et al. Incidences of vaccine-preventable *Haemophilus influenzae* type b pneumonia and meningitis in Indonesian children: hamlet-randomised vaccine-probe trial. *Lancet* 2005; **365**: 43–52.
- 2 Sgambatti de Andrade ALS, Turchi Martelli CM. Globalisation of Hib vaccination—how far are we? *Lancet* 2005; **365**: 5–7.
- 3 World Health Organization. Review panel on *Haemophilus influenzae* type b (Hib) disease burden in Bangladesh, Indonesia and other Asian countries, Bangkok, 28–29 January 2004. *WER* 2004; **79**: 173–75.
- 4 Financing Task Force of the Global Alliance for Vaccines and Immunization. Guidelines for preparing a national immunization program financial sustainability plan, April 2004. Available at: http://www.vaccinealliance.org/Task_Forces/Financing_Task_Force/guidelines.p hp (accessed Jan 26, 2005).

Cheap shot at ECT

Shame on John Horgan's gratuitous dismissal of electroconvulsive therapy (ECT) in his book review of *Weighing the Soul* (Oct 30, p 1573).¹ Readers should recall the conclusion of a study published in *The Lancet* by the UK ECT Review Group.² After analysing the available randomised controlled trials of ECT and pharmacotherapy for patients with depressive illness, the commission noted: "Treatment with ECT was significantly more effective than pharmacotherapy (18 trials, 1144 participants)."

After more than 70 years of experience, the evidence for the efficacy and safety of ECT is firmly established. We recognise that ECT is widely stigmatised, but Horgan's cheap shot should not go unchallenged.

MF, CK, and VM are present and former editors of the *Journal of ECT*.

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- 1 Horgan J. Soul searching. *Lancet* 2004; **364**: 1573–74.
- 2 UK ECT Review Group. Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. *Lancet* 2003; **361**: 799–808.

More on porphyrias

In her Seminar (Jan 15, p 241),¹ Raili Kauppinen gives a helpful outline of the familiar neurological, cutaneous, and metabolic manifestations of the porphyrias. However, these famous mimics can also present as ocular disease. Ophthalmic features may be missed by generalists and their significance might not be appreciated by the unsuspecting ophthalmologist.

In the largest ophthalmic study of porphyria cutanea tarda, 92 patients were found to have higher rates of pinguecula (eight-fold) and pterygium (two-fold) than controls.² These relatively common disorders are thought to be related to ultraviolet irradiation causing subepithelial elastotic degeneration of the conjunctiva (pinguecula) or of conjunctiva and cornea (pterygium). In porphyria cutanea tarda, these processes are presumably accelerated by uroporphyrin-induced phototoxicity in a similar manner to that occurring in the skin.¹ Involvement of the sclera can also occur with thinning of the interpalpebral sun-exposed sclera and even acute scleritis which may extend posteriorly.³ Other reported ocular complications include cicatricial ectropion, symblepharon formation, and lacrimal duct obstruction.

More serious sight-threatening complications occur in congenital erythropoietic porphyria. Bilateral necrotising scleritis can be seen alongside pigmentation of the eyelids and generalised cutaneous hypersensitivity.⁴ Porphyrins are measurable in the tears of such patients with higher concentrations being related to more severe disease.⁴ Histological changes of cornea and conjunctiva resemble the damage seen in skin, with inflammatory cells, reduced numbers of keratocytes, thickened vessel basement mem-

branes, and microfibrillar material in the extracellular spaces of the conjunctival stroma.⁵ These changes start early: damage to the corneal endothelium may even occur in utero.⁵

Ophthalmic disease in the porphyrias is probably under-recognised. Generalists caring for such patients should regard "red eye" as a potentially sight-threatening complication requiring urgent ophthalmic assessment. Prophylaxis with tinted glasses to reduce incident ultraviolet wavelengths should also be considered. Ophthalmologists see porphyric patients rarely but should consider the diagnosis in cases of photosensitive ocular disease.

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- 2 Hammer H, Korom I. Photodamage of the conjunctiva in patients with porphyria cutanea tarda. *Br J Ophthalmol* 1992; **76**: 592–93.
- 3 Salmon JF, Strauss PC, Todd G, Murray AD. Acute scleritis in porphyria cutanea tarda. *Am J Ophthalmol* 1990; **109**: 400–06.
- 4 Takamura N, Kurihara K, Yamashita S, Kondo M. Need for measurement of porphyrins in tears in patients with congenital erythropoietic porphyria. *Br J Ophthalmol* 2002; **86**: 1188.
- 5 Ueda S, Rao GN, LoCascio JA, del Cerro M, Aquavella JV. Corneal and conjunctival changes in congenital erythropoietic porphyria. *Cornea* 1989; **8**: 286–94.

Raili Kauppinen,¹ in her comprehensive Seminar on porphyrias, states that in acute porphyria "clinical manifestations arise after puberty". Although generally true, there are exceptions. Hennessy,² writing about acute intermittent porphyria in childhood, documented 13 case reports up to 1963. One of us (Singh) reported a prepubertal girl with the disease in 1967.³ More elaborate descriptions of the disease in childhood continue to appear from time to time.

Sandberg and colleagues,⁴ while reporting the disease in a child in whom there was a gap of 6 years

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between onset of symptoms and establishing the diagnosis, commented that "It is important to know that acute intermittent porphyria may even occur in children". Hessels and colleagues⁵ also documented delay in the diagnosis of acute intermittent porphyria in a 7-year-old boy because the disease is "not a very well documented condition [in children]", and that "pediatricians should be aware of it". Thus, clinicians need to be aware that prepubertal presentation of this inherited disorder is possible.

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- 2 Hennessy B. Acute intermittent porphyria in childhood. *Med J Aust* 1963; **42**: 584–86.
- 3 Gupta HL, Harjit Singh, Prabhaker BR. Acute intermittent porphyria in childhood. *Ind J Pediatr* 1967; **34**: 146–50.
- 4 Sandberg S, Brun A, Skadberg O, Iversen I, Benestad Y, Danielsen OK. Acute intermittent porphyria is a difficult diagnosis—especially in children. *Tidsskr Nor Laegeforen* 2001; **121**: 2822–25.
- 5 Hessels J, Voortman G, van der Wagen A, van der Elzen C, Scheffer H, Zuijderhoudt FM. Homozygous acute intermittent porphyria in a 7-year-old boy with massive excretions of porphyrins and porphyrin precursors. *J Inherit Metab Dis* 2004; **27**: 19–27.

Ramazzini and writer's cramp

I note the oldest description of writer's cramp in the revised 1713 edition of Bernardino Ramazzini's (1633–1714) classic book *De Morbis Artificum Diatriba* ("Diseases of Workers", figure).¹

The first edition of Ramazzini's book in 1700 is considered a foundational event for the field of occupational medicine. He is best known for discussion of the dangers of toxic inhalation by workers in various occupations, but there is recent appreciation for Ramazzini's astute observation of musculoskeletal diseases of workers as well.² Ramazzini was also attuned to neurological

occupational disorders, as acknowledged by Karp.³

For the 1713 revised edition of *De Morbis Artificum*, Ramazzini added a *Supplementum* covering 12 additional occupations. In the second chapter of this Supplement, Ramazzini discusses diseases of scribes and notaries. He notes three classes of maladies associated with these occupations: those from constant sitting, constant writing, and mental strain from frequent tedious calculations. In terms of the dangers of constant writing, Ramazzini says, "An acquaintance of mine, a notary by profession, still living, used to spend his whole life continually engaged in writing, and he made a good deal of money from it; first he began to complain of intense fatigue in the whole arm, but no remedy could relieve this, and finally the whole right arm became completely paralyzed. In order to offset this infirmity he began to train himself to write with the left hand, but it was not very long before it too was attacked by the same malady."

Writer's cramp is a focal dystonia of the hand in which an individual, usually someone whose occupation requires a significant amount of writ-

ing, has paresis or even paralysis when attempting to write despite having no weakness in the hand on standard clinical testing, no musculoskeletal problems in the arm that could account for the inability to write, and no lesions of the central nervous system or peripheral nerves demonstrable by standard imaging and electrophysiology techniques such as CT, MRI, nerve conduction studies, or electromyography. Aside from the association with occupations requiring significant amounts of writing, the aetiology or pathophysiology of writer's cramp remains unknown. However, subtle derangement of the sensorimotor cortices are thought to have a role.⁴

For treatment of writer's cramp Ramazzini offered only rubbing salves. Unfortunately, treatment still often remains insufficient today.

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- 1 Ramazzini B. *Diseases of Workers*. Translated from *De Morbis Artificum* of 1713 by Wilmer Cave Wright. New York: Haffner, 1964.
- 2 Pope MN. Bernardino Ramazzini: the father of occupational medicine. *Spine* 2004; **15**: 2335–38.
- 3 Karp BI. Botulism toxin treatment of occupational and focal hand dystonia. *Mov Disord* 2004; **19** (suppl 8): S116–19.
- 4 Lerner A, Shill H, Hanakawa T, Bushara K, Goldfine A, Hallett M. Regional cerebral blood flow correlates of the severity of writer's cramp symptoms. *Neuroimage* 2004; **21**: 904–13.

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Figure: Ramazzini B. *De Morbis Artificum Diatriba*. Modena: A Capponi, 1700.

Department of Error

Anon. *Surgery for facial carcinomas*. *Lancet* 2004; **364**—In this Talking Point (Nov 13), the final sentence should read: "In a Comment paper, Phillip Williford and Steven Feldman question the cost of MMS, and say that although the procedure is appropriate for recurrent tumours, large facial tumours, and those with aggressive histological patterns, it should be used sparingly for less risky tumours on less critical body sites."