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Letters

Winter mortality in elderly people in Britain

Action on outdoor cold stress is needed to reduce winter mortality

Editor—The paper by Wilkinson et al, on people aged over 75, makes a useful addition to the evidence that winter mortality in Britain is now not caused primarily by deprivation and failure to heat homes.1 In addition to other evidence they quote, a recent study on younger people provides positive indications that cold exposure outside the home causes winter mortality regardless of economic status.2

Manual workers (social class 5) of working age (50–59) in Britain had low cold related mortality compared with any other class. This was not the case with their wives of similar age or for men of the same class after retirement age (65–74). It implies that internal heat production from manual work protected class 5 men of working age against daytime cold stress and consequent mortality. Elderly people in sheltered housing that was fully heated, but who often went outdoors, had as much winter mortality as the general elderly population.3

Despite considerable evidence, reduction of outdoor cold stress has been largely ignored in official campaigns to control winter mortality. Heating of waiting areas for public transport, and at least windproof shelters on bus routes subject to unscheduled delays, are obvious measures that would help. Another is to broadcast warnings, which would bear the brunt of domestic tasks such as outdoor exposure to low temperature, may play a large part in determining risk. To keep moving while outdoors is also important.

Surveys in Europe and Siberia provided statistical evidence that such behaviour, as well as warm homes, is associated with low winter mortality.4 We have found advice on these lines to avoid outdoor cold stress, given via the media, well received by elderly people, provided that they are also given the evidence that outdoor cold accounts for much of Britain’s winter mortality.

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Competing interests: None declared.


4 The Eurowinter Group. Cold exposure and winter mortality from ischaemic heart disease, cerebrovascular disease, respiratory disease, and all causes in warm and cold regions of Europe. Lancet 1997;349:2341-6.


Outdoor exposure and effect of windchill should be taken into consideration

Editor—The study by Wilkinson et al, reporting a lack of effect socioeconomic gradient on excess winter mortality, contributes much to the debate seeking the best means to address this major public health issue. Currently, the UK government make a substantial financial payment to elderly people, the “winter fuel payment,” in an attempt to address fuel poverty, but it is becoming increasingly clear that other personal factors, such as outdoor exposure to low temperature, may play a large part in determining risk.

I have two hypothetical questions. Firstly, could the excess mortality in women be related to their being more likely to spend time outdoors in low temperatures, as in this age group it is still likely that they would bear the brunt of domestic tasks such as shopping?

Secondly, does the mean of air temperature used accurately reflect the temperature experienced by the individual, given that windchill is a major component of environmental exposure? If the data were re-analysed to include windchill effects for each region, how would this affect results?

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Competing interests: None declared


Lack of social gradient in winter excess mortality is obvious in Denmark

Editor—Despite smaller fluctuations in seasonal mortality in general,1 we obtained results for our analysis of excess winter mortality in Denmark to those that Wilkinson et al found for Britain:2 an increase of seasonality with age, higher excess winter mortality for women—especially for respiratory diseases—and a lack of a social gradient related to mortality in winter.

Our analysis used Danish register data and was based on all women and men aged 65 and older in Denmark between 1980 and 1998. These 1.8 million people survived on average about 100 months during the observation period (186 271 440 person months lived). Using logistic regression, we obtained the following results: the odds ratios showed that winter mortality from all causes was 17.9% higher for women and 15.7% higher for men than during summer. The disadvantage of women was even more pronounced for respiratory diseases, with an excess of 55.4% (men: 36.5%). The increase of seasonality with age was similar for women and men until the age group 85-89 years. At higher ages, men surpassed women in excess winter mortality. We could not detect any social gradient in vulnerability to excess winter mortality—regardless of whether socioeconomic status was measured as highest completed education or wealth on the family level. We found, however, that people living alone faced higher excess winter mortality than women and men who shared their household with at least one more person.

Our results thus support the findings of Wilkinson et al that lighting fuel poverty might not significantly reduce the annual,

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cold related death toll. Policies aimed at reducing winter excess mortality as suggested by Keatinge et al should aim at all elderly people, in particular women and people who are living alone.1

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Competing interests: None declared.

1 Keatinge W, Donaldson G. Winter deaths: warm housing is essential. BMJ 2004;329:647-8 (18 September.)

Author’s reply

Editor—Keatinge and Donaldson and Woodall point out the important evidence that winter and cold-related mortality may be caused by outdoor exposures to cold. We strongly support their view that to date public health strategies to reduce winter mortality have paid insufficient attention to reducing outdoor cold stress.

However, our study on winter death in elderly people should not be interpreted as providing evidence against indoor temperatures as important. The results have little bearing on this and are entirely compatible with indoor cold as an important or even dominant factor. Inadequate home heating remains a probable key determinant of winter death.

Our conclusion that tackling fuel poverty may be insufficient reflects the simple observation that the risk of excess winter death seems to be widespread, and not simply concentrated in the poorer socioeconomic groups targeted by fuel poverty strategies. Intuitively, a lack of socioeconomic gradient might seem contrary to the distribution of risk. Which Rau also reports in an analysis of socioeconomic gradient, so the lack of one, Woodall point out the important evidence—Keatinge and Donaldson and Woodall (1998/9) 578-82.

2 Joellenbeck LM, Zwanziger L, Durch JS, Strom BL, ed. Anthrax and smallpox vaccines licensed as safe and effective by the US Food and Drug Administration (FDA).3 The Department of Defense is concerned about the safety of US service members, so we vaccinate them to keep them healthy. Vaccination provides the only round the clock protection against the malicious use of microbes as weapons.

Our vaccination programmes are based on a credible military threat, recognised by multiple government agencies and administrations. Given that a few cubic metres could hide a grievous quantity of anthrax spores or variola virus, the unsuccessful hunt for weapons of mass destruction in Iraq has done little to reassure us. That anthrax and smallpox infections are not circulating naturally is irrelevant when these microbes can be targeted wilfully at our troops. Anthrax spores are all too easy to deliver, as our nation learnt in fall 2001.

The values of anthrax vaccine and smallpox vaccine are established in the medical literature, which is more extensive and more accurate than cited in the editorial. The National Academy of Sciences published a comprehensive review of anthrax vaccine safety and efficacy in March 2002.4 The FDA recently affirmed that human and animal evidence show that anthrax vaccine protects regardless of route of exposure.5 The modern military safety surveillance system first identified the rare risk of myopericarditis after smallpox vaccination,6 something otherwise unreognised in America, and then described the extent of recovery from this condition.7 The rigorous screening programme adopted in the US civilians and military smallpox vaccination programmes resulted in serious adverse event rates at or below historical expectations.8

Until improved vaccines are licensed we will not risk our troops’ lives against lethal biological weapons. We use today’s vaccines to shield our service members so they can succeed in their mission to protect our nation, and return home healthy.

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Competing interests: None declared.

1 Jefferson T. Bioterrorism and compulsory vaccination. BMJ 2004;329:529-31 (3 September.)

2 Jefferson T. Bioterrorism and compulsory vaccination. BMJ 2004;329:529-31 (3 September.)


Bioterrorism and compulsory vaccination

United States continues vaccinating to keep troops healthy

Editor—Jefferson questions military utility of anthrax and smallpox vaccines licensed as safe and effective by the US Food and Drug Administration (FDA).3 The Department of Defense is concerned about the safety of US service members, so we vaccinate them to keep them healthy. Vaccination provides the only round the clock protection against the malicious use of microbes as weapons.

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Arguments for current vaccines are based on inadequate support for older vaccines

Editor—Jefferson discussed some of the major flaws of the study by Brachman et al with respect to policies making certain vaccines compulsory in the US military.1 Additional shortcomings of the study by
Brachman et al have been described in fuller detail elsewhere.\(^1\) For example, the often reported rate of 92.5% effectiveness for the anthrax vaccine sounds impressive but should be considered against the actual results in which 99.7% (387/397) of vaccinated workers avoided anthrax infection compared with 96.4% (399/414) of placebo workers. Thus the vaccine protected only an additional 3.3% of workers compared with no treatment.

Moreover, officials from the Department of Defense continue to ignore criticism of the 2002 Institute of Medicine report on the anthrax vaccine.\(^2\) At least three major studies in England, Canada, and the United States had found problems with the anthrax or other vaccines among military veterans.\(^3\) The report mentioned on page 93 some of those studies but seems to have dismissed them largely because they were based on self reported or anecdotal data.\(^3\) The same report hails the millennium cohort study, based largely on self report, as an important asset for studying the long term safety of the anthrax vaccine, even though relatively little information has been asked about anthrax vaccination in that study.

Furthermore, the RAND Corporation's report on immunisations as a factor in Gulf war illness had been due out in 2002\(^4\) but as of early October 2004 had not yet been published. It is not clear why, other than for political reasons, it would take so long for the defense department to approve the release of a scientific text on vaccines and Gulf war illness, especially when it was being published by extraordinarily capable and distinguished scientists affiliated with the RAND Corporation. Perhaps the best approach to vaccine education is not to be found in pretending that certain scientific results are irrelevant merely because they do not fit the desired paradigms, political or otherwise. Given such considerations and uncertainties, until better evidence is available, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able, I agree with Jefferson—the choice of whether to be vaccinated or not should be able,
Treatment of impetigo

Paint it blue

EDITOR—Koning and van der Wouden in their editorial on treatment of impetigo discuss the relative merits of systemic and topical antibiotics that were reported in their recent Cochrane review and add that they have no evidence to support the therapeutic value of disinfecting agents, which they note have hardly been studied.1 They comment that studies establishing the value of disinfecting agents are therefore most welcome.

Generations of general practitioners have treated impetigo with gentian violet, and although there has been some trial evidence that its effectiveness extends to methicillin resistant Staphylococcus aureus,2 the main support for its use is clinical experience passed on from one practitioner to the next and reinforced by the rapid resolution they see when failures with more cosmetically acceptable topical antibiotic preparations lead to a trial of gentian violet.

The processes developing evidence based practice must be able to promote those treatments that have been reliably proved while somehow preventing the loss of longstanding effective remedies for which there will never be a commercial imperative to fund trials. Surveys that aggregate the collective experience of practitioners and identify treatments that are perceived as effective but have not been evaluated should trigger investigation, perhaps through the health technology assessment route, rather than lead to abandoning the treatment and sending another baby down the plug hole with the bath water.

For those who might be stimulated by this letter to try gentian violet for impetigo, the agent must be kept away from the cornea.3

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Competing interests: None declared.

1 Koning S, van der Wouden JC. Treatment for impetigos. BMJ 2004;329:695-6. (25 September.)

Health needs of Zimbabweans are poorly recognised in UK

EDITOR—In 2002 Zimbabweans were the second largest group of asylum seekers coming to the United Kingdom, 7695 asylum applications having been made, and they constitute one of the largest migrant groups of English speaking peoples from a developing country for 25 years. The lack of language barriers may help this community to use the NHS more effectively than earlier migrants, but they may face discrimination nevertheless. What is known, and what needs to be known about the healthcare needs of Zimbabweans?

We found that most published work focuses on HIV and sexual health. The prevalence of HIV seropositivity in Zimbabwe is estimated to be 25%. The proportion of all reported HIV cases in the United Kingdom acquired in Africa (90% heterosexually) is over 20% and growing.2 Several factors may pose problems when treating Zimbabweans with HIV: patients may present late and they are highly mobile (partly because of the government’s policy of dispersal for asylum seekers), making follow up and contact tracing difficult. These problems are not confined to Zimbabweans. Coinfection with tuberculosis is a major concern, raising the question of whether Zimbabwean babies should be vaccinated with BCG.

In some towns the incidence of HIV has risen considerably. Many primary care trusts, local genitourinary services, and individual general practitioners are struggling to cope with increasing demand (our two practices in Luton together serve over a hundred HIV positive patients).

However, an inordinate focus on HIV may divert attention from other health needs of Zimbabweans. Anxiety, depression, and mental distress are to be expected among a population that has suffered rapid impoverishment and family separation. People have more mundane health problems, such as hypertension and diabetes. These have often been poorly controlled, and Zimbabweans may overlook these if health professionals are preoccupied with the risks of HIV. Only by integrating primary and specialist care can earlier diagnoses and improved access be delivered—and the public health interests of the whole population be addressed.

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Private sector needs incentives for AIDS vaccine

EDITOR—Tucker and Mazithulela are right to identify the need to increase involvement of the private sector in the quest for a preventive vaccine for HIV/AIDS.1 Pharmaceutical companies are best placed to come up with vaccines and crucial new treatments for AIDS and other conditions for which no treatment exists, but as the major markets for such products are the poorest countries on the planet, there is little likelihood of a reasonable return on investment.

We therefore need to develop incentives that will bring the private sector into the hunt for a vaccine; these may include tax incentives on vaccine research, guaranteed volume sales, tiered pricing alongside anti-reimportation measures, public and intergovernmental subsidies and philanthropic donations, and perhaps patent extensions could be offered on other products.

Big Pharma needs such carrots if it is to commit to HIV/AIDS taxing vaccine research and development, rather than being damned if they do and damned if they don’t—the current activist approach.

Another problem remains: the trickle-down pattern whereby product development is followed by the recouping of costs through profits in industrialised countries, after which prices drop and become affordable in poor countries decades later, is not viable for HIV/AIDS.

The rapid transport to and effective distribution of doses to the depths of sub-Saharan Africa—where about 27 million are living with HIV, and presenting a risk to countless millions of others—will take unprecedented commitment from and cooperation between civil society, which includes the private sector, and politicians.

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