

Erythema induratum: a case of mistaken identity

306 Noel McK Bennett

306 James B Muir

306 Gary Y Chew, Christopher Henderson, John W Quin

Declining iodine content of milk and re-emergence of iodine deficiency in Australia

307 Mu Li, Kay V Waite, Gary Ma, Creswell J Eastman

Do women in rural and remote areas need different guidelines for management of low-grade abnormalities found on cervical screening?

307 Carol Breeze, Caroline M de Costa, Mark Jagusch

Research administration and privacy legislation: dealing with the HIC (Medicare Australia)

308 Simon R Brice, Marie V Pirotta

Pharmaceutical Benefits Scheme limitations on macrolides: implications for pertussis management

309 Kari AJ Jarvinen, Bradley J McCall, Clare B Nourse,

Joe G McCormack, Martyn H Tilse

The risks of a “Commonwealth Solution” for mental health

309 Michael Guy Duke

Driveway motor vehicle injuries in children: a prospective review of injury circumstances

311 Andrew JA Holland, Frank I Ross, Patricia Manglick, Fiona E Fahy, Daniel T Cass

Sports Doctors Australia

311 Neville R Blomeley

What's in a title?

312 Garry J Walter

Myasthenia gravis and a rare complication of chemotherapy — clarification and acknowledgement

312 Christina V T Ng

Erythema induratum: a case of mistaken identity

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TO THE EDITOR: In a recent issue of the Journal, Chew et al described a woman from Vietnam with skin nodules that, on histological examination, showed lobular panniculitis with granulomatous inflammation.¹ No mycobacteria were visible and a polymerase chain reaction test for *Mycobacterium tuberculosis* was negative. Two months after starting quadruple antituberculous therapy (including rifampicin), her lesions had resolved. Erythema induratum (ostensibly due to hypersensitivity to *M. tuberculosis*) was diagnosed, despite the absence of evidence of tuberculosis. Other possible diagnoses were considered, but leprosy was not mentioned.

In regions of Australia where leprosy is not endemic, the disease is frequently overlooked.² Birrell³ described a man from Malta with recurring skin lumps. Biopsy showed panniculitis with giant cells, and the man was initially misdiagnosed as having “Weber–Christian syndrome” or “relapsing febrile non-suppurative nodular panniculitis”. Soon after, another Maltese patient presented similarly. This time, leprosy was suggested, and a biopsy revealed the presence of *Mycobacterium leprae*.⁴ Re-examination of slides from the first case showed similar organisms, confirming leprosy.⁵

The patients described by Chew et al and Birrell had migrated from countries in which leprosy was endemic, and biopsies revealed granulomatous panniculitis. Weber–Christian syndrome and erythema induratum are rare, ill-defined conditions with confused aetiologies, and both lack a specific diagnostic test. Therefore, cases of leprosy can be easily misdiagnosed as one of these conditions. That the biopsy in this patient did not show visible *M. leprae* is against a diagnosis of leprosy. But in my experience, even in lepromatous (multibacillary) disease, occasionally a skin smear of a lesion or (more rarely) a biopsy specimen may fail to reveal bacilli. Of course, this would be likely if the patient had received specific treatment for leprosy previously.

Respectfully, I suggest that Chew et al should attempt to exclude lepromatous leprosy in their patient by looking for possible missed stigmata of leprosy, enquiring whether she has ever been treated for lep-

rosy, asking whether any close acquaintances have had the infection or a chronic skin condition, and following up the patient in the long term.

- 1 Chew GY, Henderson C, Quin JW. Erythema induratum: a case of mistaken identity. *Med J Aust* 2005; 183: 534.
- 2 Bennett N McK. Diagnosis of leprosy in Victoria — a non-endemic area of Australia. *Med J Aust* 1977; 2: 349-351.
- 3 Birrell JHW. Weber–Christian syndrome: report of a case. *Med J Aust* 1952; 2: 124-127.
- 4 Mancy ES. Report of two cases of leprosy. *Med J Aust* 1953; 2: 20-21.
- 5 Birrell JHW. A note on leprosy as an aetiological factor in the Weber–Christian syndrome. *Med J Aust* 1953; 2: 7. □

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TO THE EDITOR: One of the Journal’s recent *Lessons from Practice* illustrates common errors in the approach to dermatological conditions.¹ As in all areas of medicine, an accurate diagnosis is crucial to the management of any skin disease. This is especially so if a medical practitioner institutes treatments, such as oral steroids, that have considerable potential for causing morbidity. The lessons I would draw from the case of erythema induratum described are as follows.

If you suspect an unusual presentation of a common condition, perform investigations to confirm your suspicions. Although erythema nodosum classically occurs on the anterior lower leg, lesions above the knee may occasionally be seen.

To make a diagnosis, investigations need to be appropriate. The battery of blood tests ordered in the case described would not have shed light on the pathological process occurring in the skin. There is a reluctance among the general medical community to perform skin biopsies. These procedures cause little morbidity, have a high diagnostic yield, and should be within the skill set of any medical graduate. Concern over causing a scar is often cited as a reason for not doing a biopsy. But, in my experience, patients are rarely worried about such a prospect. Missing the diagnosis is surely of much greater concern. Taking a simple biopsy, including fat, at the initial presentation would have saved the patient in question a lot of trouble and risk.

If there is no response to your treatment, it may well be that the initial diagnosis was incorrect. For example, it is common to see “steroid-resistant eczema” that is actually

intraepidermal carcinoma. Erythema nodosum will usually show at least some response to non-steroidal anti-inflammatory treatment. Lack of response to a treatment that usually works should lead to a re-evaluation of the diagnosis.

Systemic steroids should not be used for a dermatological condition without a firm diagnosis. Firstly, they can suppress many of the clinical and histological changes that allow a diagnosis to be made. Appropriate investigations need to be done before starting steroids. Secondly, a drug like prednisolone may well make matters worse, especially if, as here, there is an infectious aetiology.

Patients from areas in which tuberculosis is endemic should have this condition excluded before being given systemic steroids. A lack of obvious exposure to or symptoms of tuberculosis is not unusual in patients from such areas who are subsequently shown to harbour this infection.

The authors state that, as erythema induratum can resolve with corticosteroid treatment, this can lead to an erroneous diagnosis of erythema nodosum. Using response to treatment as a quasi-diagnostic test is dangerous indeed. Steroids will cause many conditions associated with significant inflammation to improve or even appear to resolve. But this does not mean that there is no infectious or malignant aetiology.

- 1 Chew GY, Henderson C, Quin JW. Erythema induratum: a case of mistaken identity. *Med J Aust* 2005; 183: 534. □

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IN REPLY: We thank Bennett and Muir for their pertinent comments. Our patient did not have any history or clinical evidence of lepromatous leprosy. The skin biopsy did not reveal any dermal granulomatous involvement, and there were definitely no organisms seen on an auramine stain of the biopsy specimen.

Subcutaneous involvement in leprosy is uncommon except in erythema nodosum leprosum or as a neurotropic phenomenon. When present, it tends to be a neutrophil-rich hypersensitivity necrotising vasculitis — no features of which were seen in this

case. Neither the woman's partner nor child had a chronic skin condition or clinical history of leprosy or tuberculosis. Furthermore, the patient has been followed up for 12 months, with no recurrence of the rash.

We agree with Muir that an accurate diagnosis is crucial to managing any skin disease and that there were many lessons to be gathered from this case apart from the five points we listed. It is our usual practice not to begin definitive treatment until we have examined a skin biopsy of any suspicious lesion and made a diagnosis. As this patient was very concerned about getting a scar, we did not perform a skin biopsy initially, but informed her that we may need to do so if the condition did not respond to treatment.

We agree that patients from areas where tuberculosis is endemic should have tuberculosis excluded before instituting systemic steroid treatment. In this case, the patient was given a chest x-ray by the appropriate authorities before her migration to Australia. She has not returned to Vietnam since then. Furthermore, the patient had failed a trial of a non-steroidal anti-inflammatory drug and found the lesions cosmetically distressing. Consequently corticosteroids were instituted. □

Declining iodine content of milk and re-emergence of iodine deficiency in Australia

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TO THE EDITOR: Iodine is essential for production of thyroid hormone. The recommended daily intake is 100 µg for children, 150 µg for adults and 250 µg for pregnant and lactating women.¹ Sporadic surveys of population iodine intake in Sydney, New South Wales, between 1985 and 1992 showed median levels of urinary iodine excretion (UIE) >200 µg/L, indicating iodine sufficiency.² However, a recent national study demonstrated mild iodine deficiency (median UIE <100 µg/L) in New South Wales and Victoria, borderline levels in South Australia and adequate intake in Queensland and Western Australia.³

The major sources of dietary iodine are dairy milk and dairy products, seafood and iodised salt. In Australia, few people purchase iodised salt, and, except in Tasmania, the food industry does not use iodised salt in the production and preparation of food.⁴ For decades, milk contaminated with iodine residues from sanitising solutions (iodophors) used in the dairy industry has probably been the largest source of iodine in the Australian diet.

We undertook a survey of the iodine content of milk samples from supermarkets around metropolitan Sydney in 2001 and 2004. In each year, iodine levels were measured in 13 samples, comprising a range of milk types (including whole, full cream, lite and skim) and brands (including Dairy Farmers, Devondale, Farmdale, Farmland, Perfection, Pura and Woolworths).

Iodine concentrations were highly variable. Median concentrations were 140 µg/L in 2001 (range, 60–220 µg/L) and 195 µg/L in 2004 (range, 66–412 µg/L). Iodine concentrations varied between samples of the same brand and type by up to 100 µg/L. Many samples contained less than 200 µg/L (10/13 in 2001 and 7/13 in 2004).

A 1975 survey of iodine concentration in milk conducted by the Australian Consumers' Association found mean concentrations of 593.5 µg/L and 583 µg/L in NSW and Victoria, respectively.⁵ Because of concerns about iodine toxicity, Food Standards Australia and New Zealand specified an iodine limit of 500 µg/L in the Food Standards Code 1982. The replacement of iodophors by other sanitisers in the dairy industry appears to be the reason for the decrease in iodine content of Sydney milk. The perception that milk is a rich source of iodine is no longer true. A cup (250 mL) of milk a day would provide at most 50–60 µg iodine, approximating a third of the daily requirement for an adult.

We suggest that the reduced amount of iodine in milk is likely to be one of the explanations for the re-emergence of iodine deficiency in Sydney and perhaps elsewhere in Australia. Despite these changes, dairy milk remains an important source of dietary iodine. The iodine content in milk should be monitored.

Acknowledgement: We thank Dante Crisante (Institute of Clinical Pathology and Medical Research, Westmead Hospital, Sydney, NSW) for performing the milk iodine measurements.

1 Eastman CJ. Iodine supplementation: the benefits for pregnant and lactating women in Australia and New Zealand. *Obstet Gynecol* 2005; 7: 65-66.

2 Eastman CJ. The status of iodine nutrition in Australia. In: Delange F, Glinore D, eds. *Iodine deficiency in Europe: a continuing concern*. New York: Plenum Publishing, 1993: 133-139.

3 Li M, Eastman CJ, Waite KV, et al. Are Australian children iodine deficient? Results of the Australian National Iodine Nutrition Study. *Med J Aust* 2006; 184: 165-169.

4 Eastman CJ. Where has all our iodine gone [editorial]? *Med J Aust* 1999; 171: 455-456.

5 Australian Consumers' Association. Adulterated food: is milk a hazard? *Choice* 1975; Sep: 299-302. □

Do women in rural and remote areas need different guidelines for management of low-grade abnormalities found on cervical screening?

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TO THE EDITOR: The incidence of cervical cancer in Far North Queensland (FNQ) is 10 times the national average and the mortality rate five times greater.^{1,2} Of the Australian states, Queensland has the lowest average rate of regular cervical screening (57% of eligible women), and in some FNQ communities rates of less than 40% have been reported.

Cairns Base Hospital (CBH) provides all public colposcopy services in Cairns and throughout Cape York for a population that is largely rural, remote and transient. In 2004, through the outpatients department of CBH, 12 new cases of invasive cancer were diagnosed (with additional advanced cases admitted directly to the surgical services). None of these women had undergone cervical screening in the previous 4 years.

We conducted a three-part study at CBH: a 3-month retrospective study (Feb–Apr 2004) and a 3-month prospective study (Oct–Dec 2004) comparing cytological reports with histological results, and a further study (Oct–Dec 2004) of women who were referred for colposcopy but failed to attend.

In the retrospective study, of 43 new patients with a cytology report of low-grade epithelial abnormality (LGEA) who had histology performed, 19 (44%) had a histological diagnosis of a high-grade epithelial abnormality (HGEA). ("Low-grade cytology" was defined in the 1994 National Health and Medical Research Council [NHMRC] guidelines³ as two consecutive "atypical"

Breakdown of patients who failed to attend for colposcopy, by last-recorded cytology/histopathology results

	LGEA or less	Possible HGEA	HGEA	Total number of non-attenders
Newly referred patients (n = 157)	27	3	17	47 (30%)
Follow-up patients (n = 184)	44	0	15	59 (32%)

HGEA = high-grade epithelial abnormality. LGEA = low-grade epithelial abnormality. ◆

smears or one smear reported as cervical intraepithelial neoplasia [CIN 1], with or without the presence of human papilloma virus. CIN 2 or CIN 3 were defined as “high-grade” abnormalities.) In the prospective study, of 40 women with a cytology report of LGEA, 13 (33%) had HGEA on histopathology.

Although our numbers were small, the incidence of histologically confirmed HGEA in patients presenting with LGEA on cytology appeared to be higher than the 24.5% reported by the Queensland Pap Smear Registry in 2000 for Queensland as a whole.⁴

Our colposcopy attendance study showed that, of 341 women referred for colposcopy over a 3-month period, 106 (31%) failed to attend scheduled appointments. Non-attenders included 27 Indigenous women, 10 women living only transiently in the area and 40 women living in remote areas. Thirty per cent of newly referred women and 32% of follow-up patients failed to attend, despite prolonged efforts by doctors, nurses and social workers to persuade them to do so (Box). (These proportions are substantially higher than those reported in clinics in large urban centres.⁵)

Under previous NHMRC guidelines, women with reports of CIN 1 were immediately referred for colposcopy.³ However, under the recently adopted guidelines, such women are required to have at least one further smear 12 months later and demonstrate ongoing abnormality before referral.⁶ This policy assumes a stable, informed, compliant population with well motivated patients able to return for long-term follow-up. It also requires a reliable, non-labour-intensive system to track down non-attend-

ers. In the FNQ region, with limited health care personnel, a population scattered over a huge area and patients often non-compliant (for many reasons, including social, financial, geographic and educational factors), we feel that the latest NHMRC policy is likely to be counterproductive, with the women most at risk possibly slipping through the net. We believe that in FNQ, and possibly in other rural areas where the incidence of cervical cancer is high, it may be appropriate to adapt the new national guidelines and continue with policies for managing LGEA that are more akin to the former guidelines.

- 1 Australian Institute of Health and Welfare. Cervical screening in Australia 2001–2002. Canberra: AIHW, 2004. (AIHW Cat. No. CAN 22; Cancer series No. 27.) Available at: <http://www.aihw.gov.au/publications/index.cfm/title/10069> (accessed Jan 2006).
- 2 Coory M, Baade P, Muller J. Cancer incidence, mortality and survival by rurality and socio-economic status in Queensland. Brisbane: Health Information Centre, Queensland Health, 2001.
- 3 National Health and Medical Research Council. Screening to prevent cervical cancer: guidelines for management of asymptomatic women with screen-detected abnormalities. Canberra: Commonwealth of Australia, 1994. Available at: <http://www.csp.nsw.gov.au/downloads/wh16.pdf> (accessed Jan 2006).
- 4 Women's Cancer Screening Services. Queensland Cervical Screening Program State Plan 2002–2006. Brisbane: Queensland Health, 2002.
- 5 Quinlivan JA, Petersen R, Gani L, Tan J. Demographic variables routinely collected at colposcopic examination do not predict who will default from conservative management of cervical intraepithelial neoplasia 1. *Aust N Z J Obstet Gynaecol* 2005; 45: 48–51.
- 6 National Health and Medical Research Council. Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen detected abnormalities. Canberra: Commonwealth of Australia, 2005. Available at: http://www.nhmrc.gov.au/publications/_files/wh39.pdf (accessed Jan 2006). □

Research administration and privacy legislation: dealing with the HIC (Medicare Australia).

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TO THE EDITOR: During a recent year-long Primary Health Care Research, Evaluation and Development (PHCRED) research fellowship, we encountered all the usual barriers to undertaking good research (funding, time, etc). While privacy legislation has been reported to adversely affect research,^{1,2} we were unprepared for the time and cost of dealing with the Health Insurance Commission (HIC — now “Medicare Australia”).

Our research involved mailing a survey to Victorian general practitioners. For approved research, the HIC supplies a valuable service in providing representative datasets of randomly selected GPs. This was once a quick and relatively inexpensive process — a boon when conducting research with limited funding. Being the first within our department to use this service since the new privacy laws were introduced, we struck unexpected administrative and financial barriers.

To maintain anonymity of potential respondents, research materials (ie, surveys and plain language statements) must be mailed by the HIC. So, all items must first be forwarded to the HIC, from where they are remailed to respondents. This process raises a number of hurdles:

- materials need to be approved (and altered if required) by the “Privacy” department at the HIC, despite prior approval from a duly constituted university ethics committee;
- there is a limit of two reminder mail-outs (usual protocols for maximising response rates require up to four mail-outs, and inadequate response rates may render research findings unrepresentative and therefore useless); and
- each mail-out is sent with the same HIC covering letter.

Additional requirements lead to an increase in costs — sending envelopes, surveys and plain language statements in bulk to Canberra (numerous times), printing HIC covering letters, and charges for “preparing business rules, extraction specifications, project management processes to completion...”. The list goes on. We were also charged for

extraction of the same dataset again for mailing the reminder letter, as more than 2 weeks had elapsed since the original data extraction.

Finally, there is the added time. We estimated this to be around 4 weeks, which is detrimental in a limited fellowship position.

While the people we dealt with at the HIC were helpful and professional, the time and expense were almost overwhelming. We respect the need to protect the privacy of research participants. However, the “side effects” of applying the new privacy laws are having an adverse impact on primary health care research. Let this be a friendly warning to all those about to set off down the research path — excessive red tape is no longer the exclusive domain of practitioners.

1 O'Grady KF, Nolan TN. Privacy: bad for your health? [letter]. *Med J Aust* 2004; 180: 307-308.

2 Carapetis JR, Passmore JW, O'Grady K. Privacy legislation and research [letter]. *Med J Aust* 2002; 177: 523. □

Pharmaceutical Benefits Scheme limitations on macrolides: implications for pertussis management

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TO THE EDITOR: Pertussis continues to be a significant public health problem in Australia. Children aged under 1 year are most at risk from severe, life-threatening complications from the disease.¹ Traditionally, erythromycin has been the drug of choice for treatment of cases and prophylaxis in selected contacts. However, its use in neonates is known to carry a risk of infantile hypertrophic pyloric stenosis.^{1,2} Its propensity to cause QT prolongation and ventricular arrhythmias is also well described.^{2,3}

Both azithromycin and clarithromycin have been recently recommended as suitable alternatives for management of pertussis.^{2,4} The US Centres for Disease Control now regard azithromycin as the agent of choice for neonates less than 1 month of age.¹ There is evidence suggesting azithromycin

has less pro-arrhythmic potential than erythromycin or clarithromycin.^{5,6} Azithromycin does not interact significantly with the hepatic cytochrome P450 system and has less potential for significant drug interactions than other macrolide antibiotics.^{3,5,6} Azithromycin and clarithromycin also require less frequent administration (1–2 doses per day) and shorter treatment regimens (5–7 days) than erythromycin.

In Australia, roxithromycin is the most widely prescribed macrolide antibiotic. However, there are no clinical studies on its effectiveness in pertussis, and in-vitro sensitivity studies suggest it may be inferior to erythromycin. Thus, roxithromycin cannot be recommended in pertussis.⁴

Updated versions of Australian antibiotic guidelines to be released later this year will recommend azithromycin for pertussis treatment and prophylaxis. However, access to azithromycin for this purpose in Australia is currently limited by the restrictions placed on prescribing through the Pharmaceutical Benefits Scheme (PBS). Azithromycin is currently approved for *Chlamydia trachomatis* urethritis, cervicitis and trachoma. Pertussis is an approved indication only for the use of 500 mg tablets under the Repatriation PBS.

This restriction has important implications for the effective and safe management of pertussis in Australia. Widespread use of newer macrolides in the community is not advisable because of the propensity of macrolides to induce antibiotic resistance, and their greater cost. However, for pertussis infection, Australians need to be able to access agents such as azithromycin. PBS restrictions for this indication need to be revised, for both tablet and liquid formulations.

1 Tiwari T, Murphy TV, Moran J; National Immunization Program, Centers for Disease Control and Prevention. Recommended antimicrobial agents for the treatment and postexposure prophylaxis of pertussis: 2005 CDC Guidelines. *MMWR Recomm Rep* 2005; 54 (RR-14): 1-16.

2 Allen C, Jeffery H. Pertussis in the neonatal nursery. *J Paediatr Child Health* 2005; 41: 140-142.

3 Liu B, Juurlink D. Drugs and the QT interval — caveat doctor. *N Engl J Med* 2004; 351: 1053-1056.

4 Altunajji S, Kukurozovic R, Curtis N, Massie J. Antibiotics for whooping cough (pertussis). *Cochrane Database Syst Rev* 2005; (1): CD004404.

5 Milberg P, Eckardt L, Bruns HJ, et al. Divergent proarrhythmic potential of macrolide antibiotics despite similar QT prolongation: fast phase 3 repolarization prevents early afterdepolarizations and torsade de pointes. *J Pharmacol Exp Ther* 2002; 303: 218-225.

6 Ohtani H, Taninaka C, Hanada E, et al. Comparative pharmacodynamic analysis of Q-T interval prolongation induced by the macrolides clarithromycin, roxithromycin, and azithromycin in rats. *Antimicrob Agents Chemother* 2000; 44: 2630-2637. □

The risks of a “Commonwealth Solution” for mental health

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TO THE EDITOR: Rey seems to me to have struck upon the ideal solution for the 20% of Australians who suffer from the various mental illnesses.¹ Daniel Defoe (*The shortest way with dissenters*) would doubtless have approved. There is ample European precedent in the idea of a “ship of fools”.

The solution, as Rey says, is to ship everyone diagnosed with a mental illness to a Pacific island. This would solve many problems at a stroke. The population of Australia would be reduced by 20% (and this would be continually improved as more cases develop), thus freeing resources for proper healthy Australians. Thoroughly screened (for mental illnesses) refugees and asylum seekers would easily enter the depleted urban centres.

General practices would have a reduction of more than 40% of patients, as we all know this is roughly the percentage of people presenting with primarily mental health problems. No more crisis with general practitioner numbers. Hospitals would have a similar reduction of cases. No more shortages of hospital beds. Single vehicle traffic fatalities would surely reduce, if alcohol and other drug-dependent people were to be included under the umbrella of one of the mental illnesses.

I envisage a whole fleet of Tampas flowing back and forth to the Pacific nations, ferrying more than 4 million psychiatric emigrants to their proper places in the world.

1 Rey JM. The risks of a “Commonwealth Solution” for mental health [letter]. *Med J Aust* 2005; 183: 624. □

Driveway motor vehicle injuries in children: a prospective review of injury circumstances

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TO THE EDITOR: Several studies from Australasia and North America have identified that in up to 24% of children with pedestrian motor vehicle injuries (MVIs) the event occurred in a driveway.¹⁻⁴ Earlier work from our centre in Sydney and others in Auckland, New Zealand, highlighted prevention as the most effective method for reducing the morbidity and mortality associated with this unique mechanism of injury.^{2,3,5} With ethics committee approval, we prospectively reviewed injury circumstances in children under 16 years of age presenting with a driveway MVI to our institution over a 3-year period between June 2002 and May 2005.

Of 36 children injured in 35 separate driveway MVIs, 26 caregivers agreed to an interview and scene visit. Fifteen patients (58%) were male, with a mean age of 48 months. The majority of events occurred in western and south-western Sydney — a paediatric population centre — in the afternoon (18; 69%) and on a weekday (19; 73%), with a trend for greater frequency at the beginning and end of the working week. In all but two cases, the injury occurred at the child's home, which was owned by the parents in 13 cases (50%; with a mean occupation period, 47 months) and rented

1 Parental perception of factors contributing to their child sustaining pedestrian motor vehicle injuries in the driveway

Lack of supervision	15
Child playing in parked car	5
Children's behaviour around cars	5
Negligent driving	2
Excessive speed	2
Hand brake not applied	1
Front house door left open	1
Hurrying when leaving home	1

2 Injuries identified in children sustaining pedestrian motor vehicle injuries in the driveway

Head and neck

Skull fracture	1
Intracranial haematoma	1
Concussion	2
Retropharyngeal haematoma	1

Torso

Hepatic contusion	1
Adrenal haematoma	1
Haemopneumothorax	1
Multiple rib fractures	1
Pelvic fracture	1
Major soft tissue injury	1

Limb

Fractures	2
Burns	
Full thickness	4
Partial thickness	3
Major soft tissue injury	1
Minor soft tissue injury	17

in 10 (38%; mean occupation period, 22 months). The majority of homes (22; 85%) had no separation between the dwelling, external play areas and the driveway. Even when a separation was present, this had been circumvented. Sedans were the most common vehicle involved (18; 69%), with the remainder four-wheel drives (4WDs) or light commercial vehicles, and 22 (85%) were reversing. The vehicle was driven by an adult known to the child in 21 cases, but in four the vehicle was inadvertently set in motion by another child. Box 1 reports parental perception of contributing factors and Box 2 lists injuries sustained, with 23 (89%) children receiving injuries severe enough to warrant hospital admission. There were no deaths.

This review indicates that driveway MVIs persist as a common and potentially fatal problem for children in New South Wales, with at least one child injured every month.² Following our previous study published in 2000, and findings of the NSW Child Death Review Team, campaigns by the Motor Accidents Authority of NSW and others have focused on driveway safety, particularly for young children. This review suggests that further intervention is needed to reduce the frequency of these injuries, either through enhanced application of present strategies or the development of more effective, novel approaches.

Acknowledgement: This study was supported by a grant from the Motor Accidents Authority of NSW.

- 1 Bell MJ, Ternberg JL, Bower RJ. Low velocity vehicular injuries in children — "run-over" accidents. *Pediatrics* 1980; 66: 628-631.
- 2 Holland AJA, Liang RWY, Singh SJ, et al. Driveway motor vehicle injuries in children. *Med J Aust* 2000; 173: 192-195.
- 3 Murphy F, White S, Morreau P. Driveway-related motor vehicle injuries in the paediatric population: a preventable tragedy. *N Z Med J* 2002; 23: U148.
- 4 Roberts I, Norton R, Dunn R, et al. Environmental factors and child pedestrian injuries. *Aust J Public Health* 1994; 18: 43-46.
- 5 Roberts I, Norton R, Jackson R. Driveway-related child pedestrian injuries: a case-control study. *Pediatrics* 1995; 95: 405-408.

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Sports Doctors Australia

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COMMENT: I would like to draw readers' attention to a very enthusiastic and active group of sports medicine practitioners that was not mentioned in the editorial by Orchard and Brukner,¹ which introduced the Sports Medicine Practice Essentials series.

Sports Doctors Australia comprises general practitioners and others from areas such as orthopaedics, rehabilitation, accident and emergency, and sports dentistry. Virtually all fellows of Sports Doctors Australia (SDrA) have obtained a postgraduate degree in sports medicine from an Australian university (most commonly a masters degree from the University of New South Wales). We are committed to delivering excellent care in all areas of sports medicine to the general public as well as to elite athletes. Because of our wider background in general medicine, we are in an ideal position to provide overall care to teams and individual athletes. Many of our fellows are, or have been, very successful team doctors for national teams. A number of fellows are active in clinical research and have academic appointments with university medical schools.

Our main aim is not to obtain specialist status (as it is for members of the Australasian College of Sports Physicians), but to provide excellence in sports medicine care for athletes at all levels, and to provide sports medicine education to other doctors, medical students and the general public.

- 1 Orchard J, Brukner PD. Sport and exercise medicine in Australia [editorial]. *Med J Aust* 2005; 183: 383. http://www.mja.com.au/public/issues/183_07_031005/orc10689_fm.html

□

What's in a title?

Garry J Walter

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TO THE EDITOR: I read with interest Brooks' letter on the value of professorial titles.¹ It is not only in academic circles that the subject sometimes arouses passions. A short while ago, my wife had reason to speak sternly to our two young children. Losing the plot, my daughter replied, "What would you know, mum? You're not a professor." At that moment in this household, as I found myself slinking towards my study, the status of a professorial title — at least in my wife's eyes — amounted to very little.

1 Brooks PM. Academic absenteeism. *Med J Aust* 2005; 183: 602. □

Myasthenia gravis and a rare complication of chemotherapy — clarification and acknowledgement

Christina VT Ng

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TO THE EDITOR: I would like to clarify several issues pertaining to the case report published in the 7 February 2005 issue of the Journal.¹

The patient reported was under the care of Dr Craig Underhill and Dr Kerrie Clarke, who are medical oncologists at Albury Base Hospital, Albury, New South Wales. Their contribution to the reporting of this rare and interesting case must be acknowledged.

I regret any misconceptions arising from this article, and I would like to thank Dr Underhill and Dr Clarke for their support and professionalism.

1 Ng CVT. Myasthenia gravis and a rare complication of chemotherapy. *Med J Aust* 2005; 182: 120. □

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