From the Editor’s Desk

MEDICAL SCHOOLS — BLUE CHIP ASSETS

In 2002, Eugene Stead, the pre-eminent US medical educator, made the intriguing observation that: “There hasn’t been one medical school [in the United States] that has failed since the publication of the Flexner Report … If you look at other [prominent] businesses at the time of the Flexner Report [1910], you’ll find that only about 5%–7% are still in business. That’s an interesting comparison to the history of medical schools, which number in the hundreds …”

Considering that US medical students graduate with a debt of US$100 000 or more, the fiscal stability of US medical schools should be no surprise. Australian medical schools apparently mirror this strength, as all have continued in business since the first was founded in the mid 19th century, and we now have 18 schools. If these institutions were listed on the stock exchange, they would surely be considered blue chip investments.

Why should this be?

First, they produce a valued product that is continually in high demand; the school places they offer are the object of fierce competition. Furthermore, medical schools are underpinned by government support and, more recently, by a move toward fee-paying students. Infrastructure costs for clinical facilities are not burdensome, and most clinical teachers offer their services pro bono.

Stead notes that medical schools are protected in other ways: “… we have a monopoly on the creation of skilled medical manpower in the hands of schools which are mostly in the mode they were in during the Flexner Report”. He believes that the time has come for a reform of medical education, but unfortunately does not develop this theme in depth.

In any event, our medical schools continue to thrive as blue chip assets. Small wonder, then, that Australian universities vie to establish their own medical schools.

Martin B Van Der Weyden

January MJA BookClub Winner

Congratulations to Dr Robert J French, Armidale, NSW, winner of our January prize draw. Dr French wins a copy of Acland’s Atlas of Human Anatomy: Head and Neck, Part 1 & 2 (DVD set). Thanks to everyone who purchased books from the January MJA BookClub and went into the draw. Pictured right is Stephanie Tricklebank, from AMPCo’s Information Processing Department, drawing the January winner. To see this month’s MJA BookClub’s great offers, see page 282 and the inside back cover of this issue.

MJA • Volume 188 Number 5 • 3 March 2008 265
Is “nut-free” sunflower seed butter safe for children with peanut allergy?

Mimi Tang and Raymond J Mullins

TO THE EDITOR: In their report of a child with peanut allergy who developed sunflower seed allergy, Hsu and Katelaris caution against marketing claims of “safe alternatives” in allergic children.1 Their report also raises practical issues for those advising the parents of a child with food allergy: what is the risk of a new allergy developing, should a child with peanut or tree nut allergy avoid similar foods as well, and will food avoidance prevent new allergy from developing?

The natural history of peanut and tree nut allergy is for polysensitisation to develop over time. One study demonstrated that, in children younger than 2 years with peanut or tree nut allergy, 19% were sensitised and 2% were clinically reactive to more than one nut.2 By the age of 14 years, the percentages had risen to 72% and 47%, respectively. This has led to people with peanut or tree nut allergy being advised to avoid all nuts and seeds.3 Strategies commonly advised to reduce the risk of allergy developing are to avoid food allergens and to delay the introduction of allergenic foods until the age of 2 years, but evidence to support their effectiveness is limited,4 particularly for preventing food allergy.5

While studies in infants at high risk of allergic disease have reported an increased risk of eczema with early introduction of solids (before the age of 3–4 months),5 and a protective effect against asthma and eczema with the avoidance of environmental and food allergens in the first 6 months of life,6 a recent systematic review found “no strong evidence to support the association between early solid feeding and the development of persistent asthma, persistent food allergy, allergic rhinitis, or animal dander”.5 Furthermore, there is currently no evidence that avoidance strategies applied beyond 6 months of age are effective for allergy prevention, and provisional evidence that such strategies might actually promote sensitisation and food allergy rather than tolerance.6

So how should we advise patients?

The peanut and tree nut avoidance strategies advised will be largely dictated by:

- the risks of cross-contamination in commercially prepared foods; and
- the potential for confusion in young children (and caregivers) trying to differentiate one “nut” product from another.

Regarding the risk of developing new food allergy, we should advise patients that:

- new allergies may develop with time;
- this risk is unpredictable;
- we have little evidence to recommend avoidance beyond the age of 6 months as an effective preventive strategy; and
- parents should not be optimistic (given the current state of knowledge) that such strategies will prevent new sensitisation once food allergy has developed.

Mimi Tang, Associate Professor and Director1
Raymond J Mullins, Physician2
1 Department of Allergy and Immunology, Royal Children’s Hospital, Melbourne, VIC.
2 John James Medical Centre, Canberra, ACT.

rmullins@allergycapital.com.au


γ-Hydroxybutyrate poisoning from toy beads

Vicki Kotsirilos

TO THE EDITOR: The case reports presented by Gunja et al1 are a serious concern from many perspectives. The health authorities should be commended for their rapid risk assessment and alerting the community, which led to the immediate withdrawal and recall of the toy beads from the marketplace.

However, the question needs to be asked: Could this situation have been prevented, and if so, how? There are many toys in Australia that potentially pose risks to child-

ren. These can include physical dangers, such as the size of toys, with risk of choking, to toxicological dangers, as we have seen with Bindeez toy beads (containing 1,4-butanediol), and psychological and social concerns, such as the effects of sexually provocative toys on young girls and “aggressive” toys (which may encourage violence) on young boys. More research is required to test the psychological influence of such toys on children. The evidence should be used in the development of guidelines for safer toys.

At present, toy manufacturers in Australia must adhere to the Australian Toy Standard (AS/NZ 8124), established by Standards Australia.2 Toys are monitored and regulated mostly by the state governments. While the manufacturers are expected to adhere to these standards, they are in fact voluntary standards and self-regulated, and many toys can enter and be sold in Australia without meeting these standards.

When a consumer or state government inspector is concerned about the safety of a toy, or if it violates the regulation, they may contact one of the state offices of fair trading, which have the power to remove the toy from the marketplace. This is essentially a post-hoc auditing system and plays an important role in safety, but action is essentially taken after a problem is detected, such as is the case with the Bindeez toys.

In view of potential concerns, I believe what we need in Australia are stronger regulations and guidelines that we can provide to manufacturers to help produce safer toys. Our efforts should be towards preventing any potential harm by strengthening existing regulations, establishing consistent national and international standards for all imported toys, providing more resources for the verification and testing procedures and more expertise and wider consumer input into the safety and suitability of the types of toys permissible in Australia. We have a duty to protect and safeguard our children from both psychological and physical dangers.

Acknowledgement: I thank the MJA reviewers for their guidance and comments.

Vicki Kotsirilos, General Practitioner
Whole Health Medical Centre, Melbourne, VIC.

vicki.k@optusnet.com.au

Osteoarthritis — the forgotten obesity-related epidemic with worse to come
Margaret A Allman-Farinelli, Robert J Aitken, Lesley A King and Adrian E Bauman

To the Editor: Australia, like many other nations, is experiencing an epidemic of overweight and obesity. The most recent National Health Survey reported that 62% of men and 45% of women were overweight or obese. Among numerous associated concerns is the cost burden of obesity-related illnesses on individuals, the community and the health system.

Among the 45–54-years age group (the stage at which osteoarthritis becomes a significant health problem), we calculated the population attributable risk (PAR) for osteoarthritis associated with obesity to be 25% for men and 22% for women, using a relative risk (RR) of 2.4 and obesity estimates of 23.3% for men and 20.1% for women. In terms of major health sequelae of the epidemic, this is second only to obesity-related type 2 diabetes (RR, 3.2; PAR, 34% for men, 31% for women). Some obese patients will have multiple obesity-related comorbidities.

In 2005 in Australia, 2551 national hospital separations among people aged 45–54 years were for obesity-related osteoarthritis. Using data from the three most recent National Health Surveys, we projected the likely prevalence of obesity among 45–54-year-old Australians in 20251,3,4 and then estimated future hospital separations and direct health system expenditure, using costing information supplied by the Australian Institute of Health and Welfare.2 We acknowledge the Australian Institute of Health and Welfare for supplying National Health Survey confidentialised unit record files. The New South Wales Centre for Overweight and Obesity is funded by NSW Health.


Margaret A Allman-Farinelli, Research Fellow1 Robert J Aitken, Biostatistical Officer Trainee2 Lesley A King, Adjunct Senior Lecturer1 Adrian E Bauman, Professor1
1 NSW Centre for Overweight and Obesity, School of Public Health, University of Sydney, Sydney, NSW.
2 NSW Health, Sydney, NSW. margallman@health.usyd.edu.au

Correspondents
Please submit letters electronically via Editorial Manager at www.editorialmanager.com/mja/. Authors who cannot access the Editorial Manager submission system may submit letters by email to medjaust@ampco.com.au.

Letters must have no more than 400 words and 5 references. All letters are subject to editing for clarity and Journal style; proofs will not normally be supplied. There should be no more than 3 authors per letter, and each author should give one relevant position and affiliation for publication. Presentation of the reference list must follow the same guidelines as for manuscripts (see examples at www.nlm.nih.gov/bsd/uniform_requirements.html). In particular, only include material that has been published (or accepted for publication), and ensure that reference details are complete, including the names and initials of all authors for references with up to 4 authors, or of the first 3 authors then “et al” if there are more than 4.

Letters should have no more than 400 words and 5 references. All letters are subject to editing for clarity and Journal style; proofs will not normally be supplied. There should be no more than 3 authors per letter, and each author should give one relevant position and affiliation for publication. Presentation of the reference list must follow the same guidelines as for manuscripts (see examples at www.nlm.nih.gov/bsd/uniform_requirements.html). In particular, only include material that has been published (or accepted for publication), and ensure that reference details are complete, including the names and initials of all authors for references with up to 4 authors, or of the first 3 authors then “et al” if there are more than 4.
patients. It is rather to organise the care of patients who have a problem in the area of our specialty.

Jeffery M Peereboom, Orthopaedic Surgeon
Brisbane Private Hospital, Brisbane, QLD.
j.peereboom@yahoo.com.au


Tony N Smith

IN REPLY: Peereboom appears to ignore reality. Recent news media1 gave an insight into the state of radiological services at some Sydney teaching hospitals. Thousands of images have never been seen by a radiologist. Yet, all of those images were seen by radiographers, who also saw the patients. I am frequently asked by doctors for my opinion about radiographs. At times, I volunteer my opinion to junior doctors and general practitioners. Thirty years of experience tells me that, if I don’t, they miss abnormalities, delaying treatment and decreasing the quality of care.

Peereboom will have worked with radiographers capable of accurately interpreting radiographs. Today, many Australian radiography students have tertiary entrance scores in the 90s. Arguably, the only reason we cannot teach them to formally give their opinion on radiographs is because of a professional boundary drawn in the sand in the 1920s.2 However, the sand is shifting under the health care system.

I have the greatest respect for radiologists’ knowledge, skills and intellectual capacity. However, an advanced practice role for radiographers is not just about respect. It is a human resource issue. Knowing that the current service model is antiquated, do we wish to limit the potential of both radiographers and radiologists in the future?

Tony N Smith, Senior Lecturer in Medical Radiation Science
Department of Rural Health, University of Newcastle, Tamworth, NSW.
tony.smith@hnehealth.nsw.gov.au

Lack of consistency in safe-sleeping messages to parents

Sarah J Buckley

TO THE EDITOR: The concerns expressed by Byard and colleagues about “safe-sleeping messages” are based on the assumption that bed-sharing (mother and baby sleeping on the same bed surface) is intrinsically dangerous.

While some case-control studies have shown increased mortality for young (but not older) bed-sharing babies of non-smoking mothers, more detailed studies have found excess risk only among parents affected by alcohol, extreme overtiredness, overcrowded housing, or where the sleeping environment was unsuitable, including prone or side sleeping, heavy bedding, waterbeds and sofas.

Epidemiological studies support the safety of bed-sharing. For example, in Hong Kong and mainland China, bed-sharing is very common, but rates of unexplained infant death are extremely low. This implicates aspects of Western lifestyle and sleeping practices — including the V-shaped pillows (tri-pillows) highlighted by Byard et al, other suffocation and entrapment hazards, and maternal smoking — rather than bed-sharing per se.

Bed-sharing is also the evolutionary norm, providing many opportunities for “mutual regulation” of maternal-infant physiology, including body temperature, sleep cycle and breastfeeding. Modern bed-sharing mothers may appreciate the more restful sleep and easier breastfeeding.

Overnight sleep laboratory studies of bed-sharing and solitary-sleeping mother-baby pairs show that bed-sharing mothers are very aware of their baby’s presence, even in deep sleep, and move to avoid overlaying. Bed-sharing babies breastfeed more frequently, but with equivalent total sleep for mother and baby. Researchers note the rarity of unsafe prone positions among breastfeeding, bed-sharing infants.

Other studies have shown increased rates and duration of breastfeeding among bed-sharing mothers and infants.

For these reasons, bed-sharing has become more popular in Western cultures, with an Australian survey in 2000 finding around 40% of young babies bed-sharing for at least part of the night.

As with other aspects of care, it is our duty as health professionals to discuss the risks, benefits and practicalities of bed-sharing so that parents can make an informed and safe choice. The Royal Australasian College of Physicians comments, “Co-sleeping or bed-sharing is common and associated with increased breastfeeding rates, longer and more restful sleep, and a protective posture and synchrony of mother with baby . . . All parents should be informed about how to safely co-sleep with their infants.”

Safe bed-sharing recommendations are available from websites such as the UNICEF UK Baby Friendly Initiative.

Sarah J Buckley, General Practitioner Brisbane, QLD.

sarahlbuckley@yahoo.com


4 Ball HL. Breastfeeding, bed-sharing, and infant sleep. Birth 2003; 30: 181-188.


Roger W Byard, Glenda Cains, Helen Noblet and Maxine Weber

IN REPLY: Our position on bed-sharing was not based on the assumption that it is intrinsically dangerous, but that there is an increased risk of mortality for bed-sharing babies of “parents affected by alcohol, extreme overtiredness, overcrowded housing, or where the sleeping environment was unsuitable” (to quote Buckley). These risk factors were not mentioned by the telephone health advice line quoted in our letter, which rather commented that mortality in bed-sharing babies was such a rare event that the caller should not worry about it — little consolation if a fatality occurred.

We agree completely that parents need to be able to “make an informed and safe choice”, but this also requires informing...
them of potential dangers — which did not happen. Also, we do not agree that mothers are always aware of the presence of their babies, as reports of accidental suffocation during breastfeeding in bed clearly demonstrate.\(^2,3\)

An informed decision is made when all the information has been provided, not just information that supports a particular point of view. Curiously, Buckley's final point is to recommend a website for safe bed-sharing advice\(^4\) that states quite clearly (with italics): "the safest place for a baby to sleep is in a cot by your bed". We concur.

Roger W Byard, George Richard Marks
Professor of Pathology\(^1\)

Glenda Cains, Mortuary Team Leader\(^2\)

Helen Noblet, Executive Officer\(^3\)

Maxine Weber, Executive Director\(^4\)

1 Discipline of Pathology, University of Adelaide, Adelaide, SA.

2 Forensic Science SA, Adelaide, SA.

3 Kidsafe SA, Women's and Children's Hospital, Adelaide, SA.

4 SIDS and Kids South Australia, Adelaide, SA.

b byard.roger@sa.gov.au

---

**LETTERS**

In my day

Sara L Barnes, MB BS, Medical Registrar

The Austin Hospital, Melbourne, VIC.

saraitsallabout@hotmail.com

---

**2008 Dr Ross Ingram Memorial Essay Competition**

Are you an Aborigional or Torres Strait Islander with something to say about Indigenous health? Tell us your story!

The 2008 Dr Ross Ingram Memorial Essay Competition is open to any Indigenous person who is working, researching or training in a health-related field.

Essays should be no more than 2000 words long and must be submitted to the Journal by Friday, 23 January 2009.


---

**MJA Advertisers Index**

**Action Pharmaceuticals**

Tracleer — Breathless, listless, lifeless... p274

Tracleer — PBS Information................. p275

Tracleer — Where are they now?.................. p315

**Sanofi Avents**

Karvea/Karvezide.............. Inside front cover

---