LETTERS

Absence of alcohol withdrawal syndrome in a remote Indigenous community

Stephen A Margolis, Valmae A Ypinazar, Alan R Clough and Ernest Hunter

To the Editor: Impacts of alcohol consumption on health and wellbeing in remote Indigenous communities are well documented.[1] In response, governments have applied supply and demand reduction programs, including the "Meeting Challenges, Making Choices" program, which has lowered the rate of serious injury.[2] Although a pattern of heavy, episodic drinking has been documented,[3] the nature of physical dependence in relation to acute alcohol withdrawal syndrome[4] is uncertain. We report the results of sudden, temporary removal of alcohol in a small Indigenous community.

In a remote Queensland Indigenous community (population, 1021) with one licensed premises, patterns of extreme drinking (30 standard drinks per session) are commonly seen around paydays. In 2008, the Queensland Government withdrew the sole liquor trading licence with 72 hours' notice because of a breach of licensing laws. The licence was subsequently renewed after several months. During this time, there was no significant access to alternative (illegal) sources of alcohol within the community, as the prohibition against bringing alcohol into the community (initiated in 2003) was strictly enforced by police.

Health services in this community comprised a primary health care centre (PHCC) with Queensland Health resident nursing staff, Royal Flying Doctor Service medical staff on weekdays (the principal doctor was SAM), and visiting specialists provided by both organisations, including a psychiatrist (EH). When the closure was being arranged, Queensland Government authorities requested that these health providers establish a process to treat any patients who developed acute alcohol withdrawal syndrome; this was monitored by SAM.

Four weeks after the sudden cessation of alcohol availability, PHCC staff did not notice any outmigration of regular drinkers, and no patients presented with acute alcohol withdrawal syndrome. These findings are consistent with the anecdotal experience of EH, who has not encountered any cases of withdrawal delirium in this community over the past 16 years. By contrast, in recent years EH has observed several cases of withdrawal symptoms from cannabis use in this community, as seen previously in remote Northern Territory Indigenous communities.[5]

Our results suggest that people can develop physiological or psychological tolerance for heavy episodic drinking, which may be a function of adaptation to the intermittent nature of financial resources. This finding removes a potential health-related impediment preventing governments from considering sudden cessation of legal alcohol supply in these or similar environments.

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Management of kidney stone disease in New South Wales: an observational study

Finlay Macneil, James W H Macneil, Kylie L Fraser and Andrew J Brooks

To the Editor: Urinary stones are very common, with a cumulative lifetime incidence of 5%–15% and a recurrence rate of about 50%.[1] Many new treatment techniques have been developed, but availability, particularly in public hospitals, is variable.

The Greater Metropolitan Clinical Taskforce[2] assessed patterns of treatment in patients requiring urological consultation who presented to the emergency departments (EDs) of 12 New South Wales public teaching hospitals in major centres that had a specialty urology registrar.

Between February and September 2007, the urology registrar or specialist completed a survey on consecutive patients presenting with urolithiasis who agreed to participate. The survey contained questions on patient demographics, the position and size of the stone, and the preferred treatment option. One of us (JWHM) conducted a telephone interview with each patient to obtain details of treatment, and follow-up interviews at 3-monthly intervals (until treatment was completed or the study ended) to determine the outcome. Ninety-two patients entered the study: 64 men (mean age, 50.4 years) and 26 women (mean age, 47.8 years) (sex was not reported for two patients). Thirty-seven patients were subsequently treated in the public system, and the remainder in the private system, either using private health insurance or at their own expense.

The preferred treatment option of the treating medical officer, usually the urology registrar, was nominated: non-operative (spontaneous stone expulsion) with or without calcium-channel blockers, 13 patients (received by 6); rigid ureteroscopy with grasper or lithoclast, 21 patients (18); rigid ureteroscopy with laser, 4 patients (4); flex-

Duration of treatment of public and private patients with a pelvi-ureteric junction or upper ureteric stone who required more than one treatment episode*

	Public patients ($n = 18$)	Private patients ($n = 18$)
Mean duration of treatment in weeks (95% CI)	18.3 (12.9–23.7)	6.2 (3.0–9.4)
Range (weeks)	3.0–49.5	0.6–25
Difference in weeks (95% CI)	12.1 (5.5–18.7)	
P	< 0.001	

* Up to four treatment episodes. ◆

ible ureteroscopy with laser, 17 patients (2); percutaneous nephrolithotomy, 3 patients (3); extracorporeal shock wave lithotripsy, 6 patients (2); or "other", 28 patients — of whom stent was specified in 24 (23).

The preferred treatment option was not used for 34% of patients because it was not available at the hospital. The mean duration of treatment (defined as the period between initial ED presentation and final treatment episode) for patients with pelvi-ureteric or upper ureteric stones requiring more than one treatment episode is shown in the Box.

Thirty-nine patients had stents inserted in the ED, of whom four did not reach definitive management by the end of the study. Of the remaining 35, 20 were public patients and 15 were private patients. Fourteen had stents in situ for more than 3 months and required a change of stent before initiation of definitive treatment to avoid encrustation; 12 of these patients had treatment in the public system.

Despite the relatively small number of participants in this study, its findings on access to timely treatment for public patients should not be ignored. Management of kidney stones was heavily influenced by insurance status. Ureteric stents are intended to be temporary, but patients treated in the public system who had a stent inserted at initial presentation had a 60% (12/20) chance of still having it 3 months later, thus requiring a change of stent before definitive intervention — an unnecessary procedure that increases hospital re-admissions. Patients would be treated more efficiently and effectively with more timely access to appropriate resources.

This is an unacceptable burden of morbidity for patients. Urgent action is required to improve the current state of care for public patients with kidney stones in NSW.

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Booster seat use by children aged 4–11 years: evidence of the need to revise current Australasian standards to accommodate overweight children

Michael P Fitzharris and Diana M Bowman

To the Editor: The Australian Transport Council should be commended for approving the National Transport Commission's revised road rules for the safety of children in motor vehicles.[1] A key requirement is that children aged 4–7 years are to be restrained in an approved forward-facing child restraint or booster seat. It is expected that such changes, once enacted by states and territory governments, will result in fewer children being injured and killed.

In a letter in the 4 August issue of the Journal, Zurynski and colleagues argued that these changes will bring Australian rules closer to — but nevertheless fall short of — overseas jurisdictions, where children up to 12 years of age or 145 cm in height must be restrained in booster seats.[2] Notably, a wider selection of booster seats is available in these jurisdictions, including seats suitable for children weighing up to 36 kg. In contrast, the Australian/New Zealand Child Restraint Standard (AS/NZ 1754) stipulates that an "approved booster seat" is one that has a maximum design weight threshold of 26 kg.[3] Mandatory consumer information notes that booster seats are "to be used only with lap-sash seatbelt or with a seatbelt and child harness for a child weighing

from 14–26 kg", and that they are not to be used if the child's eye level is above the top of the booster back, or above the top of the car seat back or headrest when restrained in the booster seat.[3]

The matter of children exceeding the maximum weight threshold of 26 kg while failing to meet the transition height to adult seatbelts is far from trivial. Previous research published in the Journal found that about 50% of 7-year-olds whose height fell between 100 cm (the upper recommended height for child car seats) and 145 cm (the recommended seatbelt transition height) exceeded 26 kg, with only 27% having an age- and sex-adjusted body mass index > 25 kg/m^2.[4] Consequently, due to the current range of approved booster seats available in Australia, children may be placed at some unquantified risk in the event of a crash, as optimal protection above this weight threshold cannot be guaranteed. Further compounding this scenario is that pursuant to r266 of the Australian Road Rules, if a child "cannot safely be restrained as required . . . because of his or her height or weight", the use of a seatbelt may be deemed acceptable.[1] To avoid this scenario, it is essential that booster seats with a higher maximum weight threshold be made available in Australia as soon as practicable.

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Evidence to support changes to child restraint legislation

Wei Du, Caroline F Finch and Lynne E Bilston

To the Editor: Despite expert recommendation, Australian states have yet to enact legislation requiring use of child restraints beyond the age of 12 months.

Our analysis of police crash records and linked hospital separation data for the period July 2000 to June 2001 in New South Wales found that a large proportion of children who were hospitalised following motor vehicle accidents were reported by police as having used adult (standard) seatbelts at the time of injury (Box).

It is of particular concern that over 80% of 5–8-year-olds in this cohort were using standard seatbelts rather than child restraints (eg, booster seats). This pattern of premature "graduation" to seatbelts has also been reported in general populations of child motor vehicle passengers both overseas[1] and in Australia,[2] and also in presentations of child motor vehicle passengers after a crash to a NSW hospital's emergency department.[3]

Child restraints are specifically designed to provide crash protection for children's anthropometrical dimensions. Standard seatbelts are not designed to accommodate children, so they are unlikely to achieve the good fit to rigid body parts required for safety. Consequently, use of standard seatbelts by young children allows more head excursion during a crash, thereby negating their primary goal of protecting against central nervous system injury, and potentially causing Chance fractures and abdominal injuries.[4] Our results provide further evidence that such seatbelt use may not protect, or may even cause injuries, during a crash.

Child road trauma is largely preventable or controllable with the use of appropriate child restraints, including booster seats. A cost–benefit analysis showed that the use of booster seats produced a benefit–cost ratio for road trauma prevention of 9.4 (US$1854/US$197).[5] To prevent child road trauma in Australia, all child motor vehicle passengers should use appropriate child restraints.

Australian child road safety stakeholders recommend that child motor vehicle passengers use appropriate restraint systems according to their height, weight and age when travelling on road. Our findings provide further justification for proposed legislative changes that would require the compulsory use of appropriate child restraints for child motor vehicle passengers.

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Child restraint use among children (0–8 years) hospitalised for injury after a motor vehicle accident, compared with that of the general population, New South Wales

	Hospitalised children*			General population†		
Restraint use	0–4 years	5–8 years	Total	0–4 years	5–8 years	Total
Child restraint	9 (22%)	0	9 (10%)	295 (94%)	70 (31%)	365 (68%)
Adult seatbelt	11 (27%)	42 (82%)	53 (58%)	12 (4%)	153 (67%)	165 (31%)
Unknown/ no restraint	21 (51%)	9 (18%)	30 (33%)	6 (2%)	4 (2%)	10 (2%)
Total	41 (100%)	51 (100%)	92 (100%)	313 (100%)	227 (100%)	540 (100%)

* Linked hospital and police data from July 2000 – June 2001 were accessed from the NSW Injury Risk Management Research Centre. Case selection is based on corresponding codes in the International Classification of Diseases, 10th revision, Australian modification, 2nd edition.
† Based on a telephone survey conducted in NSW during 2005–2006. ◆

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Umbilical cord blood banking: public good or private benefit?

David E Roberts

To the Editor: Samuel and colleagues' article on the ethics of umbilical cord blood (UCB) banking[1] reflects much of the misinformation and bias that bedevil this debate. They argue against storage of autologous stem cells from UCB for a variety of contradictory, paternalistic or ideologically driven reasons.

The indication for autologous UCB storage is in anticipation of developments in regenerative medicine, an exciting field that holds great promise; it is not in anticipation of transplantation for malignancy, which is unlikely to occur. Samuel et al acknowledge these points, yet base their criticism of autologous storage on the latter indication.

Next, they state that autologous stem cells can be easily harvested at any time in life. Perhaps, for use in transplantation; but cells obtained later in life are likely to be of little use in regenerative medicine. Capacity for in-vitro manipulation declines with age.

Third, they argue that the two alternatives of public and private UCB storage are mutually incompatible — "public good *or* private benefit" (my emphasis). Australia's three public banks are close to achieving the desired number of cords (about 20 000) needed for transplantation medicine in the non-Indigenous population.[2] There is no shortage, and certainly no shortage of potential donors. Why argue against autologous storage as if there is?

Fourth, the authors disapprove of the for-profit motive in private-sector medicine. That may be their ideological position, but it is paternalistic to impose that view on the rest of us. Can parents not make up their own minds on the value of autologous storage? At $2000 upfront and $150 a year, storage is not so expensive that "only a small proportion of the population are able to afford [it]". I remind readers of media reports that the Australian Government's Baby Bonus (now $5000) was often used to purchase luxury items such as flat-screen televisions rather than being spent on the baby's needs.[3]

The authors are correct in one respect: some (but not all) private UCB banks have been deliberately deceptive and misleading in their marketing, and, in so doing, have been predatory and exploitative. However, it does not then follow that parents cannot access sound and sober health advice in the marketplace.

The public versus private UCB storage debate does have an ethical dimension, but not this one. This debate is really just a turf war.

Competing interests: I have worked as an advisor (unpaid) to Cryosite, 2002–2006, and as Alternative Medical Director (remunerated) to Biocell, 2006–07. I hold shares in Cryosite and Biocell, purchased at market value.

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Gabrielle N Samuel, Ian H Kerridge and Tracey A O'Brien

In reply: Roberts asserts that we are biased, paternalistic and driven by an ideological objection to private umbilical cord blood (UCB) storage. While this is impressive rhetoric, it bears little resemblance to the points made in our article.[1]

Contrary to Roberts' assertion, we do *not* object to private UCB storage. Our primary concern is that marketing campaigns make misleading or grandiose claims about the possible application of privately stored UCB in cancer care *and* regenerative medicine. For, although stem cell research does have great promise, it remains clinically unproven in the management of degenerative conditions. Offering hope of cure or amelioration of illness based on scientific speculation is enormously problematic, especially when directed at vulnerable parents concerned about their unborn child. While some private UCB banks take great care to avoid deliberate deception, many do not.[2,3] We agree that parents should be able to decide for themselves how and if to store their child's UCB, but they need accurate information to do so.

Finally, Roberts asserts that there is no shortage of public UCB units or donors. In reality, there is a vast shortage of UCB units available to ethnic minority and Indigenous patients.[4] North Caucasian donation also needs to be maintained, particularly as the impact of double-cord transplantation becomes apparent.[4]

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I went to work with a "cold" ...

John F Knight

To the Editor: I have read every issue of the Journal since graduating in 1953. In my opinion, one of the best articles I've seen is Dawn DeWitt's story, "I went to work with a 'cold' …".[1] Dr DeWitt's dilemma mirrors that of the average doctor precisely. Her "solution" gives us a good dose of common-sense that we seldom hear.

In my time as a general practitioner, I have given thousands of doses of influenza vaccine; but I have never had the flu or pneumonia shot myself (nor has my wife — a registered nurse). I took 2 weeks off duty in 1971 with a "cold", when I simply flaked out on the floor. A corneal transplant and transurethral resection of the prostate were done while "on vacation".

Luckily, I no longer have the dilemma of whether or not to go to work when I am sicker than my patients, but I will have the flu shot this week anyway. Thanks Dawn.

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1 DeWitt DE. I went to work with a "cold" … *Med J Aust* 2008; 189: 91-92. ❑