errors (SEs), from which one can calculate confidence intervals to reach the conclusions we made – that the social gradient in non-fatal accidents appears not to be increasing and the total rates are falling in men.

The data published in the Health Survey for England (HSE) 2001 refer to social class of the head of the household, as is now customary in the HSE, while the rates presented in our paper were based on the respondent’s social class, which was used in the 1995–1996 survey. The sample sizes are provided in the Table for readers’ interest.

Yours faithfully,
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Sirs,

We read with interest the article by Taylor and Cheng1 which describes the significant social class gradient in breast cancer types and the outcome of potentially unnecessary mastectomies. These important findings demand a healthcare response although the multi-factorial aetiology of breast cancer will inevitably mean that changes to service delivery will be challenging to implement. This population-based cross-sectional study made good use of postcode data and Townsend scoring to assess levels of deprivation.

We note that no adjustment was made for ethnicity or smoking history and these are both plausible confounding factors, for example, ethnicity might explain the general oestrogen receptor status gradient through the social classes. It would also be interesting to have a further breakdown of the data for the broad range of breast cancers which could potentially be contained within the ‘other’ category in order to know whether or not tumours of all histopathological types are associated with social class gradients.

The finding that there was no significant difference in time of presentation between women who were identified via the breast cancer screening programme and those who entered the system via other pathways was of particular interest and it raises questions about the effectiveness of the NHS Breast Cancer Screening Programme.

The authors correctly acknowledge the large amounts of missing data may bias the results. As a general point we are concerned that 19 per cent of patient notes were unobtainable as we think that this may have important implications for continuity of clinical care within the NHS.

References

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Situational awareness in public health

Sirs,

In his editorial1 Edmund Jessop uses the example of a crash between two 747s on the runway at Tenerife Airport to remind us of the importance of using the contribution of everyone present at a meeting when reaching conclusions or decisions. The pilot of the aircraft that started to take off in poor visibility while another aircraft was still on the runway was a very senior training captain. He was held in some awe by more junior crew members, who were likely to be uneasy about challenging his decisions.2 This ‘management by domination’, implicit or explicit, has become a feature of the NHS over the last decade, and I cannot be the only person who has heard it said that ‘if you fall out with x that is the end of your career’. Airlines have learned the hard way that this management style does not work in the longer term, and have introduced ‘crew resource management’ to overcome it. Perhaps the NHS needs to consider something similar.

Another useful lesson from this disaster is that the same word can mean different things. In the 1970s the use of ‘clear’ in aviation might mean unobstructed (‘is the runway clear?’), vacated (‘have you cleared the runway?’), audible (‘reading you loud and clear’), or an authorization (‘you are clear to take off on runway 25’). Since Tenerife the use of words has been codified more strictly, and ‘clear’ may only be used by an air traffic controller to authorize manoeuvres such as take-off, landing, routing, etc. Perhaps public health practitioners should remember that words and expressions such as ‘primary care trust’, ‘national service framework’, ‘screening’, ‘diet’, ‘sensible drinking’, and others that trip off our tongues daily, may not mean the same to the general public as they do to us.
HBV vaccination should be performed in service centres for drug users: an Italian experience

Sirs,

McGregor et al.1 analysed the factors associated with injecting drug users (IDUs) starting or completing courses of hepatitis B vaccination. This study showed that patients who were known to have hepatitis C and needle sharing were less likely to be offered hepatitis B vaccination, i.e. the patients who would benefit most from vaccination. Increasing age and the length of contact with the healthcare service was also associated with failure to accept the vaccine. The main problem for vaccination seems to be the inability of personnel to carry out the proper screening of patients and to administer the vaccine. Our experience in northern Italy suggests that services for drug users are the best place to encourage anti-hepatitis vaccination, principally because continuous contact is crucial for the success of a vaccination protocol.2–5 In our large, multi-site study, HBV vaccination among heroin users proved feasible and effective. Of 1175 IDUs studied, 88 per cent of the patients completed the vaccination series and 77 per cent of the vaccinees reached protective levels of anti-HBs.4 Hepatitis B vaccination programmes should be integrated into the regular functioning of drug abuse treatment programmes, with common expectations among both staff and patients that the vaccination series will be completed.

Other centres and institutions, who reach patients who do not go to drug treatment services (including needle exchange centres, prisons, family doctors, etc.), could contribute to further administration of the vaccine: evidence for this is provided by the McGregor study in which only 72 out of 206 patients (35 per cent) were in contact with a drug treatment centre. Nevertheless, the vaccination must be initiated and coordinated by a treatment centre with ongoing relationships with patients.

In addition, three doses do not automatically guarantee a sufficient protective titre. It is well known that the percentage of IDUs who do develop a protective titre after vaccination is lower than in the general population: 95–99 per cent of young adults in the overall population who receive a series of three doses develop a protective serum titres,6 and 77 per cent in our study.4 Often, additional doses are required for seroconversion.3

Although the concentration of antibodies to HBV depends on the time between the second and the third dose, institutions other than centres for drug users could administer quicker vaccination protocols than the classic 0–1–6 (0–1–2 or quicker), with higher doses of the vaccine, if needed (40 μg or more), since many patients are HCV positive and high alcohol consumers, both factors contributing to a negative antibody response.7

Given the high risk of hepatitis B infection among heroin users, we suggest that voluntary hepatitis B vaccination for heroin users become a standard public health practice in drug treatment service centres; this clearly requires staff training since the patients are known to be difficult to treat.

References


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