

in which haemoglobinopathies are common have been associated with faiths that do not find termination acceptable. For this reason informed consent from the mother for these tests must make it clear what these tests may lead to. Her beliefs must be respected even if this is expensive for society.

A final question to ponder is the message these screening programs give to those many individuals in our society who live with one of these haemoglobinopathies. The point has been eloquently put by the sociologist Shakespeare that a policy of termination of disabled fetuses gives the disabled in the community a strong, if unintended, message that they are not valued.<sup>4</sup>

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## Steam inhalation treatment for children

Nasal inhalation of steam has been proposed as treatment of viral colds on the assumption that increased intranasal temperature will inhibit replication of rhinovirus.<sup>1</sup> Some clinical trials looking at the effect of inhalation of steam on rhinovirus infection have used machine-generated heated humidified air.<sup>2</sup> Most people at home use the old fashioned way of head over a bowl of steaming hot water.

During January 2005, three children were assessed in our burns unit following scalds with steam inhalation. All were under the age of 5 years. Two children had burns to the feet as a result of kicking the hot bowl of water. The other child had

burns to the chest as a result of water spilling from the bowl. The total body surface area of the burn ranged from 1–3% superficial partial thickness and none of them required hospital admission. The parents of all three children claimed they were advised by their GP to use steam inhalation for symptomatic relief.

There is insufficient evidence in the literature to support the use of steam inhalation as a treatment. A Cochrane review of the use of heated, humidified air for the common cold found only three trials demonstrated beneficial effects on the symptoms of the common cold.<sup>3</sup> Other studies have shown steam inhalation has no effect on viral shedding as well as a failure to improve symptoms.<sup>2,4</sup>

The number of scalds in children has risen over the last three decades according to a Welsh study.<sup>5</sup> Scalds also remain the most frequent type of paediatric burn admissions in Denmark where majority are due to hot beverage spillage.<sup>6</sup> Murphy *et al* have reported seven cases of burns needing admission, caused by steam inhalation treatment for the common cold. In their report, two of the parents claimed they were advised by their GP to use steam inhalation treatment.<sup>7</sup> The patients in our series were fortunate not to have sustained more extensive burns. However the morbidity of the pain and distress, possibility of wound infection, parental anxiety and several trips to the dressing clinic can not be ignored.

Scalds from steam inhalation treatment are entirely avoidable. It is perhaps time to start discouraging patients from using this form of home remedy, as there appears to be no significant benefit from steam inhalation. GPs are in prime position to educate parents on how to care for their coryzal child and avoid the risky business of steam inhalation therapy.

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## Hepatitis E and meat carcasses

I would like to report an interesting case of hepatitis. The patient is a 54-year-old butcher who presented in January with nausea and vomiting. On examination he was mildly jaundiced and reported dark urine. Biochemical profile confirmed jaundice with a bilirubin of 76 and an ALT of 560. The patient had had no recent foreign travel, no blood transfusion and no history of IV drug use. His only risk factor appeared to be his occupation. Discussion with a consultant medical microbiologist suggested testing for Hepatitis A, B, C and E plus other viral antigens. Hepatitis E IgG was present, while antibody tests for Hepatitis A, B and C were negative. The patient recovered after 6 weeks and his liver function tests have returned to normal.

Hepatitis E is prevalent in large parts of the world though it is uncommon in the UK. It is usually associated with contaminated water supplies but is known to occur in animals, particularly pigs. The patient spent much of his time butchering pork carcasses imported from the European Community and the Far East. It is likely he became infected while eating his lunch without appropriate handwashing. One other patient who worked as the same butcher's was found to have hepatitis E

antibodies. Hepatitis E should be considered as a case of hepatitis in patients exposed to raw meat carcasses.

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## Treating addiction

The article by Strang *et al*<sup>1</sup> in the June edition of the Journal raises several important issues regarding what we do as GPs. I am an ex-prescriber and feel the College drive to improve treatment in this area may, on occasion, (in areas of low training take up) lead to a reduction in service. It also is ironic that it appears in the same edition as the leader by David Jewell<sup>2</sup> in which he talks of a GP as a generalist. I feel that as I do not have a 'diploma' in addiction and have not attended any College courses on this subject that I would 'be in trouble' should I prescribe and problems develop. I do not have this feeling in the many other areas in which I prescribe as a generalist (whether I have a diploma in that subject or not). I feel that the current trend will only make this feeling worse. I also find it interesting that those doctors who are prescribing are using lower doses than the 'experts' feel ideal — similar to other disease areas such as lipids and hypertension.

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## Methadone vs buprenorphine

Your review on methadone and buprenorphine treatments casts doubt upon their effectiveness in general practice due to a lack of controlled research in the community.<sup>1</sup> By the same standard, we should not be able to treat diabetes, depression or arthritis in general practice. Community, rather than specialist treatment is widely regarded as preferable for chronic conditions and it is the only feasible means of treatment outside metropolitan areas. Furthermore, adequate coverage of drug using populations in treatment cannot be achieved without extensive involvement of general practice-based treatment. The quality of clinic-based care is also quite variable.<sup>2</sup>

Despite giving 56 references, these authors fail to cite the many peer-reviewed descriptive and comparative reports of addiction treatments in general practice.<sup>3–8</sup> Yet they quote a small British study of people on low methadone doses (average 43.5 mg, range = 20–80mg) and with high prevalence of heroin use (67%) which found that modestly higher doses of methadone (average increase of 14.5 mg) increased their heroin craving and lowered feelings of wellbeing.<sup>9</sup> This study, never replicated, stands in stark contrast to strong evidence in multiple papers that higher doses, up to 100 mg daily, are associated with less heroin use.<sup>10–11</sup> The authors allude to inadequacies of methadone treatment in parts of the UK yet they fail to point out the seriousness of this neglect, with average doses as low as half the usual effective daily dose of 60–120 mg, generally given without supervision.

We should all have confidence in Cochrane reviews which find that when given in sufficient doses with appropriate levels of supervision and counselling, both methadone and buprenorphine maintenance treatments are associated with major reductions in illicit drug use.<sup>12</sup> There are also substantial improvements in general health and other important

social and economic benefits including less blood borne viral infections. For methadone this involves supervised starting doses (for example, 30 mg daily) with gradual increases as indicated clinically.<sup>13</sup> Buprenorphine can be equally successful in general practice settings where it can be very rewarding for those prepared to be involved in treating opiate dependent patients using these modalities.

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