



only, there were more positive circumferential resection margins in the laparoscopic group. Although this may not be statistically significant, the confidence limits are wide and it may have clinical significance for local recurrence. In describing our short-term results, we therefore preferred to err on the side of caution. The long-term follow-up of local recurrences, disease-free intervals, and overall survival will be available for release shortly.

K Slim is quite right to say that the term laparoscopic right colectomy has at least three different interpretations. However, when this trial was first designed, it was developed specifically as a trial of laparoscopic-assisted surgery and it was left to individual surgeons to describe precisely what they did for each procedure. Laparoscopic-assisted resections were commonest at the time. Subgroup analyses were not planned and therefore not done.

Simon Ng and colleagues are to be congratulated on the data from their ongoing trial. They do not state whether their analyses are on an intention-to-treat basis, but their results seem to be very similar to ours. However they should be regarded as preliminary, being based on 153 rectal cancers from a single centre as opposed to 381 in the CLASICC trial. Although there may be economic value in a reduction in hospital stay of less than 2 days, it is unclear what significance this has for the individual. The oncological outcomes are of greater significance to the individual patient, and the data from Ng and colleagues will clearly be very important in that regard. However, they might benefit from the type of detailed pathological examination to which the resection specimens from the CLASICC trial were subjected.

We declare that we have no conflict of interest.

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## The Lancet and the Royal Society are both right and wrong

The exchange between *The Lancet* and the Royal Society<sup>1,2</sup> is important because it brings to focus the failure of health policy to prevent the escalation of obesity, heart disease, diabetes, and western cancers. A primary reason has been the skew in perceived scientific priorities which sidelined nutritional science in relation to health. This skew deprived the UK government of comprehensive advice, with consequences that have escalated globally. I will mention three notable examples.

First, in the 1970s, the Neuberger Report on Nutrition Research to the Medical Research Council recommended that research should be done on the cause and prevention of low birthweight and its associated consequences. The House of Commons Select Committee on Children 1989, and in 1991, on Maternity Services, made the same recommendation. The failure of biomedical science and health services to respond was articulated when, in view of the attached high risk of neurodevelopmental impairment and chronic ill health, a parliamentary question by Lord Morris of Manchester in June, 2004, asked the government about its progress in reducing low birthweight. He received the written reply that the incidence was 6.6% 1953, 6.6% in 1973, and 7.6% in 2002. The UNICEF 2005 Report<sup>3</sup> puts the UK at 8%, worse than Cuba and on a par with Romania and Kazakhstan.

Second, when the price of soya rocketed, the UK government was advised that it was fine to feed animals with protein derived from animal offal etc, instead of food from plants. Their advice ignored nutritional evidence of Clausen and Moller<sup>4</sup> in Denmark, who showed in 1967 that injection of for-

eign brain protein into the footpad of rats could cross the blood-brain barrier and cause a destructive autoimmune response if the rats were depleted of the essential fats required for the integrity and function of neural cells. The nutritional requirement for the brains of cattle was ignored, resulting in the epidemic of bovine spongiform encephalopathy seen in the 1990s.

Third, changes in dietary lipid profiles across the population have been linked to increased vascular diseases. Because vascular development in the embryo and placenta is a prerequisite for fetal brain growth, of which lipid nutrition is also a dominant feature, the prevalence of mental ill health was predicted in 1972 to increase in a similar way.<sup>5</sup> At the Letten Symposium of the McCarrison Society at the Royal Society in May, 2004, an audit of the cost of the burden of ill health in the UK by Mike Rayner of the British Heart Foundation placed mental ill health second after heart disease.

Robert May and David Read<sup>2</sup> state that policymakers receive advice on medical science from a cluster of elite organisations. Much good advice has been given. However, the examples above and many others show that there is a major gap in this system. Either the gap stems from sheer ignorance of the science or there has been a wilful bias against preventive medicine in favour of curative medicine. The rise in obesity, diabetes, and mental ill health, and the spread of previously unknown western diseases across developing countries illustrates the failure of the advisory system to which May and Read refer.

At the same time, *The Lancet's* idea for an Institute of Medicine<sup>1</sup> is too narrow to deal with the challenge posed by this multidimensional threat. We have to attend to the start of life—ie, the nutrition and health of the mother, which is a high form of preventive medicine and insurance for a better future in health and prosperity. If we fail to respond to the challenge, the untellable cost will be to the health and abilities of future children worldwide.

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## Hepatitis C in haemophilia patients in the Netherlands

In his World Report (June 25, p 2165),<sup>1</sup> Grainger Laffan states that thousands of Dutch haemophiliacs may have contracted hepatitis C in the Netherlands during the 1980s, and that the Dutch Government has been reluctant to trace and inform those affected. As representatives of haemophilia treaters and haemophilia patients in the Netherlands, we would like to comment on several aspects of this misleading and alarming message.

We have a well documented group of 1600 haemophilia patients in the Netherlands, not thousands. Thanks to large cohort studies in haemophilia patients in the Netherlands,<sup>2,3</sup> we have been aware for more than 10 years that many haemophiliacs have contracted the hepatitis C virus, of which most have chronic hepatitis C. All patients with haemophilia in the Netherlands are regularly seen in haemophilia treatment centres by their physicians, who are well aware of the possible infectious

complications. As medical doctors, we have a responsibility towards our patients with respect to the complications of haemophilia treatment. This is not only a case for the Dutch Government.

Nearly all haemophilia patients have been tested and, if necessary, treatment for hepatitis C has been discussed with the patients. Antiviral treatment has been started according to local or international guidelines. In addition, several studies of antiviral treatment have been done in the Netherlands in haemophilia patients.<sup>3,4</sup> Also the patient organisation the Netherlands Haemophilia Society informs its members regularly about hepatitis C by mailings, brochures, and meetings chaired by world experts on hepatitis C treatment.

Although we recognise that hepatitis C caused by contaminated blood or blood products in the 1980s is still a major health problem and may need more attention from governments, a more thoughtful and balanced account of haemophilia patients in the Netherlands would have been more appropriate.

We declare that we have no conflict of interest.

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## Aircraft and road traffic noise and children's cognition

Stephen Stansfeld and co-workers (June 4, p 1942)<sup>1</sup> report a cross-national study of the effects of aircraft and road traffic noise on children's cognition. They found that chronic exposure to aircraft noise impaired reading comprehension and that this effect was still significant after adjustment for socioeconomic differences and other possible confounding factors. The study contains many improvements over earlier work on the topic. However, some of the findings are difficult to interpret (eg, the better memory in the high road traffic group) and it is possible that other factors should have been considered in the analyses.

One variable that has been omitted is intelligence. This was measured in the Spanish and UK children but not those in the Netherlands. It is possible, therefore, to reanalyse the data from more than 2000 children to determine whether the noise effects are still apparent when intelligence is covaried. In addition to adjustment for intelligence, it is important to do analyses that use intelligence as the dependent variable. Unfortunately, any association between noise and intelligence (eg, noise being associated with lower intelligence) could be interpreted in two ways: noise may influence intelligence, or children of lower intelligence are more likely to live in high noise areas.

Another issue that should have been examined in more detail is the relation between chronic and acute noise exposure. One interpretation of earlier research on chronic and acute effects of noise is that it is the match between regular exposure and exposure at testing that is crucial: children from quiet areas perform best when testing is in

