

100 000 new HIV infections per year, an equal number of AIDS-related deaths, and 2.7 million years of life lost.⁵

Programmes aimed at improving blood safety and eradicating the use of non-sterile injections in developing countries should be considered as global priorities in the fight against HIV/AIDS. These interventions would also limit the spread of the other two major bloodborne diseases, hepatitis B and hepatitis C.²⁻⁵

I declare that I have no conflict of interest.

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Antiretrovirals for employees of large companies in Cambodia

Heineken reports providing highly active antiretroviral therapy (HAART) to its workers in Africa (Aug 5, p 547).¹ However, we note its failure to provide similar treatment in Cambodia, specifically to its women beer-sellers.^{2,3}

The workplace risks from nightly alcohol overuse, violence, forced sex, and HIV/AIDS for sellers of Heineken (and part-owned brands Tiger, ABC, and Anchor) are alarming. Vendors of more than 25 brands compete for the custom of male beer-garden clients. Since company salaries are insufficient by half to support their families, many beer-sellers require secondary incomes, some resorting to paid sex with their

customers. Condom use could decline when beer-sellers are urged or forced to drink heavily by male clients.^{2,3} Among Siem Reap beer-sellers, HIV prevalence varied around 21.7% in 1995–2003.⁴

Heineken does not apply its own international health policies, including provision of HAART, to its saleswomen in Cambodia, suggesting that such women are classed as “promotion and advertising costs”, but not “workers”.

We applaud Heineken’s vanguard role with predominantly male brewery workers in Africa and hope other companies will follow suit. We would suggest, however, that Heineken follow up its African success story by providing antiretroviral treatment to its female beer-sellers as well as other workers, thus eliminating this gender-specific discrimination. With a prevention education programme and company doctor in place in Phnom Penh, the supply of antiretroviral treatment and medical help should be readily feasible for a small annual investment; likewise, adequate salaries.⁵

TvM has no conflict of interest. BCD, SK, and IL have helped conduct workshops and peer educator programmes for beer-sellers and clients in Siem Reap, Cambodia. IL has been in contact with Heineken executives during 2002–06.

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Neonatal respiratory distress after antenatal corticosteroids

The study by Caroline Crowther and colleagues (June 10, p 1913)^{1,2} has three major limitations: it does not investigate the dose-response relation of corticosteroids, it does not provide a stratified analysis based on gestational age, and it uses non-standard criteria to define severity of lung disease.

To be specific, 42%, 22%, 11%, and 25% of babies were exposed to one, two, three, or at least four additional corticosteroids doses, respectively; however, the growth variables are presented for the total population with Z scores. Whether a dose-dependent reduction in these variables was seen, especially in babies exposed to the highest number of corticosteroids doses, is not clear.³

The morbidity data are stratified into three gestational ages, with most babies (51%) being in a single group of 28–33 weeks. Surely the morbidities seen in babies born at 28 weeks’ gestation are markedly different from those born at 33 weeks’ gestation. No further breakdown for each gestational age is given, which leads one to wonder whether more babies in the placebo group were born closer to 28 weeks’ gestation or farthest along after receiving the first course of corticosteroids, and what proportion of babies at each gestational age received two or more additional corticosteroid doses. More importantly, was there a correlation between the number of corticosteroid doses, gestational age, and the reduction in cardiorespiratory morbidities between and within each treatment group?

The rationale for choosing mean airway pressure and fractional inspired oxygen instead of the widely used oxygenation index⁴ and ratio of partial pressure of oxygen in arterial blood to partial pressure of airway oxygen (PaO₂/PAO₂) to reflect pulmonary disease also remains unclear.

It is potentially unsafe to support the use of multiple corticosteroid doses in the absence of tangible short-term benefits and without the long-term cardiorespiratory and developmental data, especially for babies who received four or additional doses over and above the first course of corticosteroids.

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Authors' reply

Our study protocol permitted the trial treatment to be repeated weekly if the woman was regarded by her clinician as remaining at risk of preterm birth at less than 32 weeks' gestation. This regimen reflected best how repeat antenatal corticosteroids had been used in clinical practice in Australia and New Zealand.¹ Women were not randomised to a given number of doses of treatment. In particular, women were not randomised to four or more doses. At trial entry, for the individual women, it was not possible to predict reliably the number of treatment doses for which they would be eligible.

Our study was powered to detect differences in respiratory morbidity and growth between infants exposed and not exposed to repeat corticosteroids. It was not powered to show differences in subgroups, such as by gestational age at trial entry or number of treatment doses given, for growth or clinical outcomes. Any subgroup analyses would need to be interpreted with caution and could be misleading. Particularly, we caution

against post-hoc subgroup analyses. Our published paper reports all a-priori primary and secondary outcomes in keeping with best practice. Data will be made available for inclusion in the planned subgroup analyses for the Cochrane review update on repeat doses of prenatal corticosteroids.² These will include the gestational age at which the treatment was given and the dose.

Gestational age was stratified at randomisation into younger than 28 weeks and 28 weeks or older. There was no difference in the median gestational age at entry between treatment groups as shown in table 1 of our paper. Birth was a post-randomisation event. Gestational ages at birth were, however, similar between treatment groups, including the proportion of babies born closer to 28 weeks' gestation. The proportion of babies who received more than two treatments was similar across the gestational age ranges.

The definition of severity of pulmonary disease chosen for the protocol is recognised by neonatologists and includes standardised data collected within the Australian and New Zealand Neonatal Network.³ The beneficial treatment effect on respiratory distress syndrome was similar across our entry-stratified gestational age groups.

Our trial results provide evidence of short-term benefit for babies exposed to repeat antenatal corticosteroids. As stated in our paper, we agree with Shabih Hasan that there is a need for assessment of the later health of the children.

We declare that we have no conflict of interest.

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Opiate substitution treatment in the former Soviet Union

The Profile of Vladimir Mendelevich (July 22, p 279),¹ which highlights his efforts to educate fellow physicians about opiate substitution treatment, brings much needed attention to the public health crisis created by the lack of methadone in Russia. However, the statement that most other former Soviet states have legalised substitution treatment obscures the true scope of the emergency facing the region.

Legal status bears little relation to access to methadone treatment on the ground in the former Soviet Union. With the exception of the Baltic states, methadone is either unavailable or offered to only a tiny minority of those in need. In countries such as Kazakhstan and Ukraine, the governments have for years delayed the establishment of even small pilot programmes despite offers of financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Drug control agencies fearful of diversion and health ministries afraid to step out of the long shadow cast by Russia's prohibition have mired treatment efforts in bureaucracy. Patients and physicians committed to helping those dependent on illegal opiates are paying the price, since they are denied a treatment that could help prevent HIV infections and save thousands of lives.

I declare that I have no conflict of interest.

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