

relevant databases to access and can probably help to search more effectively. For example, PubMed has a lot of useful features that aren't obvious (more information at www.bl.uk/services/information/blmedline.html).

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Competing interests: The British Library runs the STM online search service, provides Medline training, and produces AMED and zetoc.

1 Delamothe T. Navigating across medicine's electronic landscape, stopping at places with Pub or Central in their names. *BMJ* 2001;323:1120-2. (10 November.)

Medline and PubMed will be able to synthesise clinical data

EDITOR—In their editorial Smith and Chalmers call for a new and most welcome initiative that would provide access to a synthesis of valid, relevant clinical information.¹ Those of us responsible for the original Medline database wish success to any endeavour that hopes to transform health care (and that might bring honour to the Queen). Your readers might be interested to learn about some recent improvements of our own in this direction.

The US National Library of Medicine began to link sources on the internet from the inception of free PubMed access to Medline in 1997. (It was vice president Al Gore, not the then first lady Hillary Clinton, who announced free access to Medline via PubMed at a ceremony in the US Congress.) The LinkOut feature of PubMed is designed to provide users with a wide variety of relevant web accessible resources, including full text articles, biological databases, consumer health information, research tools, and more. PubMed also links users to an extensive database, *ClinicalTrials.gov*, which provides patients, family members, and the general public with current information about clinical research studies. In 2002 PubMed citations will include links from the American College of Physicians Journal Club and other evidence based medicine journals to the original journal article being commented on.

Late in 2001 we complemented our "clinical queries" feature, which filters references using a method based largely on the work of Haynes et al, with a new filter called systematic reviews.² This feature has much the result in mind as the proposal by Smith and Chalmers—the ability to retrieve systematic reviews and meta-analysis studies for a specific search topic. Since the systematic reviews filter is so new and as yet unpublished, they were not mentioned in the editorial. The *Cochrane Database of Systematic Reviews*, which has been indexed in Medline since 2000, is among the evidence based resources. Moreover, *Clinical Evidence* has been approved for indexation in Medline,

and its citations, with full text links, will begin to appear in PubMed early in 2002.

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1 Smith R, Chalmers I. Britain's gift: a "Medline" of synthesised evidence. *BMJ* 2001;323:1437-8. (22-29 December.)

2 Haynes RB, Wilczynski N, McKibbon KA, Walker CJ, Sinclair K. Developing optimal search strategies for detecting clinically sound studies in Medline. *J Am Med Assoc* 1994;1:447-58.

Vitamin A programme in Assam probably caused hysteria

EDITOR—Did the recent campaign to distribute vitamin A in Assam, India, cause an epidemic of illness or hysteria? The public health science underlying vitamin A prophylaxis and the reports that emerged after the same-day dosing of some 2.5 million preschool children point to hysteria.

Firstly, did vitamin A kill a child the day after dosing, and up to 13 children the next week, as claimed (overdosage by a new, larger delivery cup is being cited as the cause)?¹ Almost certainly not. Even twice the prophylactic dose of 200 000 IU, had it been given (it is not clear that this routinely happened), is the recommended treatment for xerophthalmia.²

In blaming deaths on vitamin A critics have chosen to ignore the current mortality among 1-4 year old children in India of about 7 deaths per 1000 children per year.³ Thus 17 500 of these children would be expected to die over the coming year without getting vitamin A, including 48 the next day, or over 325 within a week—far more than the 14 deaths claimed to have been caused by the campaign. The inference to be drawn from this calculation suggests that vitamin A saved the lives of children, not took them.

Was there an unexpected epidemic of illness? Not unexpected. High potency vitamin A causes transient nausea, vomiting, and headache in 3-9% of children.⁴ Ailments resolve within 48 hours, as reportedly occurred in Assam. In young infants a similar percentage may develop an isolated, bulging fontanelle that subsides within 72 hours.⁵ These consequences pose the "risk" of this programme.

At a rate of 5%, 125 000 dosed children would have been expected to develop side effects—far in excess of the 15 000 cases reported by the media. Still, this number presenting to health clinics on the same day in one state results in a concentration of risk that could readily invite public scrutiny and a media outcry. Educating functionaries of the programme and the public that transient ailments may arise from receipt of vitamin A may prevent such difficulties in the future.

A nutritious diet is undeniably preferred for preventing vitamin A deficiency, but until

such a goal is achieved periodic delivery of vitamin A can prevent xerophthalmia, reduce severity of infection, and improve children's survival.² This is the "benefit" side of the equation, which seems to have been ignored in the hysteria surrounding the Assam programme.

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1 Mudur G. *BMJ.com* news roundup. Deaths trigger fresh controversy over vitamin A programme in India. *BMJ* 2001;323:1206. (24 November.)

2 Sommer A, West KP Jr. *Vitamin A deficiency: health, survival and vision*. Oxford: Oxford University Press, 1996.

3 Unicef. *The state of the world's children 2001—early childhood*. New York City: Unicef, 2000.

4 Florentino R, Tanchoco CC, Ramos AC, Mendoza TS, Natividad EP, Tangco JB, et al. Tolerance of preschoolers to two dosage strengths of vitamin A preparation. *Am J Clin Nutr* 1990;52:694-700.

5 Agoestina T, Humphrey JH, Taylor GA, Usman A, Subardja D, Hidayat S, et al. Safety of one 52-mumol (50,000 IU) oral dose of vitamin A administered to neonates. *Bull WHO* 1994;72:859-68.

Full time forensic pathology service

Practical alternative to forensic pathology service exists

EDITOR—Milroy and Hunt draw attention to the adverse publicity surrounding several wide ranging issues involving the medical profession.¹ We agree that the investigation of deaths has deficiencies and the decision to undertake necropsy should be assisted by experienced and appropriately trained practitioners who could, in addition, be responsible for collecting, correlating, and analysing data so that unusual events or trends and practices are rapidly identified and investigated.

There are major practical problems in establishing a full time forensic pathology service to undertake this role. Forensic pathology services in England and Wales are depleted, overstretched, and in an apparent state of decline. There are, for example, now no university based forensic pathology services in London, a major capital city. A notable number of pathologists now work independently of any academic body, involved in neither research nor training the next generation of forensic pathologists. Given the current depleted numbers, barely able to cover current workload and subject to an apparent lack of future succession planning, it is difficult to see where the forensic pathologists required by Milroy and Hunt in their regional strategy proposal will be found.

There is, however, a body of medical practitioners with experience in law and forensic medicine which has considerable practical experience in assessing and examining medical evidence and skills in presenting this evidence in court. These are forensic physicians or police surgeons. They are used to working independently in the criminal justice and civil legal systems, often