LET’S NOT WORRY ABOUT THAT

In March 2005, the conference “Medical education towards 2010: shared visions and common goals” was held in Canberra. Sponsored by the Committee of Deans of Australian Medical Schools and the Australian Medical Council, it was attended by nearly 200 delegates from Australian medical schools, clinical colleges, postgraduate education bodies and other stakeholders. Its ambitious agenda tackled issues such as forging links between medical education and health systems; professionalism in education and practice; and curriculum development, assessment and review. Recently, a detailed conference report was released, along with a raft of recommendations. These included calls for yet more reviews of clinical teaching and learning and potential teaching environments, marrying medical education with other health workforce needs; and provisions for rational processes in career development.

The Canberra conference’s recommendations are not new. Since the groundbreaking Flexner Report of 1910 which endorsed modern medical education principles, there have been innumerable reviews. What is remarkable is the repetitiveness and constancy of their recommendations: the need for medical education to reflect societal needs; to address medical workforce issues; to cope with burgeoning medical knowledge; and the need for generalism. Recommendations consistently advocate teaching in ambulatory care; an emphasis on social and behavioural sciences; the teaching of lifelong learning and self-learning skills; and centralising curriculum control.

But there is a problem. Educational reform is heavy on rhetoric and recommendations, but light on hard evidence on whether educational reforms lead to better clinical outcomes or better doctors. It seems that the need for evidence is taught, but not pursued. Is research for rigorous evidence in medical education just too hard, or does its absence reflect a “let’s not worry about that” attitude?
High rate of immediate systemic hypersensitivity reactions to tiger snake antivenom

Geoffrey K Isbister, Alan S Tankel, Julian White, Mark Little, Simon G A Brown, David J Spain, Chris F Gavaghan and Bart J Currie

TO THE EDITOR: During a national multicentre study of snake bites — the Australian Snakebite Project (ASP), involving over 40 hospitals — we have recently noted a high rate of early allergic reactions following the administration of tiger snake antivenom in Australia. People with suspected or definite snake envenoming are recruited to ASP, and laboratory and clinical data and serial blood samples are collected to measure venom and antivenom concentrations.

From 1 November 2005 to 31 January 2006, 14 patients who had been given tiger snake antivenom (CSL Limited, Parkville, VIC) were recruited. These patients are briefly described in the Box, and include bites from several different groups of snakes. Of the 14 patients, 11 exhibited immediate systemic hypersensitivity reactions to antivenom infusion. Reactions were mild in five patients, moderate in three, and severe in three, according to the grading system by Brown. The six patients in the moderate and severe groups fulfilled the criteria for anaphylaxis according to a recent consensus definition. All patients required specific treatment in addition to ceasing antivenom therapy, and nine were treated with adrenalin. Antivenom was recommenced in all patients at a slower rate, although an adrenalin infusion was required in four of these and repeat doses of intramuscular or subcutaneous adrenalin in another four while the antivenom infusion continued.

Over the same period, there were seven administrations of broad snake antivenom (over 30 vials of antivenom) reported to ASP without any hypersensitivity reactions.

There has been a previous report of allergic reactions to tiger snake antivenom in a single hospital, and we are concerned that there may be a particular problem with tiger snake antivenom. The reaction rate in this series is similar to reported rates in parts of the world where high reaction rates have been attributed to relatively impure antivenom preparations. The reactions here were traced to at least four different batches of tiger snake antivenom.

We have informed CSL of this high rate of reactions and the antivenom batch numbers, and we have encouraged the treating doctors to make formal reports of each adverse reaction to CSL and the Adverse Drug Reactions Advisory Committee.

Health care professionals treating patients with tiger snake antivenom need to be aware of the possible higher risk of anaphylaxis with tiger snake antivenom and be prepared to treat with adrenalin. Recommendations for the diagnosis and treatment of anaphylaxis have recently been reviewed. However, this current problem with CSL tiger snake antivenom should not cause health professionals to reduce or cease its use. In all patients described here, control of the adverse reaction and continuation of antivenom was possible. The rapid identification of this problem over a short period was only possible because of our large multicentre collaborative study, and supports such studies for recognising uncommon envenoming syndromes.

Competing interests

Julian White is employed by the Women’s and Children’s Hospital, Adelaide, which is paid by CSL Ltd to provide a clinical toxicology service for users of CSL antivenom and venom detection products.

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Fourteen patients administered tiger snake antivenom for snake envenoming

<table>
<thead>
<tr>
<th>Age/sex</th>
<th>Previous antivenom</th>
<th>Snake</th>
<th>Clinical features</th>
<th>Grading</th>
<th>Treatment of reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>47 M No; SH BHS</td>
<td>No reaction</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 M No TSG</td>
<td>No reaction</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 M No TSG</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 M No TSG</td>
<td>Generalised erythema, urticaria, tachycardia</td>
<td>Mild</td>
<td>IM adrenalin (0.5 mg), then IV adrenalin infusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 M No RBBS</td>
<td>Generalised erythema</td>
<td>Mild</td>
<td>IM adrenalin (0.2 mg x 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 M No RBBS</td>
<td>Generalised erythema, urticaria</td>
<td>Mild</td>
<td>IM adrenalin (0.25 mg x 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 F No TSG</td>
<td>Pruritus, erythema and moist cough (no wheeze)</td>
<td>Mild</td>
<td>Promethazine (10 mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53 M No TSG</td>
<td>Generalised pruritus</td>
<td>Mild</td>
<td>Promethazine (25 mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 M No TSG</td>
<td>Dizziness, chest tightness, tachycardia, vomiting</td>
<td>Mod.</td>
<td>SC adrenalin (0.3 mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 M Yes; SH SBS</td>
<td>Generalised rash and pruritus, vomiting</td>
<td>Mod.</td>
<td>IV adrenalin infusion for 1 hour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 M No SBS</td>
<td>Urticarial rash, chest tightness</td>
<td>Mod.</td>
<td>IV adrenalin infusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55 M No; SH PHS</td>
<td>Generalised pruritus, diaphoresis, confusion, hypotension</td>
<td>Severe</td>
<td>SC adrenalin (0.5 + 0.5 + 1 mg), IV fluid, IV hydrocortisone (100 mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M No RBBS</td>
<td>Rash, wheeze and hypotension</td>
<td>Severe</td>
<td>Adrenalin, IV fluid, antihistamines, steroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 F No TSG</td>
<td>Hypotension, sweaty and unwell appearance</td>
<td>Severe</td>
<td>IV adrenalin infusion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BHS = Broad-headed snake (Hoplolchus bungaroides); IM = intramuscular; IV = intravenous; Mod. = moderate, PHS = Pale-headed snake (H. bitorquatus); RBBS = Red-bellied black snake (Pseudochis porphyriacus); SBS = Stephens’ banded snake (H. stephensi); SC = subcutaneous; SH = snake handler; TSG = Tiger snake group (any snake from the Notechis, Hoplochus, Tropidechis, and Austrelaps genera).

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Jane Leong

COMMENT: Thank you for the opportunity to comment on the letter by Isbister et al regarding hypersensitivity reactions to tiger snake antivenom.

CSL has been notified about the cases of hypersensitivity reactions to tiger snake antivenom in general, but has only received two individual case reports. We have been in contact with the study investigators and have requested more detailed information on the other patients so that we can further our investigations.

A thorough check of product manufacturing records revealed no deviations from approved specifications for tiger snake antivenom. It is important to note Isbister et al have advised health professionals not to reduce or cease the use of tiger snake antivenom. We would like to draw physicians’ attention to the approved Product Information before use of the product. The tiger snake (and other antivenom) Product Information lists the possibility of both anaphylactic and anaphylactoid reactions. Hypersensitivity and skin reactions (including urticaria, rash, hypotension, bronchospasm, anaphylaxis and delayed serum sickness) are listed as common, and are more likely to occur in people who have had previous exposure to equine-based products.

In addition, the Product Information describes an anaphylactoid reaction which can occur because the antivenom has the ability to bind complement. The risk of this reaction can be minimised by adequate dilution of the antivenom (1:10 for adults and 1:5 in small children) before infusion. Further, the Product Information states that a syringe already loaded with 1:1000 adrenaline must be available during antivenom therapy.

CSL is continuing to monitor this situation closely and is awaiting further details on the patients from the reporting physicians. In the meantime, we encourage users of all antivenom products to report any untoward reaction to CSL so that these can be fully evaluated.

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An African strain of community methicillin-resistant Staphylococcus aureus in a Burundi refugee

Annabelle Donaldson and Lain B Gospell

TO THE EDITOR: Community strains of methicillin-resistant Staphylococcus aureus (MRSA) are increasingly seen in Australia, particularly in certain population subgroups, such as Pacific Islander and Aboriginal people. We report the case of an African with community MRSA to highlight its existence in yet another subgroup. Given the increase in people arriving in Australia from Africa under the Humanitarian Program (with around 8500 arrivals from Africa in 2004–2005) and their widespread dispersal around the country, it is possible that African community MRSA will be seen increasingly in Australia.

A 53-year-old Burundi refugee presented with an infected wound overlying the left lateral malleolus after laceration 6 weeks previously in a Tanzanian refugee camp. An unknown antibiotic was given for 2 weeks before travel to Australia. On the patient’s arrival in this country, the wound appeared purulent, erythrocyte sedimentation rate was 82 mm/h (reference range [RR] < 10 mm/h), and C-reactive protein level was 9 IU/L (RR < 5 IU/L). Plain x-rays and bone scans suggested osteomyelitis.

A wound swab grew S. aureus, Streptococcus pyogenes and Pseudomonas species. The patient was initially given intravenous cefazolin, and then definitive therapy (for MRSA and S. pyogenes, ignoring the colonising pseudomonad) with oral ciprofloxacin (450 mg three times daily). Clinical resolution was complete, and levels of acute-phase reactants returned to normal.

The antibiotic sensitivity pattern of the S. aureus isolate raised suspicion that it might be an unusual strain: it was resistant to methicillin, tetracycline and trimethoprim-sulfamethoxazole, but sensitive to erythromycin, clindamycin, ciprofloxacin, gentamicin, vancomycin, linezolid, mupirocin, rifampicin, fusidic acid and chloramphenicol.

The mecA gene was detected by polymerase chain reaction testing, confirming methicillin resistance. The organism possessed staphylococcal cassette chromosome mec (SCCmeC) element type IV. The Panton–Valentine leukocidin gene, staphylococcal enterotoxins A to E and toxic shock syndrome toxin-1 were not detected. As DNA fingerprinting with standard pulsed-field gel electrophoresis showed a novel banding pattern, the “gold standard” of multilocus sequence typing was used for identification. This confirmed an ST140 allelic profile, which has not been seen previously in Australia. On the balance of probabilities, the isolate represents an African community MRSA strain, not previously detected in Australia.

Non-multiresistant community MRSA is not widely recognised in African countries. Hospital MRSA rates vary widely in Africa (eg, between 21% and 30% of all S. aureus isolates in Nigeria, Kenya and Cameroon, and fewer than 10% in Tunisia and Algeria), but most are multiresistant.

Medical practitioners in Australia who treat African refugees need to be aware that pyogenic soft tissue infections could be caused by community MRSA, and these MRSA strains may have a different antibiotic sensitivity profile to Australian community MRSA strains. It is essential to take appropriate specimens for microbiological analysis (wound swabs and possibly blood cultures and/or tissue samples), as antibiotic susceptibility profiles are increasingly unpredictable.

References

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Acknowledgements

We thank Joanne Mercer, Thelma Barbagianakos, Robert Porritt and Yvonne Kwok (South Western Area Pathology Service, Liverpool, NSW) for performing pulsed-field gel electrophoresis and polymerase chain reaction testing for meca and virulence genes; Flavia Huygens, Phil Giffard and Alex Stephens (Cooperative Research Centre for Diagnostics, Queensland University of Technology, Brisbane, QLD) for performing multilocus sequence and SCCmeC typing; and Mitchell Smith (Refugee Health Service, Sydney South West Area Health Service — Western Zone, NSW) for supplying data about refugees.

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References


Invasive meningococcal disease presenting with cellulitis

Karina J Kennedy, Jhumur Roy and Paul Lamberth

To the Editor: We recently treated two patients with invasive meningococcal disease presenting with cellulitis. This presentation contributed to a delay in diagnosis and appropriate antibiotic treatment.

The first patient was a 33-year-old woman, recently diagnosed with nephrotic syndrome, who had been unwell for a week with mild upper respiratory tract symptoms. During this time, her nephrologist began treating her with prednisolone (15 mg daily). The day before presentation, she developed abdominal pain, vomiting, chills, myalgia and headache. A rash developed on the day she presented to hospital. The temperature was 39.2°C, heart rate 148 beats per min, and blood pressure 146/57 mmHg. She had an area, measuring 20 cm × 20 cm, of tender cellulitis on the right thigh (Box) and mild neck stiffness.

The diagnosis was initially unclear, leading to a delay of several hours before ceftriaxone was administered, and a lumbar puncture performed. Cerebrospinal fluid (CSF) examination revealed a leukocyte count of 4500 × 10⁶/L (98% polymorphs) (reference range [RR], < 5 × 10⁶/L), gram-negative diplococci, and protein concentration of 2073 mg/L (RR, 150–450 mg/L). The patient subsequently required intensive care admission for non-invasive ventilation and inotropic support. Neisseria meningitidis serotype C was detected in the CSF by polymerase chain reaction testing. The patient was discharged well except for mild headache and lethargy after 6 days. At 1-week review, she remained lethargic but was otherwise well. The rash was slowly resolving.

The second patient was a 51-year-old woman with fever and a 2-day history of progressive pain, swelling and erythema of the anterolateral area of the neck. The temperature was 38.5°C, heart rate 115 beats per min, and blood pressure 134/86 mmHg. There was no evidence of upper airway involvement. The anterior area of the neck and upper chest wall were swollen, erythematous, tender and warm. No fluid collections or masses were detected on ultrasound examination.

The patient was admitted to hospital with a diagnosis of cellulitis, and treatment was begun with intravenous flucoxacinil and metronidazole. After 17 hours, culture of blood taken on admission showed N. meningitidis serotype W135. Antibiotic treatment was changed to ceftriaxone. After 5 days, the patient had mild residual inflammation and tenderness of the neck. She completed another week of treatment with oral amoxycillin.

Only 14 cases of N. meningitidis cellulitis have been published.1-3 Seven cases involved children with periorbital cellulitis. In adults, three cases involved the face and neck, and four the limbs. N. meningitidis was isolated from blood (eight patients), conjunctival swabs (three), aspirates of the cellulitic areas (two) or CSF (one). There was one death: an elderly woman with bacteraemia and cellulitis of the face and neck.2 As illustrated by our cases, the many guises of meningococcal disease continue to challenge clinicians.

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References

TO THE EDITOR: The CanMEDS 2000 report\(^1\) and its 2005 revision\(^2\) have emphasised that effectiveness as a medical specialist requires competencies in addition to clinical and medical expertise. These include being a communicator, collaborator, manager, health advocate, scholar and professional.

Building the non-clinical skills of doctors has been the focus of a professional development project in Australia that is targeting registrars. Junior doctors usually step up to the role of registrar in the 3rd year of their prevocational training. A national workshop convened by the Postgraduate Medical Council of Victoria in March 2004 agreed on a framework for the professional development of registrars, comprising the following 10 competencies: leadership; communication skills; supervision; mentoring; teamwork; self-awareness and empathy; time management; problem solving; professionalism and ethics; and safety and quality.\(^3\)

To provide content for these competencies, a job-shadowing exercise involving two registrars at two different Victorian hospitals was undertaken in April 2005 to get a first-hand understanding of the roles of medical registrars as managers. The registrars were voluntary participants, and permission was obtained from all participants. I shadowed the two registrars during their entire 9-hour shifts. No major issues arose in relation to the shadowing process itself, and the consultants overseeing the two registrars were extremely accommodating in this process. The two observed registrars authenticated the veracity of the recorded observations. The observations from the job-shadowing exercise were clustered into competencies using the framework developed for the professional development of registrars discussed above. The Box summarises these observations and highlights the range of registrar interactions that are influenced by non-clinical competencies.

While the small number of registrars is an obvious limitation of the study, this job-shadowing exercise did demonstrate that managerial skills, knowledge and behaviour represent a significant component of the work of clinicians, especially as they move up the medical hierarchy. This assertion should not be misconstrued as suggesting that the clinical skills and knowledge become any less important. As noted in the 2005 CanMEDS framework, the medical expert role is the central role for doctors.

It is also worth noting here that some pilot professional development programs con-

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### Observations during job-shadowing of two registrars at two Victorian hospitals

<table>
<thead>
<tr>
<th>Competency</th>
<th>Observed interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>• Reviewing patient treatment plans and test results and prescribing a course of action</td>
</tr>
<tr>
<td></td>
<td>• Ensuring that procedures are followed</td>
</tr>
<tr>
<td></td>
<td>• Coaching intern on test procedures, completion of patient records, etc</td>
</tr>
<tr>
<td></td>
<td>• Giving ongoing feedback to intern</td>
</tr>
<tr>
<td></td>
<td>• Delegating tasks to intern</td>
</tr>
<tr>
<td></td>
<td>• Coordinating patient treatment with other units</td>
</tr>
<tr>
<td>Leadership</td>
<td>• Dealing with other health professionals, some of whom take directions from the registrar, as well others over whom there is no formal authority</td>
</tr>
<tr>
<td></td>
<td>• Providing advice to intern and role modelling desired behaviour</td>
</tr>
<tr>
<td></td>
<td>• Demonstrating the ability to respond quickly and with confidence</td>
</tr>
<tr>
<td></td>
<td>• Involving subordinates and providing opportunities for them to participate in decision making</td>
</tr>
<tr>
<td></td>
<td>• Using networking skills with other departments</td>
</tr>
<tr>
<td></td>
<td>• Using negotiating skills in dealing with other departments, hospitals, etc</td>
</tr>
<tr>
<td>Communication skills</td>
<td>• Using communication skills with patients, intern, medical colleagues, other health care professionals, and service departments</td>
</tr>
<tr>
<td></td>
<td>• Dealing with cross-cultural diversity issues with patients, their families, and staff</td>
</tr>
<tr>
<td></td>
<td>• Using negotiating skills in dealing with other departments, hospitals, patients, and family members</td>
</tr>
<tr>
<td></td>
<td>• Using recording skills to ensure treatment plans properly documented for others</td>
</tr>
<tr>
<td>Time management</td>
<td>• Prioritising patient list for ward rounds</td>
</tr>
<tr>
<td></td>
<td>• The constant need to re-assess priorities during ward rounds, in light of time constraints</td>
</tr>
<tr>
<td></td>
<td>• The ability to deal with constant interruptions from other colleagues, to provide necessary clarifications</td>
</tr>
<tr>
<td>Problem solving</td>
<td>• Making decisions on patients’ continued treatment or discharge, and stipulating any follow-up action</td>
</tr>
<tr>
<td></td>
<td>• Task contingency management skills to deal with patient treatment plans not proceeding as planned</td>
</tr>
<tr>
<td></td>
<td>• Dealing with information gaps in patient historical records</td>
</tr>
<tr>
<td></td>
<td>• Involving intern and other staff to assist in the decision-making process and raising issues with consultant</td>
</tr>
<tr>
<td>Professionalism and ethics</td>
<td>• Dealing with demarcation issues with other doctors and professionals</td>
</tr>
<tr>
<td></td>
<td>• Role modelling professional behaviour to patients, staff, and the public</td>
</tr>
<tr>
<td></td>
<td>• Balancing the interests of patients with hospital needs, without sacrificing patient trust</td>
</tr>
<tr>
<td></td>
<td>• Obtaining patient consent for procedures</td>
</tr>
<tr>
<td>Teamwork</td>
<td>• Coordinating treatment plans with other doctors and health professionals</td>
</tr>
<tr>
<td></td>
<td>• Sharing information and agreeing on treatment plans with allied health staff</td>
</tr>
<tr>
<td></td>
<td>• Joint meeting with other colleagues to advise a patient and family members on surgical procedures and associated risks</td>
</tr>
<tr>
<td></td>
<td>• Ability to work in both collaborative and individual modes during the day</td>
</tr>
<tr>
<td>Mentoring</td>
<td>• Providing advice to intern to be more assertive and confident when dealing with consultant</td>
</tr>
<tr>
<td>Self-awareness and empathy</td>
<td>• Patience and empathy in giving bad news to family</td>
</tr>
<tr>
<td></td>
<td>• Dealing with patients who are aged or mentally or physically challenged</td>
</tr>
<tr>
<td>Safety and quality</td>
<td>• Knowledge and application of safe practices in relation to patient management</td>
</tr>
<tr>
<td></td>
<td>• Ensuring that procedures are followed, such as obtaining consent, ordering of tests, etc</td>
</tr>
<tr>
<td></td>
<td>• Reviewing records before dispensing treatment</td>
</tr>
<tr>
<td></td>
<td>• Recording treatment plans and medications</td>
</tr>
</tbody>
</table>
Effective shade structures
Kay R Coppa and John S Greenwood

TO THE EDITOR: We were pleased to read Turnbull and Parisi’s short piece on the effectiveness of shade structures, highlighting the challenges of ensuring adequate and effective shade protection, particularly in children’s settings.\(^1\) Cancer councils in various states have long recognised these challenges and provided assistance to those who design or manage facilities for children, in the form of training workshops, resources and guidelines.

Epidemiological evidence indicates that childhood exposure to ultraviolet (UV) radiation is a strong determinant of risk of melanoma but there is also evidence of its contribution to the development of non-melanocytic skin cancer.\(^2\,3\) It is estimated that living in Australia for the first 15 years of life contributes about two-thirds of the lifetime risk of melanoma of a lifelong resident.\(^4\) Sun exposure in childhood, especially that leading to sunburn, is the main environmental determinant of the number of melanocytic naevi. An individual’s number of naevi is the strongest measurable predictor (after age and ethnicity) of risk of melanoma.\(^5\)

Our publication, \textit{Under Cover}, referred to by Turnbull and Parisi, is one such resource, developed as a comprehensive reference tool for anyone involved in shade planning and design in New South Wales and has been adapted for use in other states by state cancer councils.\(^6\)

Turnbull and Parisi comment that \textit{Under Cover} provides inappropriate advice regarding the use of deciduous trees, as solar UV radiation levels can be hazardous during winter in subtropical Queensland. As might be expected, the NSW edition of \textit{Under Cover} does not address winter solar protection issues in northern Queensland.

We note that the “requirements for effective shade” cited by Turnbull and Parisi are identical to those prescribed in \textit{Under Cover}.

For those interested in determining when UV protection is required throughout the year in different locations, an interactive shade planning software program will be available shortly at \textit{www.webshade.com.au}. In it, ShadeCalendar recommends what type of shade would be most appropriate for comfort and solar protection in different months of the year. The Bureau of Meteorology now issues the SunSmart UV Alert when the UV Index is forecast to reach 3 or above, highlighting when sun protection is required (\textit{www.bom.gov.au/products/uvindex_national.shtml}). The SunSmart UV Alert is reported in most newspaper, television and radio weather forecasts across Australia.

Shade is only one of a range of sun protection strategies recommended by the Cancer Council. With Australia having the highest skin cancer rates in the world, general practitioners play a pivotal role in providing sun protection counselling advice to parents of children aged 1–13 years.\(^7\) The Cancer Council NSW recommends a range of sun protection measures including UV avoidance during the peak UV times (10:00–14:00 or 11:00–15:00 during daylight saving time), shade, clothing, hats, sunglasses and use of sun protection factor 30+ broad spectrum, water resistant sunscreen.

Competing interests
John Greenwood owns shares in, and is a Director of, WebShade Pty Ltd.

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