Response to: Association of perceived environment with meeting public health recommendations for physical activity in seven European countries

Sirs,
The paper by Bamana et al.\(^1\) raises important public health issues regarding the increasing levels of obesity and the numerous implications for healthcare services.\(^2\) Bamana et al.\(^1\) are exploring the associations with these obesity levels in order to identify gaps in motivation and awareness of available facilities. Hence, the conclusions could potentially influence initiatives to promote physical activity.

However, we have identified some causes for concern within the methodology which we wish to discuss. First, a cross-sectional study that creates too many constraints for the analyses of the strengths of the associations and we suggest a cohort study over at least 2 years would have been more suitable to enable regular questioning about the variables. Thus, the snapshot of physical activity undertaken would not solely consider the summer months when activity levels are most likely to be at their highest.\(^3\)

Secondly, there is a high percentage of unemployed participants (34.8%) who may be less motivated or possess lower self-esteem.\(^4\) However, this may be due to the time at which the information was obtained. Also, it would seem to be important to take into account the power of individual schema types. For example, passive and fatalistic types would be less likely to pay attention to motivation, whereas more active and dynamic individuals will be more alert to what is available and more aware of motivations.\(^4\)

Thirdly, obtaining reliable information through self-reports in response to a telephone call is problematic. For example, it permits exaggerations of physical activity and poor estimations of weight and height, thus affecting BMI calculations.

Finally, we suggest that Bamana et al’s study\(^1\) should be used as a starting point for a cohort study at national level with regular questioning incorporating inquiries into the perceived and the objective environment. The results could then be compared with other countries to try to identify suitable environments to assist physical activity.

References


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Measles outbreak in Qassim, Saudi Arabia

Sirs,
We read with interest the report on epidemiology and evaluation of an outbreak of measles in Saudi Arabia.\(^1\) This has particular relevance to UK readers due to the current rise in measles in the UK and well publicized outbreaks in London and Cheshire.

The authors present an analysis of notified cases of measles. In this outbreak (and others), they attribute the high proportion of notified cases who had been vaccinated to vaccine failure. This is one potential explanation of the results presented, but an alternative and more likely explanation is that a significant proportion of the notified cases was not measles. In fact, 154 samples (of 226) were negative for measles IgM. Even allowing for a significant false-negative rate due to early testing (well described and assay dependent\(^2\)), the analysis of notified cases includes a large number of non-measles cases. The use of notified cases will
underestimate the effectiveness of the vaccine and overestimate the number of vaccine failures.

We would welcome an additional analysis using only confirmed cases by age group and vaccine status to provide a better estimate of vaccine effectiveness. This would also clarify the at-risk age groups, potentially those aged 6–11 months with waning maternal antibody but below the age of routine MMR vaccination.

References


Response to: Measles outbreak in Qassim, Saudi Arabia 2007

Sirs,

We are thankful to William and Rosemary for their interest in our article.1 They suggested an additional analysis using only confirmed measles cases during the outbreak, in order to clarify at-risk age group and the extent of vaccine failure. We reviewed our analysis using the lab-confirmed cases by age group and vaccine status. The results showed almost similar patterns, when compared with the analysis findings of total notified cases during the outbreak.

A total of 48 lab-confirmed measles cases were reported during the measles outbreak in Qassim, 2007. These patients ranged in age from 5 months to 48 years (median 14.2 years). Table 1 displays the comparison of age group distribution of lab-confirmed versus total notified measles cases. Having a similar pattern to total notified cases, among the lab-confirmed cases also, more than one-third (35.4%) of the patients were 0–4 years of age. Children aged 6–11 months accounted for the highest number of cases among all age groups. Of the 12 cases reported among infants, 9 (75%) occurred in 6–11 months age group.

The age-specific incidence for lab-confirmed cases was highest for children aged <1 year (94.7 per 100 000 population), followed by age groups 1–4 years (8.3 per 100 000 population) and 15–44 years (7.8 per 100 000 population). The children aged 5–14 years had the lowest age-specific incidence rate (4.9 per 100 000 population).

Vaccination status was known for 43 (89.6%) reported cases; of these, 19 (44.2%) were vaccinated. The number of administered doses was reported for all 19 vaccinated persons; 15 (78.9%) had received two doses while 4 (21.1%) had received single dose.

The additional analysis of the lab-confirmed measles cases concludes that the most common age group affected during this outbreak was 6–11 months, suggesting increased susceptibility of infants to measles after 6 months of age.2 In addition, vaccine failure also seems to be responsible for a substantial number of cases, during this outbreak.

References


2. Altintas DU, Evliyaglu N, Kiline B et al. The modification in measles vaccination age as a consequence of the earlier decline of trans-