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). However, we note its failure to provide similar treatment in Cambodia, specifically to its women beer-sellers.1,2

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 their custom. Many beer-sellers require secondary incomes, some resorting to paid sex with their customers. Condolence could decline when beer-sellers are urged or forced to drink heavily by male clients. Among Siem Reap beer-sellers, HIV prevalence varied around 21.7% in 1995–2003.4

Heineken does not apply its own 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

I declare that I have no conflict of interest.

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1 Simon V, Ho DQ, Quanarsha AF. HIV/AIDS epidemiology, pathogenesis, prevention, and treatment. Lancet 2006; 368: 489–504

Neonatal respiratory distress after antenatal corticosteroids

The study by Caroline Crowther and colleagues (June 10, p 1913)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, 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, is not clear.

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 index 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.