Injury-related mortality and indigenous people

We congratulate The Lancet on its series on the health of indigenous people, who make up around 6% of the world’s population. However, injury-related problems were rarely noted. Injury is second only to heart disease as the leading cause of death among Native Americans and Australian Aboriginals,1 and is the leading cause of death among Aboriginal Canadians.2 In 1996 and 1997, compared with the total Canadian population, Aboriginal people were over six times as likely to die of injuries. Most of the 18 health regions in Canada’s high-Aboriginal group were identified as having the nation’s lowest life expectancies or lowest disability-free life expectancies.2,3

Decades of health-related research have produced a large body of knowledge describing alarming rates of morbidity, mortality, and social and cultural disruption among indigenous people throughout the world, but have failed to deliver sustainable interventions to arrest the deepening spiral of ill-health. Effective interventions in indigenous health will require transdisciplinary, holistic approaches that explicitly incorporate indigenous health beliefs and engage with the social and cultural drivers of health. Culturally appropriate interventions tailored to specific local settings and problems will be necessary to reduce deaths from injury among indigenous people.

We declare that we have no conflict of interest.

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1 Sepkowitz KA. Health of the world’s Roma population. Lancet 2006; 367: 1705–08.
2 Kabalchicheva E, Vassileva S, Kelly JA, et al. HIV risk behavior patterns, predictors, and sexually transmitted disease prevalence in the social networks of young Roma (Gypsy) men in Sofia, Bulgaria. Sex Transm Dis 2006; published online April 19. DOI: 10.1097/01.olt.0000204533.20224.56

Anticonvulsants for protracted seizures in children


First, Ahmad and colleagues’ table 1 shows that median seizure duration before treatment is around 2 h. Even if the seizure is not caused by hypoxia and median oxygen saturation at enrolment is 98–99%, such a prolonged seizure must induce hypoxic brain injury. For this reason, the patient’s condition before arrival should be mentioned in more detail.

Second, this study simultaneously compared two different variables: drug type and delivery route. Some studies have suggested that intranasal drug delivery results in higher drug uptake into the brain than intravenous injection.2 But paraldehyde injection is no longer given in developed countries. Although we agree that intranasal drug delivery is easier, cheaper, and faster, it is difficult for us to estimate whether the result of this study is due to the anticonvulsant, delivery route, or both.

Increasing evidence has revealed the effectiveness and lower complication rate of intranasal midazolam.3,4 Therefore, a comparison between intranasal benzodiazepines with high affinity for γ-aminobutyric acid receptors—eg, midazolam and lorazepam—should be done to investigate the control of prolonged convulsion outside the hospital.

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