

Re: Parents Know Best

12 June 2003



Sylva Dolenska,
Consultant
Anaesthetist
*William Harvey
Hospital, Kent
TN240LZ*

Dear Deborah,

I quite agree that there are many things wrong with the BMJ articles and the accompanying editorial. What is also worrying is that the Daily Telegraph published on the same day extracts from the article, reiterating the same misconceptions presented as "evidence" or "research".

Send response to
journal:

[Re: Re: Parents Know
Best](#)

I have written several responses; as one who has been affected I feel that I acquired considerable experience. One of the problems is, as Wendy McLellan says in her reply, that nothing beats curing the primary source.

Abandoning the "no nits" policy (not that many schools in the UK have them, anyway) makes sense on the grounds presented but does nothing for curing the primary source. Some parents (often those of the primary source) do not know best, i.e. do not know about the infestation or how to treat it, and it is the school nurse who is in the best position to do something about it. Schools elsewhere in the world would be shut for a few days if there is a headlice epidemic, and that tends to sharpen the mind of parents to the problem. At the very least, during an epidemic the school nurse should check heads and actively seek out parents of affected children to help them get rid of the infestation. This could be done in the form of the school letter, given to all children when infestation is reported. The policy should be re-named "no lice policy" and re-enforced, not abandoned.

I find it worrying that the Telegraph, read by millions of readers, can reprint things which plainly go against common sense (see also replies to the actual clinical review section).

As a president of the National pediculosis association, are you going to be more proactive in dispelling the myths perpetuated by the clinical review, and are you going to advise Local Educational Authorities in the same vein?

May I also point out (it has also been pointed out by several readers in the replies section) that lindane is not available in the UK as it was voluntarily withdrawn, and the data on toxicity of the other agents is actually fairly favourable. Proprietary preparations may still have their place in some cases, as bug busting requires a high degree of determination and perseverance.

Competing interests: None declared

Head lice: update on biology and control

12 June 2003



Anita M. Bailey,
Independent
researcher
*C/O Microbiology &
Parasitology Dpt,
University of
Queensland, St Lucia
4072, Australia,
H. Phillip Petersen*

Editor, recent lice articles, including 'BestTreatments' (1), need updating. Without serious medical investigation, head lice advice has sometimes relied on speculation from a few entomologists. For eg, advice to avoid hair-cutting originated from a well-meaning but baseless suggestion in the 1970's.

Resistance to pediculicides is well-documented. Over-reliance on insecticidal treatment is putting children's health at risk. Non-drug measures should be recommended. Unchecked transmission in schools is causing higher prevalence. Routine screening is advised. Without it, treatment decisions should take into account repeated exposure. (2, 3).

Send response to
journal:

[Re: Head lice: update
on biology and control](#)

Head lice are not harmless. They can cause dermal injury and sensitization. Some

people resort to household poisons to relieve persistent cases. A disproportionate amount of family time and money is wasted. Millions (pounds) are spent in each of the UK, USA and Australia on louse treatment annually (3).

Detection and removal of lice in some hairstyles is more difficult than previously thought. Our group has confirmed life-stage sizes as small as 0.6mm. Louse camouflage and various hair factors can cause false negatives and under-estimations. Without such knowledge, clinical product assessments are questionable (4).

Those who use a tiered diagnostic approach to screening have found that manual treatment is more successful than chemical. Fine-toothed combing is so helpful that it is one of the tools by which therapies are better assessed. Perhaps only head-shaving and microscopic examination are the gold standard (2, 3, 4).

Dry-hair parting with a lamp-magnifier can help practitioners to identify continuous egg deposition at the scalp-hair margin outwards of chronic cases. Old 'nit' removal facilitates examination. Patients who remove eggs may also find hidden lice. Further fine-combing may helpfully confirm the live lice (2, 3, 4).

Removed head lice are alive but probably less of a concern than direct transmission or unrecognised relapses. Longer or thicker hair impedes detection and removal of resistant infestations. Hair-shortening improves comfort and access to residual lice. Pediculosis is not self-limiting and undetected failures (some relapsing monthly for years) are common in longer hair of girls (3).

Lice can transfer instantly across hair tresses with a vigorous rub. Severely neglected head lice may also bite further down the body. New biological findings place head and body lice in the same species. Body lice carry typhus, relapsing fever and trench fever, which are reemerging overseas. We suggest that pediculicides should be reserved to assist with control of such outbreaks. Lack of thorough screening and treatment will allow more resistant lice to proliferate (5).

(1) 1. Nash B. Treating head lice BMJ 2003; 326: 1256-8.

(2) Bailey AM, Prociv P. Persistent head lice following multiple treatments: Evidence for insecticide resistance in *Pediculus humanus capitis*. *Australas J Dermatol* 2000; 41: 250-54.

(3) Bailey AM, Prociv P. *Pediculus humanus capitis* infestations in the community: A pilot study into transmission, treatment and factors affecting control. *Australian Infection Control* 2001; 6: 95-101.

(4) Bailey AM, Prociv P. Head lice appearance and behaviour: implications for epidemiology and control. *Australian Infection Control* 2002; 7: 62-71.

(5) Bailey AM, Prociv P, Petersen HP. 2003. Head lice and body lice: shared traits invalidate assumptions about evolutionary and medical distinctions. *Australian Journal of Medical Science* 2003; 24: 48-62.

Competing interests: None declared

