

Obesity and Public Health Law

TO THE EDITOR: Mello et al. (June 15 issue)¹ discuss obesity as the new frontier of public health law. Public strategies including legislative regulation against obesity must take into account the fact that obesity is closely associated with low income.² Obesity in low-income families originates at an early stage of life, possibly through unhealthy food selection³ and eating patterns and a sedentary lifestyle.⁴ Aside from economic considerations, a lack of knowledge about⁵ and a limited access to⁶ healthy food choices seem to be crucial aspects of the problem. Therefore, strategies against obesity need to encompass educational efforts to promote a healthy lifestyle and remove obstacles to the achievement of that goal for persons at high risk for obesity.

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TO THE EDITOR: As Mello et al. state, legal as well as voluntary measures are needed to prevent the health consequences of obesity, but they do not mention the importance of the size of food portions. Fast-food outlets tend to encourage the sale of large portion sizes, with the financial incentive that the large size is just a little more expensive than the standard size. In 2004, Willett and I¹ suggested that standard portion sizes should be specified for selected high-calorie food items (e.g., hamburgers, pizzas, and sugary drinks), and larger sizes should be priced in a manner that is proportional to size, so that double-sized portions should cost at least twice as much as standard portions. Financial and health goals would then be better aligned, and there would be one policy for all vendors, in which competition over the standard-portion price would be preserved.

Public health agencies have used pricing to influence consumption in effective ways (e.g., in reducing the sale of cigarettes). Changes in pricing with respect to the size of food portions should be explored, alongside accepted strategies that include education, food labeling, and the provision of healthier institutional meals.

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Medical Mystery: Abnormal Chest Film — The Answer

TO THE EDITOR: The medical mystery in the July 27 issue¹ involved a chest film (Fig. 1A) showing cardiomegaly and a left-sided pacemaker, the leads from which took an unusual course through the mediastinum, to the left of the midline. A persistent left-sided superior vena cava was suspected. A right-sided paratracheal soft-tissue den-

sity was also present (Fig. 1A, arrowheads). Contrast-enhanced computed tomography (CT) showed that this density was caused by a right-sided aortic arch and not by an aortic-arch aneurysm (Fig. 1B, arrow). An aberrant left subclavian artery arising from a dilated diverticulum of Kommerell (Fig. 1C, curved arrow) passed posterior to the esoph-

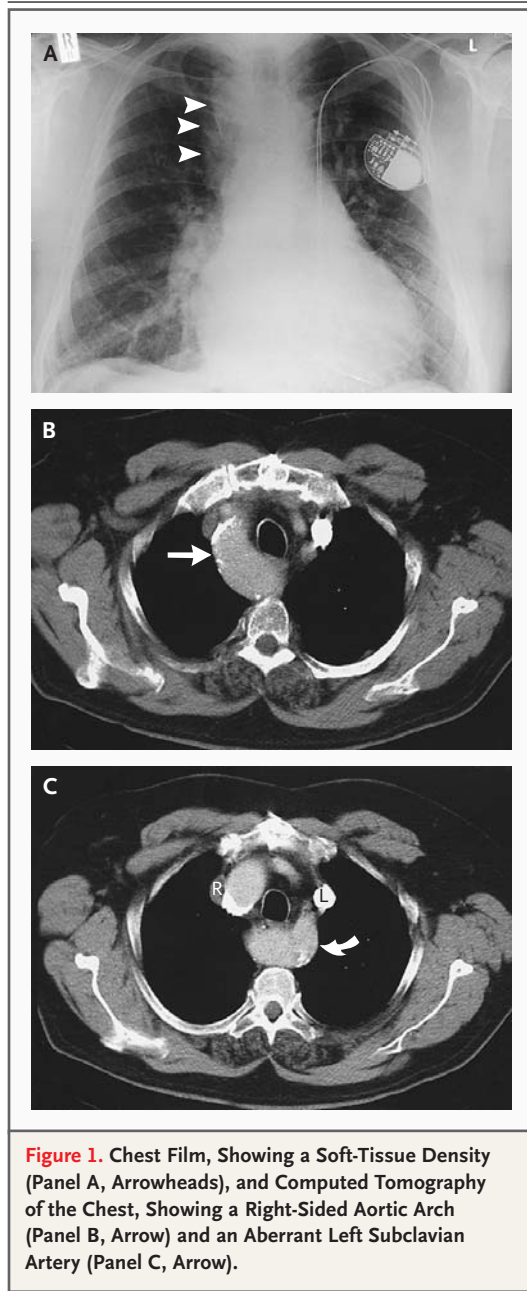


Figure 1. Chest Film, Showing a Soft-Tissue Density (Panel A, Arrowheads), and Computed Tomography of the Chest, Showing a Right-Sided Aortic Arch (Panel B, Arrow) and an Aberrant Left Subclavian Artery (Panel C, Arrow).

agus. CT without contrast medium confirmed the presence of a persistent left-sided superior vena cava (L in Fig. 1C) within the right-sided superior vena cava (R in Fig. 1C) owing to the absence of a left brachiocephalic vein. A persistent left-sided superior vena cava occurs in 0.3% of the normal population and is often not recognized unless a central venous line or pacemaker is inserted. A right-sided arch with an aberrant left subclavian artery is the most common type of right-arch anomaly, with an incidence of approximately 1 in 2500.

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Editor's note: We received 900 responses to this medical mystery — from 66 countries. Of these responses, 62% were from physicians in practice, 22% from physicians in training, 8% from medical students, and 8% from other readers. Many of the responses continue to reflect a team effort — such as after a discussion of the case during a teaching conference.

Forty-seven percent of responses correctly identified the left-sided superior vena cava with the pacemaker correctly inserted into the right heart, including 10 respondents (1%) who also noted the right-sided aortic arch. Twenty-one percent of respondents suggested that the answer was aortic disease (e.g., aneurysm, unfolding of the arch, aortic dissection, and arterial placement of the pacemaker), 6% suggested mediastinal disease, and the remaining 26% suggested a variety of conditions, including situs inversus with an inverted display of the image, pericardial effusion, azygous lobe, collapse of the left lower lobe, congestive heart failure, mitral valvular disease, and cannulation of the thoracic duct.

Positive *Clostridium difficile* Stool Assay in a Patient with Fatal *C. sordellii* Infection

TO THE EDITOR: A 61-year-old woman presented with nausea, vomiting, abdominal pain, and non-bloody diarrhea. A stool assay for *Clostridium difficile* was positive (*C. difficile* Tox A/B II, Tech Laboratory), and she was treated with metronidazole. However, her symptoms worsened during the sub-

sequent week, prompting her to return to the hospital. On examination, her vital signs were normal apart from tachypnea. The abdominal examination revealed diffuse tenderness but no peritoneal signs. Laboratory evaluation revealed a hemoglobin level of 129 g per liter, a white-cell count of