

travel to areas with malaria is stated in the article. Many possible approaches to dissuading a determined traveler who already has firm plans and tickets in hand are conceivable. The most frequently successful strategy is a change of destination to one allowing a similar experience but without the malaria risk. A specialized travel medicine clinic (listings at www.istm.org and www.astmh.org) would have access to country-by-country malaria maps and would also be familiar with common and practical destinations. Many game parks in South Africa are outside the

malaria zone, though the itinerary described in the vignette is by far the most popular. Delaying the trip by a year would involve exposing an infant to malaria, an equally risky situation, or separating mother and child by thousands of miles for a significant period. Despite our best efforts, pregnant women travel not infrequently to malaria zones, and we need to offer them information on the best possible prevention strategies.

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The FDA and Tobacco Regulation

TO THE EDITOR: The American Heart Association enthusiastically supports the editorial by Curfman et al. (Sept. 4 issue)¹ on a bill that would grant authority to the Food and Drug Administration to regulate tobacco products. We believe that this legislation has several strengths; it would require full disclosure of the ingredients in tobacco products, reduce the burden of tobacco-related illnesses, and especially limit underage smoking. Each day, about 4000 people 12 to 17 years of age will try a cigarette for the first time, and an estimated 1140 persons in this age group become daily smokers.² According to a U.S. Surgeon General's report, about 80% of people who use tobacco begin to do so before 18 years of age.³ A major curtailment of underage tobacco use may be the greatest potential public

health benefit of this legislation. As the incoming president of the American Heart Association, I applaud the position of the *Journal* editors and join with them in expressing unequivocal support for this legislation.

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1. Curfman GD, Morrissey S, Drazen JM. The FDA and tobacco regulation. *N Engl J Med* 2008;359:1056-7.
2. Office of Applied Studies. Results from the 2005 National Survey on Drug Use and Health: national findings. NSDUH series H-30. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006. (DHHS publication no. SMA 06-4194.)
3. National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Preventing tobacco use among young people. Washington, DC: Government Printing Office, 1994.

Restless Legs Syndrome and Spinal Anesthesia

TO THE EDITOR: The restless legs syndrome (RLS) is a common sensorimotor disorder of unknown cause affecting approximately 10% of the population.¹ One uncontrolled study showed that spinal anesthesia caused postoperative RLS.² We conducted a prospective study to determine whether the occurrence of postoperative RLS was associated with the type of anesthesia.

Patients scheduled for surgery and general or spinal anesthesia were recruited from our hospi-

tal's lists of patients undergoing elective surgery (Table 1). Using a standardized questionnaire (see the Supplementary Appendix, available with the full text of this letter at www.nejm.org), one of us interviewed patients — on admission and at 1 and 4 weeks postoperatively — about symptoms, including diagnostic criteria for RLS³ and symptoms of depression and daytime sleepiness. The questions regarding RLS symptoms were interspersed among other questions to mask