While diagnosis of maternal varicella in pregnancy is relatively straightforward, it is much more challenging to identify in utero the unborn baby who might have been affected.

Enders and Miller proposed fetal ultrasound plus PCR testing to estimate the risk of congenital varicella syndrome. Initial PCR testing of amniotic fluid at 17–21 weeks may be negative, with a normal detailed ultrasound, suggesting low risk of congenital varicella syndrome. A positive PCR result at 17–21 weeks with a normal ultrasound should lead to repeated ultrasound at 22–24 weeks. A normal ultrasound at that stage means congenital varicella syndrome is unlikely. By contrast, abnormal ultrasound suggests a high likelihood of congenital varicella syndrome. Detailed ultrasound can allow detection of limb deformities, microcephaly, hydrocephalus, polyhydramnios, soft-tissue calcification, and intrauterine growth retardation. At least 5 weeks should be allowed between onset of maternal symptoms and sonography, as imaging before 4 weeks has failed to detect deformities.

The failure of existing cohorts to identify congenital varicella syndrome in late pregnancy merely reflects the limited statistical power of epidemiological efforts. That only around 110 cases of congenital varicella syndrome have been published out of the many thousands of babies affected must involve a combination of diagnostic and reporting failures. With 4 million births a year in the USA, three out of every 1000 pregnant women have varicella, and of these 1·5%—an estimated 15 cases a year—have congenital varicella syndrome. Hence, 900 cases have occurred in the USA alone since 1947.

In summary, congenital varicella syndrome is not a condition that is escaped by the third trimester of pregnancy. With the current wide-scale vaccination programmes against varicella in childhood, it is likely that the incidence of congenital varicella syndrome will fall, as has happened with congenital rubella syndrome. However, diagnostic vigilance must remain a priority, as the long-term effectiveness of the vaccines is yet to be quantified.

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*Enders and Miller combined genitourinary and gastrointestinal abnormalities.

Is public health coercive health?

Historically, governments have been unwilling to counteract the use of taxation to encourage desired behaviours (eg, by making cigarettes more expensive) or legislation to coerce the population into a healthier way of living. Yet a recent population-based study in Poland showed that deaths from cardiovascular disease were reduced substantially by economic and agricultural policies rather than by health initiatives. In the UK, public-health policy is now at the top of the social and political agenda, and looks set to expand the scope of prophylactic government. After the success of Mary Creagh, member of Parliament, in the Private Members' Ballot, the Children’s Food Bill will now be put forward as possible legislation. The purpose of the
bill is to prevent ill-health related to food and drink, such as childhood obesity, through active intervention by the state, including the prohibition of marketing certain foods and drinks to children and the introduction of regulations on the sale or provision in schools of any foods and drinks other than those which form part of set school-meals. Allowing voluntary self-regulation of the food industry may be akin to Dracula guarding the blood bank. But the avowedly interventionist Children’s Food Bill recognises that it is in corporate boardrooms and marketing suites that appetites are cooked up: “individual choices” are never natural nor a priori, but have always been manipulated or at least carefully directed.

Although a 2004 WHO paper points to the need for a more comprehensive approach to the regulation of marketing techniques, in the UK the fear of “nanny” is still so strong that the draft legislation in the Children’s Food Bill appears unconscionably radical. It was Margaret Thatcher who, in 1979, coined the phrase “Nanny State”, in a speech announcing her plans to dismantle it. Tony Blair has also called for a “change to the way the Government and the state relate to the individual citizen”. British libertarians and “small-state” conservatives argue that compulsion leads to “the end of autonomous self-control and the strangling of self-reliance”—in short, to a morally flabby society. For such people, the State should be there to provide the basic framework that allows us to flourish . . . or go to hell in a handcart. For others, including some communitarians, government interventions, such as those proposed in the Children’s Food Bill, blur the distinction between civil society and the State.

Arguments about the pervasiveness of the nanny state persist because there is no broad agreement about the lineaments of government, or about the appropriate boundaries between public and private. Thus, when public health addresses the supposed freedoms articulated by lifestyle choices, the temperature begins to soar. Legislation opens a Pandora’s box, but this should excite rather than dismay public-health policymakers. The policymakers have before them an opportunity to reformulate legal debates which reach to the core of what it is to be a subject in contemporary UK. As Blair implies, a reordering of the public’s contract with the government is an urgent task. Yet such progress has been impeded by the absence of a consensual working definition of the polity, embodied in a written constitution, which would act as a framework setting the limits of government.

Rather than being configured as the baffling intrusion of arbitrary authority, state intervention could be conceptualised as “intelligent government”. Such intervention has been welcomed in the past—from the Factory Act (1833), which set minimum standards for working conditions and compelled employers to provide at least 2 h of education to child employees, through to advice from the Department of Health on how to put your baby to sleep to reduce the risk of cot death. Often, however, it is only retrospectively, when legislation has become internalised, that it is seen as a force for good. Few people would now think twice about tobacco legislation and, at least in younger people, seat-belt legislation is now common sense. Research across 16 European countries shows the extent to which legal statute acts as a powerful tool to change behaviour, as “people start integrating it into their own behaviour and value set”. Even if legislation acts only as a guideline, as the new English law against smacking children perhaps does, it gives out an unequivocal message, showing society’s views which everyone then begins to accept. In Denmark and Sweden, the logic of abstaining from smacking is now second nature.

An expanded definition of public health should seek to maximise not only liberty but also what Aristotle coined “virtue”. In a contemporary setting, virtue is a
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compact between society and the individual which results in a trained habit of choice. It is an explicitly political formula in which the State plays a crucial role. “Nanny” need not infantilise us, but offer succour and guidance. Similarly, the interventions of the government make it possible to be virtuous by protecting us from that version of ourselves that is preyed on by the worst excesses of the market.

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