entations, and he was out of hospital and back to normal within four weeks. This is in contrast to the treatment reported by Merrison et al, which did not include antitoxin treatment and resulted in neurological morbidity seven months after treatment.

The problems of management in both cases are associated with comorbid opiate withdrawal signs and symptoms and non-obvious cutaneous evidence of a wound infection, but the most important in the above reported case was the stigma of a history of injecting substance misuse.

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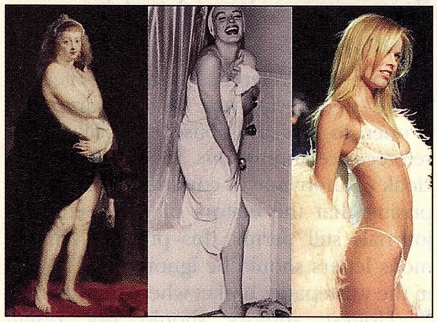
1 Merrison AFA, Chidley KE, Dunnett K, Sieradzan KA. Wound botulism associated with subcutaneous drug use. *BMJ* 2002;325:1020-1. (2 November.)

Shapely centrefolds



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Are women changing or is *Playboy*?

EDITOR—First, sexual images were blamed for causing sex crime. Now, it seems they're responsible for eating disorders too. Voracek and Fisher's analysis of the changing shape of *Playboy* centrefolds tells us more about the changing face of sexual material than the changing shape of women's bodies.[1] The authors are correct to challenge existing research that claims that women in sexual materials represent the "hourglass" figure, but despite a more thorough analysis of *Playboy*, it is fair to point out that *Playboy* is only one sex publication and is well known for having close links with fashion and mainstream media.[2]

Had the authors chosen to analyse other magazines, they may well have seen an increase in women's shape, body size, or even age of models.[2] Furthermore, they overlook other reasons why images of women in *Playboy* have changed. Anecdotal evidence shows that more women are looking at sexually explicit materials, particularly those seen as easily accessible and similar to "fashion magazines"; and evidence shows that they are more critical of female bodies than men are.[3] Therefore rather than *Playboy* representing a changing shape of women, it may be that women's distorted views on body image are now being played out through pages of sexual magazines catering for an increase in female readership.

Whatever the explanation, it is important to remember two issues when analysing sexual materials. Firstly, the range of titles and topics covered is vast, catering for every taste. Secondly, it is overly simplistic to say that media images alone cause women's body image to change.[2] Several complex social factors lead to eating disorders, not a picture in *Playboy*.

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1 Voracek M, Fisher ML. Shapely centrefolds? Temporal change in body measures: trend analysis. *BMJ* 2002;325:1447-8. (21 December.)
2 Boynton PM. The contextual evaluation of research on sexually explicit materials. Birmingham: Aston Business School, Aston University. [PhD thesis.]
3 Boynton PM. Is that supposed to be sexy? Women discuss women in "top shelf" magazines. *J Community Applied Soc Psychol* 1999;9.

Sexual desire, fatness, and class are connected in sociohistorical context

EDITOR—Voracek and Fisher analysed the changing shape of centrefold models in *Playboy* and found that they seemed to be becoming thinner.[1] In fact, the principal eating disorder in the United Kingdom today is overeating. Its consequence, obesity, is vastly more important as a public health issue than anorexia nervosa. Obesity is also a progressive condition, unlike anorexia nervosa, which tends to ameliorate with age.

I speculate that in society the changes in the "maximally sexually attractive" woman's body, from the chubby Mrs Rubens to the sinewy model Eva Herzigova, are due to the social significance of fatness. In the 17th century being thin indicated poverty—the poor laboured hard, starved, and as a result of overcrowding and poor sanitation contracted infectious diseases. Being fat represented ease—the rich did less physical work, ate plenty, and lived in more sanitary conditions. In the 21st century, in this part of the world, this has reversed. Being fat implies a bad, cheap, energy rich diet and a lack of physical activity and is associated with being poor. Being thin is, however, associated with wealth, presumably through greater health awareness, a healthier diet, and more opportunity for recreational exercise.

With this theory you don't have to assume a genetically inbuilt attraction to a given body mass index, ratio of hip to waist measurement, or fertility. One only needs to assume (or observe) that people are attracted by social dominance (high social class). Social dominance is associated with health and longevity. In the 17th century the rich lived longer than the poor partly because they were better nourished. Nowadays rich people live longer because poor people are unhealthily fat and die earlier, from the so called diseases of affluence.

Of course there is geographical as well as historical variation, and I assume that in a country where starvation is significant the maximally sexually attractive body is fatter. The person with anorexia nervosa is, however, a different matter. By definition this is an abnormal case, and you should look for the individual causes, not the societal ones.

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1 Voracek M, Fisher ML. Shapely centrefolds? Temporal change in body measures: trend analysis. *BMJ* 2002;325:1447-8. (21 December.)

A curriculum can be latent and informal

EDITOR—Prideaux has provided an interesting and useful summary of approaches to a medical school curriculum.[1] However, there are two parallel curricular processes at work.

The first is the latent curriculum, first described by Eisenberg, whereby students learn what is "really" important from role models, especially clinicians. For example, students continue to report that some specialists denigrate family medicine as a career path because it is not intellectually challenging or "interesting." Another longstanding example is the dismissal of behavioural and social science as "soft" and less worthy of attention than the biological sciences.

The second is the informal curriculum. I differ from Howarth in that I take this to be the curriculum that students themselves create outside of the formal curriculum. One example is the prevalence of workshops on the business of medicine, generally organised by the students out of hours. Another more altruistic example is the development of sessions on social issues, including reproductive choice.

We must learn from and respond to what students see as lacks in the formal curriculum as well as to the attitudes expressed by influential role models that shape students' behaviour.

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1 Prideaux D. ABC of learning and teaching in medicine: curriculum design. *BMJ* 2003;326:268-70. (1 February.)

Dataset on deaths related to taking ecstasy looks incomplete

EDITOR—I wonder whether the data of Schifano et al, on deaths related to taking ecstasy in England and Wales, are complete.[1] During their study (1 August 1997 to 31 July 2000), 45 coroners' cases in which the toxicological findings indicated that one of the "ecstasy" group of drugs was implicated in the cause of death were investigated in my laboratory. It is unlikely that we received more than half of the samples related to ecstasy deaths in England and Wales. This implies that the way in which coroners, or their pathologists, incorporate toxicological findings in their causes of death is not uniform. Future studies could use not only the