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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Strongyloidiasis in ex-prisoners of war in south-east Asia

SIR,—Last year we reported in your pages persisting *Strongyloides stercoralis* infections in 88 of 602 (14·6%) former prisoners of war (POWs) of the Japanese, investigated a mean period of 31 years since repatriation.[1] We were fascinated to read Dr D I Grove's finding (1 March, p 598) of strongyloidiasis in 44 of 160 (27·5%) similar ex-POWs from Australia.

The high prevalence found is partly due to a greater index of suspicion and the more stringent diagnostic tests used in his study than our own retrospective case note study. However, there is also an important difference in the type of POW studied. Dr Grove is not quite correct when he surmises that his patients are "reasonably representative of all prisoners of war," as all of them worked on the Thai-Burma railway. We have reviewed our data, and have details of locality of imprisonment in 319 from our series of 602 POWs. Two hundred and six of these had worked on the railway, and 44 (21·4%) were later found to have persisting strongyloidiasis. Of the 113 who did not work on the railway, only 10 (8·8%) were later found to harbour the worms. The difference between these figures is significant ($\chi^2 = 8{\cdot}120$, $p < 0{\cdot}005$), indicating work on the "Death Railway" to be a significant risk factor for chronic strongyloidiasis.

Regardless of these considerations, we agree that even the most careful studies are likely to underestimate the true prevalence of strongyloidiasis, as parasitological methods are insensitive and supportive investigations such as blood eosinophilia and serum IgE are unreliable in individual cases.[1 2] All ex-FEPOWs of the Japanese should therefore be screened for the infection, as it is potentially dangerous but can be easily eradicated. The DHSS in Britain is actively supporting this view,[3] and we hope that Dr Grove's report gives further publicity to this fascinating affliction among these unfortunate men.

V GILL

Department of Clinical Biochemistry and Metabolic Medicine, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP

DION R BELL

Department of Tropical Medicine, Liverpool School of Tropical Medicine, Liverpool L3 5QA

[1] Gill GV, Bell DR. *Br Med J* 1979;ii:572-4.
[2] Gill GV, Bell DR, Fifield R. *Clin Exp Immunol* 1979;**37**:292-4.
[3] Mayne GO. *Health Trends* 1980;**12**:12.

Infant feeding and vitamin D

SIR,—I read with interest the statement in the article on feeding and feeding problems (16 February, p 457) by Dr H B Valman that infants receiving breast milk should receive vitamin supplements, particularly of vitamin D. However, Jelliffe and Jelliffe[1] say, "In mothers who have been well-nourished in pregnancy and in lactation there is no evidence that additional vitamins are needed for their solely breast-fed offspring in the first six months of life. A possible exception is relatively cloudy, cold countries where the lack of maternal exposure to the ultraviolet radiation of sunlight could make additional vitamin D necessary for the body."

The problem where it exists seems, then, to be with the mother's vitamin D status rather than that of the infant. Would it not be more logical to recommend instead that both expectant mothers who intend to breast-feed their babies and lactating mothers in relatively sunless climates such as that of Northern Europe should take a modest vitamin D supplement daily in addition to their intake in food? Perhaps their daily requirements,[2] 10 μg of cholecalciferol (formerly expressed as 400 international units), would be a safe supplement that would usually ensure the mother's optimum nutritional status in this respect: 10 μg is contained in 5 ml of cod liver oil *BP*.

R COOK

Regional Office for the Eastern Mediterranean, World Health Organisation, Alexandria, Egypt

[1] Jelliffe DB, Jelliffe EFP. *Human milk in the modern world*. London: Oxford University Press, 1978:41.
[2] World Health Organisation. *Handbook of nutritional requirements*. Geneva: WHO, 1974.

Development surveillance at 8 months

SIR,—I cannot let Dr H B Valman's article on development surveillance at 8 months (12 April, p 1049) pass without some comments on his assessment of vision. He makes the surprisingly common mistake of stating that when one eye that has been covered with a card moves when that eye is subsequently uncovered means there is a squint. This is quite incorrect. All that his test has shown is that when fusion is disrupted the eye under cover has moved to its position of rest, which may be one of convergence or of divergence. The way he has described the test has nothing whatsoever to do with the presence or not of a squint.

The way the test should be carried out is as follows. After the configuration of the lids and the presence or absence of epicanthic lid folds have been observed the position of the corneal reflex in each eye should be inspected. Then, while holding some target of visual interest to the infant the doctor's hand is moved in front of one of the infant's eyes. If the *uncovered* eye has to make a movement to maintain the fixation on the target then a squint is present. This test should be repeated in front of each eye in turn. The second thing that must be noted is the infant's behaviour when each eye is covered. If the vision in one eye is reduced for any reason, then when the fellow eye is covered by the doctor's hand the