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## LEADING ARTICLES

DHSS in the witness box.....	1023
Millions of mild hypertensives.....	1024
Uraemic pruritus.....	1025
Sterilisation of mentally retarded minors.....	1025

Arrhythmia in hypertrophic cardiomyopathy .....	1026
Pathophysiology of Raynaud's phenomenon...	1027
An appalling Panorama.....	1028

## PAPERS AND ORIGINALS

Relation between age of mothers with breast cancer and sex of their children	H OLSSON, L BRANDT.....	1029
Treatment of vasospastic disease with prostaglandin E <sub>1</sub>	P C CLIFFORD, M F R MARTIN, E JANE SHEDDON, J D KIRBY, R N BAIRD, P A DIEPPE.....	1031
Breast-feeding and respiratory syncytial virus infection	C R PULLAN, G L TOMS, A J MARTIN, P S GARDNER, J K G WEBB, D R APPLETON.....	1034
The neuropsychiatry of megaloblastic anaemia	S D SHORVON, M W P CARNEY, I CHANARIN, E H REYNOLDS.....	1036
Renal embolisation in Glanzmann's thrombasthenia	E BRIËT, F J VISMANS, A E VAN VOORTHUISEN.....	1039
Benzodiazepines cause small loss of body weight	IAN OSWALD, KIRSTINE ADAM.....	1039
Do housemen take an adequate drinking history?	I G BARRISON, L VIOLA, IAIN M MURRAY-LYON.....	1040
Single-car road deaths—disguised suicides?	J JENKINS, P SAINSBURY.....	1041
Plasma exchange in herpes gestationis	A VAN DE WIEL, H CH HART, J FLINTERMAN, J A M KERCKHAERT, J A DU BOEUFF, J W IMHOF..	1041
Accuracy of computed tomography in diagnosis of fatty liver	G M BYDDER, L KREEL, R W G CHAPMAN, D HARRY, SHEILA SHERLOCK, LUCYNA BASSAN.....	1042
Suppression of "rubral" tremor with levodopa	L J FINDLEY, M A GREASY.....	1043
Adverse reaction to bupivacaine: complication of intravenous regional analgesia	A M HENDERSON.....	1043
Long-term dietary treatment of hyperlipidaemia in patients treated with chronic haemodialysis	T L DORNAN, R GOKAL, J S PEARCE, D O OLIVER, J G G LEDINGHAM, J I MANN.....	1044
Correction: Porphyria cutanea tarda and beta-thalassaemia minor	CHAPMAN.....	1040

## MEDICAL PRACTICE

A diagnostic survey of infants referred for chromosome analysis in the neonatal period	R M WINTER, M A C RIDLER, J A MCKEOWN.....	1045
Procedures in Practice: Aspiration and injection of joints (2)	PETER WILLIAMS, MICHAEL GUMPEL.....	1048
Surgical audit: Comparison of the work load and results of two hospitals in the same district	O J A GILMORE, N J GRIFFITHS, J C CONNOLLY, A W DUNLOP, S HART, J P S THOMSON, I P TODD.....	1050
ABC of Blood Pressure Reduction: Vasodilator drugs and resistant hypertension	LIAM T BANNAN, D G BEEVERS, NOEL WRIGHT.....	1053
Listening and talking to patients: IV—Some special problems	CHARLES FLETCHER.....	1056
Lesson of the Week: Streptococcus pyogenes: a forgotten occupational hazard in the mortuary	P M HAWKEY, S J PEDLER, P J SOUTHALL.....	1058
Letter from Manila: Where the bougainvillea blooms	GEORGE DUNEA.....	1059
Any Questions?	.....	1047, 1052
Words	B J FREEDMAN.....	1060
Medicine and Books.....	.....	1061
Medicine and the Media—Contribution from C PALLIS.....	.....	1064
Personal View	ALAN LYELL.....	1065
Correction: Peripheral vascular disease	CLYNE.....	1058

CORRESPONDENCE—List of Contents.....	1066
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OBITUARY .....	1075
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## NEWS AND NOTES

Views .....	1078
Medical News.....	1079
BMA Notices.....	1080

## SUPPLEMENT

<b>The Week.....</b>	1081
<b>An opportunity missed at Brighton</b> W RUSSELL.....	1082
<b>From the CCHMS.....</b>	1083
<b>Review Body reassures BMA on remit .....</b>	1086
<b>New effort to curb NHS drug costs.....</b>	1086

# CORRESPONDENCE

<b>BCG in Britain</b> J Lorber, FRCP..... 1066	<b>Surveillance of food poisoning and salmonella infections</b> F G Miskelly, MRCP, and R Orr, MB.... 1069	<b>Hazards of surgical glove powders</b> I D L Fraser, FRCS..... 1072
<b>Collecting and banking human milk: to heat or not to heat</b> J D Baum, FRCP..... 1066	<b>Primary biliary cirrhosis: an epidemiological study</b> W S Hislop, MRCP..... 1069	<b>Breast cancer trials—a new initiative</b> P A M Walden, MRCP..... 1072
<b>Perinatal practice and compensation for handicap</b> Gilliane M McIlwaine, MD, and others; P L C Diggory, FRCOG; R S Illingworth, FRCP..... 1067	<b>Finger wrinkling after immersion in water</b> S M O'Riain, FRCS; D J Williams, FRCS; G Alvarez, MD..... 1070	<b>Parity and breast cancer</b> E Trapido, MD..... 1072
<b>The Steve Biko case: politics and medical ethics</b> R Hoffenberg, FRCP..... 1068	<b>Porphyria cutanea tarda and beta-thalassaemia minor with iron overload</b> R W G Chapman, MRCP..... 1070	<b>Mexiletine for supraventricular tachycardia</b> S D Slater, FRCPGLAS, and others..... 1072
<b>Feeding patients with advanced dementia</b> C J Burns-Cox, FRCP..... 1068	<b>Laboratory features of pleural effusions</b> P P Sutton, MRCP, and S W Clarke, FRCP.. 1070	<b>Risks of coronary arteriography</b> C A Layton, MRCP..... 1073
<b>Disturbed behaviour induced by high-dose antipsychotic drugs</b> T R E Barnes, MRCPsych, and P K Bridges, FRCPsych..... 1068	<b>Comparison of continuous and intermittent papaveretum after cholecystectomy</b> J J Church, FFARCS; J G Jones, FFARCS, and others..... 1071	<b>Confusion of filters: potential hazard from ultraviolet lamps</b> E F J Ring, MSC, and others..... 1073
<b>Allergy to insulins</b> P Diem, MD..... 1068	<b>Anthropometric and dynamometric variables and serious postoperative complications</b> R W Parnell, FRCP..... 1071	<b>Driving after anaesthesia</b> J M Cundy, FFARCS..... 1073
<b>Anaphylactic reaction to desensitisation</b> Pamela W Ewan, MRCP..... 1069	<b>Antibiotics in surgical treatment of acute abscesses</b> D H Wilson, FRCS..... 1071	<b>A rare case of atypical angina</b> H A Cameron, MB, and others..... 1073
<b>Unprecedented increase of infantile hypertrophic pyloric stenosis</b> J A Dodge, FRCPED and others; T E Sensky, MB..... 1069		<b>Vomiting as a diagnostic aid—or diagnostic pitfall</b> A M N Gardner, FRCS..... 1074
		<b>Women in hospital medicine</b> Anne C MacLeod, MB..... 1074
		<b>Restore the medical superintendent?</b> S T H Jenkins, FRCP..... 1074
		<b>Excluded from practice</b> A E Ward, MB..... 1074
		<b>Two lessons about rabies</b> D Parker, MRCP..... 1074

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*Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.*

## BCG in Britain

SIR,—Your leading article (27 September, p 825) on BCG in Britain does full justice to the effect of BCG in mass vaccination programmes but barely mentions its importance for contacts; yet it is in this field that BCG has its greatest value and it is in this field that the highest number of individuals are likely to benefit.<sup>1</sup> Unfortunately, this does not seem to be realised by many doctors today, including some chest physicians—with disastrous results.

Although tuberculous meningitis is very uncommon almost every case that I have had in the last few years would have been easily preventable had the child had BCG. Within the last three years I had two children whose mother, grandmother, grandfather, or any combination had had tuberculosis and yet the child was not given BCG, even when the mother asked. These patients included one whose mother had recovered from tuberculous meningitis in her childhood and yet the child was not given BCG. Another tragedy is that as tuberculous meningitis is now, fortunately, unknown or uncommon, diagnosis is commonly delayed because people do not think of it. Although we have effective treatment to ensure recovery without sequelae in every patient who presents early enough, grave

sequelae can still occur in those who have been in a coma for days before they are referred to a proper centre.

It is essential that BCG should be given to every baby—which could be done on the first day effectively—with a positive family history, even if there are no active cases known at the time; and that BCG should be given to any

contacts of newly discovered cases. By contacts I mean even next-door neighbours and friends, not just relations.

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<sup>1</sup> Lorber J. *Br Med J* 1953;iii:1122-6.

## Collecting and banking human milk: to heat or not to heat

SIR,—I wish to disagree with the recommendations of Dr Bengt Björkstén and others (20 September, p 765) in their paper on collecting and banking human milk.

The essential points in their paper can be summarised as follows: they have seen no ill effects from feeding donated raw human milk to newborn infants; pasteurisation is an inexact process which not only eliminates pathogenic bacteria but also damages the bacteriostatic mechanisms present in human milk; as a result pasteurised human milk will be more susceptible to later contamination; therefore nurseries should use raw breast milk.

These apparently reasonable arguments oversimplify, and in places misrepresent, some of the issues involved. Of key importance is the

fact that pasteurisation need not be an inexact and unreliable process. To my knowledge there are at least two commercially available machines specifically designed for the precise heat treatment of human milk. We have shown that such a machine *can* preserve the majority of the antimicrobial factors while reliably eliminating potential pathogens from pooled banked milk.<sup>1</sup> The milk is exposed in 100 ml bottles to a temperature of 62.5°C ( $\pm 0.5^\circ$ ) for 30 minutes with a rapid and reproducible heating and cooling cycle. Furthermore, the machine is automated and adaptable to other time and temperature settings. Our recent studies (unpublished) have shown that at shorter time and lower temperature settings the bacteriocidal effect is retained with a