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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Malnutrition and refeeding

SIR,—I hope the trustees administering Band Aid famine relief will support practical research into the effects of refeeding on disease in the starving communities.

During and after the drought and famine in eastern Sahel in 1974 Murray *et al* studied the impact of starvation and refeeding on the occurrence and course of an outbreak of falciparum malaria in two groups of children, nomadic Fulani and non-nomadic Kanouri, in southern Niger.[1]

There was no difference in nutritional status between the two groups, members of which were surviving on what remained of their normal diets. Relief consisted of supplements of millet, sorghum, manioc, and rice.

The first case of malaria occurred within a week of the start of refeeding. Thereafter there were 35 uncomplicated cases and 20 cases of cerebral malaria in the Kanouri and 41 uncomplicated and three cerebral cases in the Fulani. The three cases of cerebral malaria in the Fulani occurred in children whose parents had shared a whole sack of sorghum, which they used as a sole source of food. The appearance of malaria so soon after refeeding and the absence of rain and malaria over the previous eight months in the Sahel indicated that the cases of malaria were relapses and not fresh infections. Outbreaks of malaria after refeeding are thus something that relief workers should expect in the present emergency.[2]

Apart from the three children living temporarily on sorghum, no complicated malaria occurred in the Fulani, who were surviving on their normal diet of dairy products from their herds, supplemented by the relief grain. This compares remarkably with the high incidence of cerebral complications in the Kanouri children, living on millet, supplemented by further grain. Together with the usual low incidence of clinical malaria in healthy Fulani, this supports the view that the basic milk diet might be suppressing the malaria parasites.[3]

The influence of starvation and of the host diet on bacterial and parasitic infections has been clearly shown in animals,[3-5] but more human fieldwork is urgently needed on these aspects.[6-8]

The initiation and support of such research before, during, and after refeeding could well be one of the few good things that might come out of the present disaster.

I was struck by the relevance of these problems when I saw a recent press picture of Mr Bob Geldof taking a well earnt rest on some sacks of grain. It made me think about the milk and the importance of restoring to the famine victims their normal diet as soon as possible. The latter point is pertinent to the observations made by Dr Andrei Kisselev and colleagues (28 September, p 897), who noted that, "In the Sahel scurvy has been a problem owing to nomads losing their camels' milk." Those workers also regarded malaria as a serious problem. It would be interesting to have their figures for the appearance of overt malaria in nomads during starvation and refeeding and subsequently with and without milk.

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Gastrointestinal haemorrhage complicating Wegener's granulomatosis

SIR,—The patient of Dr R A Coward and colleagues (28 September, p 865) suffered active gut vasculitis at a time when all other evidence indicated a response to immunosuppression. We have experienced a similar pattern in a patient with the Churg-Strauss variant of polyarteritis.

A 37 year old man presented in April 1984 with a three month history of malaise, back pain, intermittent fevers, cough, and weight loss. For four weeks he had had vague abdominal pain and myalgia in the legs and for one week paraesthesia and numbness in both lower legs. He had suffered from asthma for 18