using intravenous infusion of increasing doses in eight of these patients. The pressor response to the alpha agonist was significantly reduced during treatment with ketanserin (table).

Thus, these results suggest that during chronic treatment with ketanserin, at least part of its hypotensive effect might be mediated by α_1 antagonism. Although ketanserin inhibits the platelet aggregation induced by 5-hydroxytryptamine in short term experiments on normal volunteers, this could not be shown during long term treatment of patients with hypertension. As the hypotensive action of ketanserin was maintained this could suggest that it was not mediated by 5-hydroxytryptamine type 2 antagonism.

The hypothesis that the hypotensive effect during long term treatment with ketanserin in patients with hypertension is not mediated through its 5-hydroxytryptamine antagonism but mainly caused by the α_1 antagonism is further supported by animal experiments. Some recently synthesised 5-hydroxytryptamine type 2 receptor blockers and analogues of ketanserin (R 56413 and R 55667) do not bind to α_1 adrenoceptors. In contradistinction to ketanserin, these agents do not reduce blood pressure in spontaneously hypertensive rats, indicating that not 5-hydroxytryptamine type 2 blockade but α_1 blockade seems responsible for the hypotensive effect of ketanserin in the rat.⁶

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The incidental malignant melanoma

SIR,—Dr Robin Russell Jones (29 October, p 1304) correctly indicates that various forms of malignant melanoma may have differing aetiologies. Certainly we would agree that lentigo maligna, or lentigo maligna melanomas, for the most part arises in sun damaged skin, and because it appears to show a relatively "benign" course, should be assessed separately from superficial spreading or nodular malignant melanoma.¹ To correct Dr Jones, we did not write that the histogenetic type was of no prognostic value, rather we indicated that several series show that maximal tumour thickness appears to be a more direct and accurate indicator of prognosis (and in particular survival) than histogenic type.²⁻⁵ He cites the work of Day *et al* as showing that a

Cox multivariate analysis of 79 stage I lesions ≥ 3.65 mm indicated that histological type was of value in predicting bony or visceral metastases.⁶ It should be emphasised, however, that in their report Day *et al* wrote that this finding was at variance with six other analyses of their various clinical stage I subgroups and that they discussed the possible reasons for this. They particularly emphasised that the lateral growth phase component may be missed for those superficial spreading malignant melanomas composed of a large nodule and a small plaque if histological sections are not prepared with care. Our experience suggests that some nodular lesions have a superficial spreading element also, and in our table (17 September, p 837) lesions designated "nodular and superficial spreading with nodule(s)" represent tumours that would simply have been designated nodular without this qualification.

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Anorexia nervosa

SIR,—The remarks of Dr M Brincat and others (29 October, p 1306) regarding possible hormone replacement treatment in anorexia nervosa should be viewed in perspective. It is not clear for which group of patients the authors are advocating treatment. Our study to which they refer was based on a small group of patients whose history of amenorrhoea ranged from 14 to 27 years.¹ These patients represent a very small proportion of patients with anorexia nervosa seen at the Maudsley Hospital over many years. We do not know whether younger patients with a shorter period of amenorrhoea (even five years) would show evidence of decreased bone mass. This is a subject that clearly requires further investigation.

Our expectation when we treat patients with anorexia nervosa is that they will be restored to a healthy weight. Follow up studies on inpatients have shown that two thirds of patients have achieved a reasonable weight four to eight years later.^{2,3} Inpatients represent the most severe cases. Of those who achieve a normal weight 80% will menstruate within two years.⁴ Although patients are seen who recover and achieve a healthy weight after many years of illness one study has shown that the number of patients achieving a normal weight did not increase significantly between four and 10 years of follow up.⁴ Follow up studies of patients with anorexia nervosa at the severe end of the range indicate that somewhere between

50% and 80% are menstruating four to eight years later.^{2,3}

There might, therefore, be a group of patients in whom one might consider hormone replacement treatment. How many years of preceding amenorrhoea would warrant this is still unclear. There are in addition two other important considerations. Firstly, the group of chronic sufferers of anorexia nervosa will be further diminished by the high mortality of this condition. A follow up study of 20 years or more has shown a mortality of about 17%.⁵ Secondly, these patients usually do not wish to menstruate and they might be reluctant to accept hormone replacement treatment. This has in fact been the case with one of the patients in our series who had a 27 year history of amenorrhoea.

We conclude, therefore, that the number of patients who at present would warrant hormone replacement treatment is small. Also, we cannot accept the statement of Dr Brincat and his colleagues that hormone replacement treatment should be "an integral part of the management of patients with anorexia nervosa." There may, however, be a small proportion of patients with a chronic illness in whom such treatment would be helpful in reducing the risk of osteoporosis.

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Excess mortality among children discharged from hospital after treatment for diarrhoea in rural Bangladesh

SIR,—The fact that four fifths of the total number of children in the study by Dr S K Ray and others (15 October, p 1097) were under 2 years of age, an age band which shows the highest mortality for the population, would suggest that deductions made from this study could reasonably be applied to the general child population in Matlab, Bangladesh.

I notice, however, that only one twelfth of those children aged less than 2 had severe malnutrition as compared with one quarter of those aged 2 and older. Also, the observed deaths in those aged less than 2 were in fact two thirds of expected deaths for the same age group in the normal population. Could the smaller proportion of severely malnourished children in the under 2s account for the fact that the effect of severe malnutrition in the overall mortality has not shown up as convincingly as it has done in those aged 2 and over? In the study by Chen *et al*¹ the proportion of severely malnourished children in those under 2 was one quarter of the total number of children in this age group, and the effect of severe malnutrition was well shown.

Table III of Dr Roy's article shows a lower mortality in severely malnourished children compared with moderately malnourished