assess this. We should be told how many patients receiving long-term anti-inflammatory therapy were examined in order to find the 249 patients who had no gastric lesions at the initial endoscopy, incorrectly named the pretreatment endoscopy. If few were rejected this would support the view that the lesions are often transient. We do not accept the authors' reasons for not including a control group, and would suggest the use of paracetamol in a group with osteoarthritis.

This is an important area of work in which much more information is required, but we would reluctantly question the conclusions drawn by these workers. Further studies of better design should be undertaken.

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¹Holdstock GE, Smith CL, Isaacson P. *Gut* 1979; 20:A901.

*We sent a copy of this letter to the authors, whose reply is printed below.—ED, *BMJ*.

SIR,—Drs Colin-Jones and Frost in their letter raise several interesting points and we undoubtedly agree with their statement on the importance of studies whose aim is to define the incidence and the characteristics of gastric injury due to anti-inflammatory agents in patients with rheumatic disease.

They wonder how "gastric lesions" were defined in our work. In this research endoscopic findings were classified as ulcers and erosions (and only these have been counted as "gastric lesions") and normal (the latter including also mild mucosal erythema or hyperaemia or both). Gastric ulcer, in agreement with a recent report by Silvoso *et al.*¹ was represented by a sharply circumscribed, three-dimensional lesion with a white base. Gastric erosion was represented by a superficial, white, two-dimensional defect in the gastric mucosa.

We also agree with Drs Colin-Jones and Frost on the importance of having histological support for the definition of such lesions; but the purpose of our study was limited to ascertain the degree of gastric injury due to anti-inflammatory drugs endoscopically visible, and not to speculate on its pathophysiological meaning.

Regarding the incidence of gastric lesions in patients who underwent the initial endoscopy, we would like to emphasise that, since only patients without visible mucosal abnormalities were included in the study, to find the 249 patients suitable for the research we had to examine 366 consecutive patients.

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¹ Silvoso GR, Ivey KJ, Butt JH, *et al. Ann Intern Med* 1979;91:517-20.

Lactation and breast cancer

SIR,—If breast-feeding reduces the risk of breast cancer it will probably not be through the magic of putting the baby to the breast, but will more likely be found in women whose babies are totally breast-fed for the first six months, with mixed feeding thereafter, and

with more than one baby. The state of prolonged amenorrhoea caused by breast-feeding could very well be the factor associated with the hormonal state that protects against cancer. In this day and age, when supplementary feeding and the early introduction of solids is popular, most breast-feeding is token, not total, and is not associated with the customary prolonged amenorrhoea of the totally breast-fed infant.

Neither Dr A Kalache and others (26 January, p 223) nor the study by MacMahon and colleagues¹ have secured adequate data to rule out this possible preventive factor.

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¹ MacMahon B, Lin TM, Lowe CR, *et al. Bull WHO* 1970;42:185-94.

Carbon monoxide yield of cigarettes

SIR,—Mr P N Lee says that there seems no strong case for publication of carbon monoxide yields of cigarettes (15 December, p 1584). We disagree.

Firstly, there are individuals with poor cardiac or respiratory function in whom even a small reduction in the oxygen-carrying capacity of the blood could be clinically serious. Such individuals may not always be able to stop smoking, and it may be helpful to advise them which cigarettes deliver the least carbon monoxide. Secondly, measurement of the carbon monoxide absorbed from each cigarette is an objective index of inhaling which may help to identify smokers at special risk of developing smoking-related diseases, and this cannot be done without knowing the carbon monoxide yields of the cigarettes. Thirdly, there is still uncertainty about the components of cigarette smoke responsible for producing an increased incidence of vascular disease, and carbon monoxide could be a contributory factor. It is therefore important that research workers should have the data relating to carbon monoxide yields, so that they can undertake appropriate clinical and epidemiological inquiries.

These, we think, are strong reasons for publication of the carbon monoxide yields of individual brands of cigarettes. We hope that the Department of Health and Social Security, which has the information, will publish it shortly. Up to now we have failed to obtain it.

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SIR,—Professor G E Moore (2 February, p 331) has not appreciated that my conclusion (15 December, p 1538) that the tar reduction in cigarettes occurred before publication of the first tar table in 1973 related only to the situation in the United Kingdom and to official publication.

His 1967 paper,¹ which gave data on United States brands only, was in any case not the first publication to do so there. Information was publicly available from two sources between 1953 and 1967: a series of reports from the laboratories of the Consumers Union and similar reports from Foster D Snell Inc, prepared for the *Readers Digest*.²

In the United Kingdom the first publication

of any sort was by the Consumers Association in 1971.³ A major part of the reduction in sales-weighted tar levels occurred earlier, from 31.4 mg in 1965 to 23.9 mg in 1968.⁴ Evidence that industry took an early initiative towards publication of tar and nicotine yields in league table form has appeared previously in the *BMJ*.⁵

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¹ Moore GE, Bross I, Shamberger R, Bock FG. *Cancer* 1976;20:323-32.

² Owen TB. In: Wynder EL, Hoffman D, Gori GB, eds. *Modifying the risks for the smoker* (Proceedings of the Third World Conference on Smoking and Health, vol 1). Washington: US Department of Health, Education, and Welfare, 1975:73-80.

³ Consumers Association. *Which?* September 1971: 280.

⁴ Lee PN. *Tobacco Research Council Research Paper No 1*, 7th ed. London: Tobacco Research Council, 1976.

⁵ Bentley HR. *Br Med J* 1975;iii:308.

Ketotifen in adult asthma

SIR,—The recent report by Drs A J Dyson and A D Mackay (9 February, p 360) on ketotifen in adult asthma suggests that drowsiness was a troublesome effect of the drug. However, the incidence of drowsiness was less than in a series of patients studied in this department.

Seventeen adults with asthma, including 11 atopic subjects, were given ketotifen 1 mg twice daily. After one week the drug had to be withdrawn in 11 patients because of severe drowsiness. It was subsequently withdrawn in a further three patients who were troubled by minor drowsiness which was sufficient to interfere with their normal occupation, which included driving. Two patients, both of whom had some drowsiness, had episodes of sudden and unpredictable loss of balance causing falls and injury. They also complained of a feeling of lightheadedness. All symptoms resolved when the drug was stopped. In one patient the drug was reintroduced while she was an inpatient and the symptoms, including the loss of balance, recurred.

Drs Dyson and Mackay concluded that the beneficial effect of ketotifen on asthma appeared slight, and the high incidence of side effects appears a high price for marginal benefit.

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Resuscitation of the newborn

SIR,—I have followed your series on the first year of life and found the summaries helpful.

I would like to take issue with the recommendation of the equipment suggested for assisted ventilation (24 November, p 1345). Fortunately most infants respond to the first few attempts at assisted inflation. In those where difficulty is experienced in initiating ventilation the limitation of inflation pressures to 30 cm H₂O may be insufficient. This applies to lungs when the alveoli are fluid filled and particularly to the premature infant.¹ High pressures of up to 70 cm H₂O may be required, but it is important that these peak pressures are only transitory. The use of a large-volume bag as in the Resuscitaire may tempt the less experienced to apply a more sustained pressure and be more likely to cause airways rupture rather than a transitory high pressure.