Perinatal mortality

SIR,—In the light of the figures supplied in your issue of 26 January (p 261), which show that perinatal mortality has almost halved in a decade, is it not time that correspondents such as Dr M J Boscoe, whom I note writes from Holland, stopped talking about our “appalling” perinatal mortality statistics? In my view we should leave such hyperbole to journalists and advertising agents who have a different axe to grind than those of us who are trying to improve the care offered to mothers and babies at delivery.

The first step might be to recognise that this is as much a social as a medical matter and that so far as our figures are unsatisfactory (and mortality is not the whole story) we should draw the attention of the Government and the fourth estate to the fact that young married women are the most downtrodden section of our community whereas in any civilised society, and particularly one that subscribes to the Christian myth or even one whose only aim is biological survival, their needs should be put first and not last. It might even be that were we to increase children's allowances to an adequate sum much of the pressure from married men with children for higher wages would abate.

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Breast-feeding in Sarawak

SIR,—I would like to congratulate Mr T H H G Koh for his interesting paper on breast-feeding in Sarawak (12 January, p 95), in which he was justifiably disappointed by the 67% breast-feeding rate of Chinese mothers—declining to 25% after the first month despite the custom of secluding mother and baby together during the neonatal period. This observation emphasises that successful breast-feeding depends upon a variety of factors, including mother-child bonding, preparation of the mother for breast-feeding, information on infant nutrition, the advertising of milk powders, urbanisation, wealth, and social values.

Although the postpartum seclusion of the mother with her newborn infant should have enhanced mother-child bonding, the rigid enforcement (usually by grandmother) of rules which include forbidding the mother to wash her hair for 30 days can be intolerable, particularly in a hot, humid climate. Inadequate motivation and preparation of young mothers for breast-feeding and the lack of early skin contact between mother and infant after birth¹ are other important factors that militate against breast-feeding in middle-class Chinese women in urbanised communities of South-east Asia. The special traditional diet offered to postpartum Chinese mothers excludes tea, coffee, and water, thus restricting fluid intake to concentrated soups rich in fats and alcohol, insufficient for the demands of breast-feeding in a tropical climate. The high incidence of neonatal jaundice in South-east Asia associated with glucose-6-phosphate dehydrogenase deficiency is related to drugs, naphthalene, and herbs used in postpartum diets.² This has influenced some mothers to abandon breast-feeding rather than incur the wrath of grandmother by asking for a change in her diet.

The significantly lower breast-feeding rate in English-educated Chinese mothers highlights the influence of feeding practices in Britain and the United States on women in urban areas of the developing world. It is disconcerting to observe the uncritical adoption of practices of the West by middle-class people in developing countries who misinterpret the fashionable for that which is progressive and valuable. The medical profession in these countries is not blameless because it has, in the main, been uninterested and uninformed about infant nutrition, thus encouraging the manufacturers and distributors of milk products to give advice to the public on infant feeding. I have seen advertisements of milk powders in recent issues of medical and child health journals from South-east Asia. Although it would be naive to blame the advertisement and promotion of milk products solely for the decline of breast-feeding in developing countries, it is easy to adopt such an attitude when one considers the evidence in South-east Asia. I hope that the implementation of the recommendations on appropriate marketing and distribution of infant formula and weaning foods that emerged from the WHO-UNICEF meeting on infant and child feeding in October 1979³ will put an end to this unethical practice.

I do not share the concern of Mr Koh that solids should be introduced only after four to six months. Healthy term infants in Singapore double their birth weight by the fourth month⁴ and solids would then be needed to ensure an adequate source of calories.

Finally, I suggest that the optimism of the production manager in a baby food firm quoted in the paper is not based on reality. In oil-rich Libya, where there is a government ban on advertisements of milk powders, a rapid decline in breast-feeding⁵ has occurred in the past five years because mothers prefer to buy powdered milk from the grocers rather than breast-feed. The influence of wealth on social behaviour is complex and in some societies it has led to ill health.

Doctors practising in urban areas of developing countries have to be concerned with all aspects of health for the individual and the community. They will have to be more active and vocal in the community if they are to fulfil their role as guardians of health.

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¹ Klaus MH, Jerauld R, Kreger NC, et al. *New Engl J Med* 1972;286:460-3.

² Brown WF, and Wong HB. *Pediatrics* 1968;41:1055-62.

³ WHO and UNICEF. *Meeting on infant and young child feeding*. Geneva: World Health Organisation, 1979.

⁴ Wong HB, Tye CY, Quek KM. *J Singapore Paediatr Soc* 1972;14:68.

⁵ Stephens AJH. *Garyounis Med J* (in press).

Randomised controlled trials

SIR,—With your help I want to support the stand made by Sir Richard Doll and Mr R Peto (5 January, p 44) against the attempt by Dr Lawrence Cranberg (17 November, p 1265), Dr G J M Tevaawerk (19 January, p 185), and others to undermine the authority of the prospective, randomly controlled trial.

Starting in 1957, I have published reports of seven prospective randomly controlled trials. Three were “acute” (postoperative

pulmonary embolism) and four were “long-term,” lasting two years (three on inguinal herniorrhaphy, one on the primary treatment of varicose veins). In 1975 I addressed the Belgian Association of Surgeons on the topic of prospective randomly controlled trials.

From my “long-term” trials I learnt how very difficult it is to keep the efficiency of the follow-up at 90%, even for two years. By comparison a cancer follow-up for longer is easy. My first point is that at 90% efficiency the failure rate of the trial can be 0.0% or 10.0% or some intermediate figure. A trial with only a 50% follow-up can have a failure rate of 0.0% or 50.0%, or some unknown intermediate figure. Obviously to compare two such trials, with one as the retrospective control of the other, is futile. Of 15 huge North American trials on herniorrhaphy, the largest numbering 5525 cases, only seven had a follow-up rate of 50%, and their value was destroyed because the length of the follow-up of individual patients ranged from three months to over 10 years. The authors seemed unaware of the useless comparisons they were making. The result of these retrospective studies was chaos. The senior American surgeon, A R Koontz, complained that there was more confusion about the correct way to repair an inguinal hernia than about the treatment of any other surgical condition.

Recently I have abandoned a bootless argument with the Shouldice Hospital, which treats ruptures but no other condition. This experience makes one fear that, in North America, there are few who understand that in nature there is no “law of uniformity” ensuring that the missing part of a series will be a mirror image of the part traced.

The main point I want to make is that, apart from “acute” trials where very few patients are “lost,” to use retrospective controls for “long-term” trials on benign conditions would put back the study of even the simplest and commonest conditions by 25 years.

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Elimination diets in childhood

SIR,—To the silly question (and title) “How necessary are elimination diets in childhood?” (19 January, p 138) your leader gave an extremely silly answer, because it saw the subject through smoked gastrointestinal spectacles. Silliness and the denigration of our controlled eczema study do not matter much; but, now that progress is at last being made in a large and complex subject that is at present grossly underapplied because of professional obtuseness and NHS rigidity, such a misleading article can be very damaging.

If the subject had been elimination diets in gastrointestinal disease the article could have been accepted as a cautious statement of the present position. Even the most obtuse sceptic cannot gainsay that a gluten-free diet is needed for coeliac disease. Though villous atrophy is seen in some other gastrointestinal food allergies it is not present in all,¹ so the diagnostic value of intestinal biopsy can be overstated; and the claim that the splendid report of Heiner and his colleagues on iron-deficiency anaemia due to milk allergy constitutes “proof” is quite unsound since the studies were descriptive, open, and un-

controlled (it is, of course, convincing—is "proof" ever possible?), but this is still acceptable.

It has, however, been obvious for years that this vast field needed expansion. I selected eczema as an example of a case where unscientific scepticism was depriving patients of effective treatment. I, and many parents, knew that some children with eczema got better when they avoided certain foods, but most British paediatricians and dermatologists did not believe it. These sceptics included my colleagues Dr D J Atherton and Dr R S Wells but they had the intellectual integrity to test their view, by doing the first double-blind controlled trial of food antigen avoidance in any disease.² My purpose was education of my colleagues, immediate and nationwide, of what was obvious to me; and I hoped that people would then extrapolate in planning more positive approaches to other syndromes suspected to be due to food intolerance. Since your leading article gives it as an example of "uncontrolled enthusiasm" clearly it has been less educationally effective than I had hoped. Your article recommends maintaining the present scepticism, which I think is based on ignorance, arrogance, and lack of scientific criticism. Clearly some of the wilder claims are wrong; but many may be right, and the ostrich posture of the profession is driving more and more intelligent and observant parents into the hands of quacks and cranks—and so depriving them of critical dietary treatment, properly dietetically controlled to avoid the dietary deprivation which may occur, as you stress. The overall negative attitude of your article, however, will not reduce this risk but increase it, as the patients are forced into the hands of cranks.

There is now impressive preliminary evidence of food allergy symptoms, very commonly, in nearly every organ; and much more work is needed. But allergy is only a part of the subject covered by your title. Food intolerance includes idiosyncrasy (systemic—for example, phenylketonuria—as well as gastrointestinal—for example, alactasia) as well as allergy, though some of the soft literature uses the word allergy for diseases which are probably idiosyncrasy. The medical profession has done far better in these diseases, whose treatment falls under your title; but neither you nor the cranks give us the credit, and your article may reduce the availability of the necessary services for managing them as well as the allergies. May I urge the *BMJ* to try to help us to supply these treatments, which may be dangerous as well as very effective, and so need expert hands, in these difficult times when resources are liable to be cut, and not just to add to our difficulties?

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¹ Syme J. In: Pepys J, Edwards MJ, eds. *The mast cell*. Tunbridge Wells: Pitman Medical, 1979.

² Atherton DJ, Sewell M, Soothill JF, Wells RS. *Lancet* 1978;i:401-3.

Unsolved problems for the '80s

SIR,—Your leading article (5 January, p 3) rightly points out that the global problems of greatest concern for the next decade will be those pertaining to the availability of resources in relation to an increasing world population.

And since most of this population lives in poverty which is often desperate, it is reasonable to assume that such people will as they develop need a larger share of resources.

To suggest, however, that the developed countries should be primarily concerned with reducing the increasing Third World's population is poor advice, unlikely to be heeded or result in successful projects. May I quote from Barbara Ward's recent book:¹ "For the poorest peasant the chief resource of energy is human labour. It is perfectly rational, in such a context, to try to ensure that there is enough of such labour. Children perform a multitude of farm duties, they take care of little brothers and sisters, and the farmer expects at least some of them to survive and care for him in his old age. . . . In the Third World falling birth rates everywhere coincide with the diversification and increasing sophistication of resources, including energy, in the rural scene."

Further, such a child consumes in his lifetime only a fraction (some 1/36th) of the non-renewable resources a European child disposes of. When industrial societies use energy less wastefully (as your leading article says, deploying energy from the sun, conserving, wasting less in processing and packaging, deriving more protein from cereal) more will become available to the less industrialised. Exhortations on populations may then have greater effect.

As you point out, one fears that politicians in responding to short-term problems will fail to come to grips with those of greatest significance. We will need strategies such as those outlined by Barbara Ward, strategies which include a frugal use of non-renewable resources, a sharing of technology and skills, and the direction of research to appropriate problems. Articulate and intelligent members of the electorate, one hopes, will persuade their government of the urgency of the task to preserve and improve the wellbeing of our global village.

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¹ Ward B. *Progress for a small planet*. Harmondsworth, Penguin, 1979.

SIR,—In your leading article "Unsolved problems for the '80s" (5 January, p 3) you note that "In both Northern and Western Europe the annual rate of population increase is now 0.1% or lower." You go on to report that "if the population became stabilised at an average of two children per family in the year 2000 total numbers would continue to grow to a plateau of 8000 million."

In Britain we have over 50 million people. Why do we suppose that this figure should be stabilised? It is obvious that it should be reduced. In the long term (say 200-300 years) we must obtain a population size which will be able to live safely without fossil fuels. This is certainly well below 10 million people. In the nineteenth century the population expanded from 10 to 30 million. The situation of populations struggling at about subsistence level has been terrible. What will occur when huge populations face relatively sudden collapse of resources? Even in the short term the prospects of unemployment among our children surely point to the need for a prompt reduction of population.

The only possible general recommendation

must be that the ethical size for a family is one child only. Our voice would be better heard in the rest of the world if we accepted our own responsibility in this matter. With such a policy population may fall, say, 10% every 20 years. This would be well within tolerable limits. Resources released from child care and unemployment benefit would abundantly provide for the elderly.

Must humanity continue its tragic course; struggling from tragedy to tragedy? Can we not take warning from the hideous record of human conflict? Must our leaders always opt for disastrous policies? Governments are looking for cannon fodder and churches are trapped by the muddled moral philosophy of a brutal past.

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Incidence of gallstones and ischaemic heart disease in the West of Scotland

SIR,—Since several factors—for example, obesity and high cholesterol diet—are classically considered of aetiological importance in both cholelithiasis and ischaemic heart disease, we were surprised to read of the negative correlation between the two conditions recently reported by Dr D J P Barker and others (1 December, p 1389). Accordingly, we have tried to review the relationship between gall stones and ischaemic heart disease in the West of Scotland, which appears to have a high incidence of coronary artery disease.

In a previously reported review of the prevalence of gall stones in 10 748 necropsies in two Glasgow hospitals, it was found that the prevalence in males under 60 years was 3.4%.¹ The WHO statistics for 1977 reported the death rate from ischaemic heart disease in male Scots aged 45-54 as 364.9/100 000.² In females, corresponding figures were a gall-stone prevalence of 10% and an ischaemic heart disease death rate of 84.1/100 000. The prevalence of gall stones at necropsy in the nine English cities reported by Dr Barker and his colleagues was strikingly similar to our experience in the West of Scotland. In contrast, the figures for ischaemic heart disease were considerably lower. This latter finding is reflected in the WHO statistics which report the death rate from ischaemic heart disease in England (age 45-54 years) as 289.5/100 000 for males and 51.3/100 000 for females.²

Like Dr Barker, we found the prevalence of gall stones at necropsy greater in females but we feel this is unlikely to be associated with exogenous oestrogen administration. Oral contraceptive and postmenopausal oestrogen therapy has become widespread in Britain only over the past 15 years; accordingly, we would not expect to see this reflected in necropsy studies until the present generation dies—that is, around the turn of the century. We would also question whether economic differences—while of significance globally—are sufficiently marked between various parts of the United Kingdom to be major factors in the incidence of these two multifactorial diseases. Regional variations in other factors—for example, hardness of water, diet, and amount of salt ingestion, would appear just as likely reasons for the differences in the incidence of gall stones and ischaemic heart disease noted by Dr Barker.

In conclusion, the West of Scotland, with