because their pain and discomfort have not been relieved by antacids. Am I to deprive them of rapid symptomatic relief? Some of them will never need the expensive cimetidine and those who do can surely hope for relief while waiting for their gastric acid levels to be lowered.

Many doctors in general as well as consultant practice are still unaware that the pain of an ulcer is often due to spasm or cramp of the gastric musculature. While this is often provoked by hyperchlorhydria, it may not be relieved immediately by its correction. Most patients who get this type of pain are relieved rapidly by either metoclopramide or a liquorice preparation before meals and at night. Among the liquorice preparations my preference is for Caved S, which is cheap and does not cause fluid retention. Apart from drugs many patients will be helped by a discussion of the stresses which have provoked their hyperchlorhydria.

In the same issue of the journal (p 1154) a general practitioner, Dr S Schrire, emphasises how much kinder doctors tend to be when they themselves have suffered from a complaint. I heartily agree and would recommend those of your readers who have missed this Personal View to look back at it.

DENIS CRADDOCK

S Croydon, Surrey

Increasing prevalence of breast-feeding

SIR,—In a recent paper from the Department of Health and Social Security Multicentre Postneonatal Study¹ the infant feeding practices of 130 primiparous and 166 multiparous mothers randomly selected from seven areas of England and Scotland were analysed from data collected during an interview at their homes. The results generally supported the findings of Dr E C Coles and others (21 October, p 1122), although the feeding practices of primiparous mothers were highly significantly more satisfactory than those of multiparous mothers.

In all, 161 (54%) of mothers attempted to breast-feed and 69 (23%) were still doing so at 12 weeks. Disappointingly, 50 (17%) introduced solids before six weeks and 32 (11%) admitted to giving overconcentrated milk feeds.

Although the incidence and duration of breast-feeding may improve with campaigns of encouragement to mothers, there will always be mothers who do not wish to breast-feed for social, emotional, or physical reasons. It may be counterproductive to encourage these mothers to breast-feed as they may be made to feel guilty, resentful, or inadequate when the attempt, which was made under protest, fails.

The associations between bottle-feeding and obesity in infancy, hypernatraemic dehydration, and the sudden infant death syndrome are now much less clearcut, owing to improvements in bottle-feeding practices as much as to the increased incidence of breast-feeding. In clinical practice the undernourished breast-fed baby is becoming an increasingly common problem.

Correct bottle-feeding comes a very close second to breast-feeding, and, while most mothers can be encouraged to breast-feed, the medical profession should not become over-zealous in the attempt to attain 100% breast-feeding. Positive encouragement for breast-feeding should continue, but continuing

emphasis on correct bottle-feeding practices and delayed introduction of solids for those mothers who do not, or will not, breast-feed must be given at least equal importance.

J R OAKLEY
Clinical Co-ordinator,
DHSS Multicentre Postneonatal Study,
University of Sheffield

Children's Hospital,
Sheffield

¹ Oakley, J R, *Archives of Disease in Childhood*, 1978, **53**, 688.

Treatment of hydatidosis

SIR,—We read with interest the article by Dr A Bekhti and others (22 October, p 1047) on the treatment of hepatic hydatidosis with mebendazole. But the findings reported in this paper, including the drop in the concentration of antibodies and the regression of hepatic hydatid cysts, are after all indirect evidence. The essence of the problem really lies in our ignorance of what is going on inside the hydatid cyst in man when the patient receives the recommended dose of mebendazole. We have additional information that provides direct evidence and confirms the findings of Bekhti *et al.*

A 20-year-old woman was the first in a series of patients to be investigated for the effect of mebendazole on hydatid cysts. She had confirmed multiple hydatid cysts (one in the left lobe of the liver, one in the right lobe, and one in the lower pole of the left kidney). She received the recommended dose of mebendazole for 21 days, starting on 27 April 1978. She had an uneventful postoperative course after an operation on 27 June to remove the cysts and was well when seen three months after operation.

Macroscopically, the three cysts were brownish-grey and soft and friable. They had lost the characteristic "touch" of hydatid cysts which is familiar to surgeons with experience of hydatidosis. The thick hydatid fluid was sterile when cultured for bacteria. Microscopic examination of hydatid fluid collected from the cysts proved negative for the presence of protoscolices and brood capsules. No growth of secondary hydatid cysts was demonstrated after 105 days in three rats and three albino mice injected intraperitoneally with 1 ml and 0.5 ml of pooled hydatid fluid respectively. Histological studies of different parts of the hydatid cysts removed from the patient showed complete degeneration of the germinal layer and absence of protoscolices and brood capsules. The laminated and fibrous layers were intact.

Full results of the investigation will be published later.

M I AL-MOSLIH T A AL-JANABI
A Y AL-RAWAS M A SHAFIK
S RASSAM M S AL-ANI
M A AL-DABAGH

Medical College,
Baghdad University,
Iraq

Gamma-glutamyltransferase in ascitic fluid in primary hepatoma

SIR,—We would like to comment on the paper by Dr T J Peters and others (18 June 1977, p 1576), in which they reported significantly raised levels of γ -glutamyltransferase in the ascitic fluid of five patients with primary hepatoma in comparison with patients with liver cirrhosis or ascites due to other causes. We have determined γ -glutamyltransferase levels (method of Persijn *et al.*²) in ascitic fluid from 44 patients, including 10 with hepatoma

Gamma-glutamyltransferase levels in ascitic fluid

Diagnosis	No of patients	Enzyme activity (mU/ml)	
		Mean $\pm$ SE	Range
Hepatoma	10	20.47 $\pm$ 12.93	5.5–83.0
Hepatoma (not confirmed)	10	15.50 $\pm$ 10.44	5.0–39.5
Cirrhosis	24	13.00 $\pm$ 12.93	1.0–47.0

proved either by peritoneoscopic biopsy or at necropsy, 10 with raised α_1 -fetoprotein levels but without clinical or peritoneoscopic evidence of hepatoma, and 24 with apparently ordinary liver cirrhosis. The results, shown in the table, were analysed statistically by the Mann-Whitney U test.

Differences between the γ -glutamyltransferase levels in ascitic fluid from the three groups of patients were not significant. Thus we have been unable to confirm the assumption that the assay of this enzyme in ascitic fluid may be a useful investigation in diagnosing hepatoma. Perhaps our cases are not strictly comparable to those of Dr Peters and his colleagues, which might represent more advanced lesions; six of our 10 patients with hepatoma were diagnosed by peritoneoscopic biopsy, which allows the sampling of relatively small lesions; while Dr Peters and his colleagues apparently used blind biopsy, which, in our experience, is successful only in extensive hepatocellular carcinoma.

M CORTÉS-RIUS
J ESCODA
L FUSTÉ
J M QUERALTÓ
F VILARDELL

Escuela de Patología Digestiva,
Universidad Autónoma de Barcelona,
Hospital de la Santa Cruz y San Pablo,
Barcelona, Spain

¹ Persijn, J P, and Van der Slik, W, *Journal of Clinical Chemistry and Clinical Biochemistry*, 1976, **14**, 421.

Data sheets and lactation

SIR,—In your issue of 21 October (p 1122) there is a report by Dr E C Coles and others on the increasing prevalence of breast-feeding. Only seven pages later (p 1129) there is an article by Drs A Herxheimer and N D W Lionel proposing the minimum information needed by prescribers and the format of the standard UK product data sheet. There is not one mention of drugs and lactation and this is typical of almost every data sheet in the ABPI *Compendium*. Articles in the medical press are usually incomplete, inaccurate, and misleading when dealing with drugs in breast milk.^{1 2} Lists of drugs such as carbimazole, amantadine, and morphine are of little relevance to everyday prescribing.

Drugs which might harm the breast-fed baby must not be given inadvertently through ignorance or lack of information. It is also unreasonable to deny the lactating woman the benefits of modern drugs simply because the necessary information is not available. There is no reason to penalise her by denying control of her hay fever, epilepsy, or IUCD menorrhagia. The general practitioner wants to know which drugs he can safely prescribe, and recent experience in my practice shows that they include antibiotics, anticonvulsants, anxiolytics, antihistamines, antiemetics, and aminocaproic acid.

The data sheet should indicate where

possible whether or not: (a) the drug affects the production of milk; (b) the drug is excreted in the milk and, if so, whether the amount is of clinical significance; and (c) the amount excreted would adversely affect the neonate or infant. The information would then be readily at hand when the increasing number of lactating mothers consult their practitioners. I am trying to assemble such data to produce a useful reference to drugs which are safe rather than the negative lists which currently predominate.

C D E MORRIS

Walsall, W Midlands

¹ Lewis, P, *Journal of Maternal and Child Health*, 1978, 3, 128.

² Harvey, D, *Modern Medicine (Great Britain)*, 1978, 23, 87.

Serum trypsin concentrations in diabetes mellitus

SIR,—The paper by Dr P Dandona and others on serum trypsin concentrations in diabetic subjects (21 October, p 1125) is an interesting contribution to the accumulating evidence of dysfunction of the exocrine pancreas in diabetes. Their observation that serum trypsin concentrations are low in insulin-dependent diabetic patients, with a lesser decrease in diabetic patients treated with oral hypoglycaemic agents, certainly corresponds to the pattern of reduced pancreatic trypsin output described in similar groups of diabetic subjects.¹ (Exocrine pancreatic function in these patients was in fact studied in response to an intravenous infusion of secretin and cholecystokinin-pancreozymin and not to a Lundh test meal as the authors state.) However, while serum trypsin concentrations vary in different clinical conditions,² the value of this measurement as an index of the secretory capacity of the exocrine pancreas can only be inferred. Their interpretation that low serum trypsin concentrations in diabetic subjects are indicative of exocrine pancreatic deficiency would be strengthened if a direct correlation could be demonstrated with stimulated outputs of pancreatic trypsin in the same patients. It would also be interesting to know if the authors found a relationship between the serum trypsin concentrations and the duration of diabetes in each group of patients.

The authors further refer to our study demonstrating a direct relationship between exocrine pancreatic function and endogenous insulin secretion³ (as measured by C-peptide concentrations) to support their premise that the abnormality of serum trypsin concentrations parallels the degree of beta-cell deficiency in their diabetic patients. We observed a significant correlation between endogenous insulin secretion and the outputs of pancreatic amylase and bicarbonate in a group of insulin-dependent diabetic patients but could not demonstrate a relationship with pancreatic trypsin output, although the latter was undoubtedly diminished in diabetes.³ Animal studies have also failed to show that insulin will enhance pancreatic protease enzyme secretion in alloxan diabetic rats.^{4,5}

The effect of endocrine factors on pancreatic trypsin production and secretion are not well established and dietary carbohydrate restriction in diabetes is another factor which may influence trypsin secretory capacity and serum trypsin levels. Therefore, while it is likely that low serum trypsin concentrations in diabetes are secondary to exocrine pan-

creatic dysfunction, the suggested relationship to the severity of beta-cell deficiency cannot be supported by present evidence.

BRIAN M FRIER

Royal Infirmary,
Edinburgh

¹ Frier, B M, *et al*, *Gut*, 1976, 17, 685.

² Elias, E, Redshaw, M, and Wood, T, *Lancet*, 1977, 2, 66.

³ Frier, B M, *et al*, *Diabetologia*, 1978, 14, 301.

⁴ Ben Abdeljlil, A, Palla, T C, and Desnuelle, P, *Biochemical and Biophysical Research Communications*, 1965, 18, 71.

⁵ Adler, G, and Kern, H F, *Hormone and Metabolic Research*, 1975, 7, 290.

Repeatability and reliability

SIR,—Discussing observer variations in their useful series of articles about epidemiology Drs Geoffrey Rose and D J P Barker note (7 October, p 1006) that repeatability is less satisfactorily known as reliability.

If reliability is defined as the degree of agreement between different observations it is possible to distinguish test-retest reliability, or repeatability, when the observations are made on different occasions by the same or different observers, and single test inter-rater reliability, when the observations are made on the same occasion by different observers; these two measures have produced different results regarding the presence of a psychiatric symptom.¹

Reliability is thus a more generic concept than repeatability.

M L ROBINSON

University Department of
Psychiatry,
Royal Liverpool Hospital,
Liverpool

¹ Wing, J K, *et al*, *British Journal of Psychiatry*, 1967, 113, 499.

Autoimmunity in juvenile diabetics and their families

SIR,—Dr Eva Kohner (19 August, p 568) has criticised our paper (15 July, p 165), in which we tentatively suggested that autoimmune diabetes has a stronger tendency to run in families and might be more liable to complications than in non-autoimmune families. She states that diabetic microangiopathy is a manifestation of the duration of the disease and also points out that the seven patients in our study developing proliferative retinopathy were all diabetics of long standing.

HLA typing of the patients with retinopathy has, however, provided a little further evidence that some diabetics may be more liable to complications than others. The 10 patients in our study with diabetic retinopathy (who were all members of autoimmune families) had a significantly higher frequency ($P < 0.05$) of HLA-B8 than diabetics without complications (see table). There is also a tendency, not

Distribution of HLA antigens in diabetics with and without retinopathy

Antigen	Retinopathy (n = 10)	No complications (n = 70)
A1	6 (60%)	26 (37%)
B7	2 (20%)	14 (20%)
B8	8 (80%)	29 (41%)
B15	2 (20%)	30 (43%)
BW35	1 (10%)	8 (11%)
A1 B8	5 (50%)	21 (30%)
B8	2 (20%)	8 (11%)
without A1		

statistically significant, towards a higher frequency of B15 among diabetics without complications. This is, of course, a very small series, but the frequency of B8 among our patients with retinopathy is virtually identical to that reported recently by Dr R G Larkins and his colleagues (29 April, p 1111) among 16 patients with proliferative retinopathy in Australia.

We agree entirely with Dr Kohner about the importance of both duration and degree of control in determining the development of complications but suggest that there is at least some evidence that a subgroup of diabetics (those with serological evidence of autoimmunity and HLA-B8) may be more liable. This suggestion certainly warrants further investigation, since if this is shown to be correct diabetologists might pay special attention to such patients.

J I MANN
B WINEARLS
M THOROGOOD
G F BOTTAZZO
J D BAUM

University of Oxford and
Middlesex Hospital,
London W1

Tetracycline preparations for children

SIR,—It should by now be common knowledge among practitioners that tetracyclines stain and deform the developing teeth. The antibiotics section of the current edition of *MIMS* is headed by the statement, "Tetracyclines should not be used in the latter half of pregnancy or in children up to 12 years of age." However, the following tetracycline preparations are listed in the same publication with recommended dosages for children: Achromycin V syrup (Lederle); Deteclo syrup (Lederle); Ledermycin drops; Ledermycin syrup; Megaclor syrup (Pharmax); Mysteclin syrup (Squibb); Terramycin syrup (Pfizer); Vibramycin syrup (Pfizer). There are a number of other tetracycline preparations, manufactured by Berk, Glaxo, and ICI, in syrup form and therefore liable to be prescribed to children.

It is therefore small wonder that we continue to encounter cases of tetracyclines being prescribed to pregnant mothers or children.

R J ROWLATT

North Lonsdale Hospital,
Barrow-in-Furness, Cumbria

Paget's disease of bone among British migrants to Australia

SIR,—Earlier this year (24 June, p 1655) we reported on the radiological prevalence of Paget's disease in British migrants to Australia, showing it to be higher than in a comparable Australian resident population and lower than in a British resident population. We have since completed a case-control study on age at migration and place of origin in Britain among the British migrants, exploring further the possible reasons for these differences in prevalence rates. The particular aims were to ascertain whether migrants with Paget's disease had emigrated at a later age and came more often from areas of higher prevalence within Britain in comparison with migrants without Paget's disease.

Forty-eight cases of Paget's disease were identified among the British migrants in the