Britain this solution is called Synthamin. Recently minor elevations of serum bilirubin concentration and major elevations of serum alkaline phosphatase and aspartate aminotransferase activities have been observed in six patients receiving this solution following surgery of the head and neck. These patients did not have evidence of metastatic disease and no abnormalities have been observed in patients undergoing similar operations who did not receive nutritional support.

However, the same type of biochemical abnormalities have been seen in a patient receiving the intravenous amino-acid solution Vamin. Furthermore, 15 patients who received a nasogastric diet based on the beef protein derivatives Albumaid or Serameen and the glucose polymer Caloreen showed the same biochemical response. This latter observation would suggest that cholestasis occurring in patients receiving intravenous nutrients is unlikely to be due to a lack of stimulation of bile flow by food in the gut. Are these changes due to the absence of some dietary component or presence of some chemical agent that is common to artificial diets whether given intravenously or by the nasogastric route? These results will be reported in detail elsewhere.^{2,3}

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¹ Allardyce, D B, in *Advances in Parenteral Nutrition*, ed I D A Johnston. Lancaster, MTP, 1978.

² Skidmore, F D, et al, *Annals of the Royal College of Surgeons of England*. In press.

³ Tweedle, D E F, et al, *Research and Clinical Forums*. In press.

Primary autoimmune diabetes mellitus

SIR,—We were interested in the further evidence provided by Dr G F Bottazzo and his colleagues (4 November, p 1253) in support of a primary autoimmune type of diabetes mellitus (type 1a). Our own experience, including 61 (6 male, 55 female) insulin-dependent diabetics (IDDs) with coincident Graves's disease and 107 (16 male, 91 female) IDDs with primary thyroid failure confirms the characteristics of such a group of IDDs to include female preponderance, lack of seasonal variation in incidence, late age of onset, and a strong family history of organ specific autoimmune diseases including insulin-dependent diabetes.

Dr Bottazzo and his colleagues estimate that type 1a diabetics account for less than 10% of insulin-dependent patients but provide no evidence in support of this figure. We have considered the prevalence of the more common organ-specific autoimmune diseases in 445 IDDs attending the diabetic outpatient department of this hospital consecutively during the months April and May 1978. We found 23 (5.2%) to have had Graves's disease, 11 (2.4%) to have overt primary hypothyroidism, 14 (3.2%) to have pernicious anaemia, and one to have Addison's disease. Allowing for one patient who had both pernicious anaemia and Graves's disease, 48 patients (10.8%) had one or more organ-specific autoimmune disease, of whom 37 (77%) were female and 31 (65%) were first recognised to be diabetic over the age of 30 years.

These figures do not take account of the

prevalence of unrecognised thyroid failure in the diabetic population. Of 184 IDDs in whom a diagnosis of thyroid failure had not previously been suspected, 24 (13%) had a raised serum thyrotrophin concentration, of whom 8 (4.3%) had a low serum thyroxine concentration.

Thus we are confident that Dr Bottazzo and his colleagues have underestimated the proportion of IDDs who should be included in the category of type 1a diabetics.

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Tetracycline preparations for children

SIR,—Dr R J Rowlatt's remarks (18 November, p 1436) on this subject prompt me to report the following information on the extent of prescription of these preparations.

I examined all prescriptions issued during February 1976 by a randomly selected sample of 12 general practitioners in the Grampian Area. A total of 328 prescriptions for tetracyclines had been issued, but only seven of these were for liquid tetracycline preparations. Four of the 12 doctors were responsible for these prescriptions and each had issued from one to three prescriptions for liquid tetracycline during the month in question, the mean quantity per prescription being 150 ml.

Not all of these prescriptions for liquid tetracycline would necessarily have been issued to children. The information therefore suggests that, in this area at least, the prescription of tetracyclines to children had been reduced to insignificant levels by 1976.

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Practical problems with insulin infusion pumps

SIR,—In their article on the use of intravenous insulin infusions in diabetic emergencies (11 November, p 1343) Drs R D G Leslie and J D Mackay mention that on two occasions the insulin infusion pump was accidentally switched off. We have encountered similar practical problems with the use of infusion pumps in the management of diabetic ketoacidosis. On two occasions the connection at the proximal end of the drip tubing has been slightly dislodged from the indwelling intravenous cannula by restless, uncooperative patients and the pump has subsequently infused the bedclothes rather than the patient. On two further occasions a three-way tap situated between the pump and the patient has been inadvertently closed, resulting in failure of insulin delivery. We have even seen failure to switch on the mains supply. Fortunately these slips have had no serious consequences, but they nevertheless illustrate the potential for human error in the use of these pumps, which we feel detracts seriously from their value in acute situations. Mishaps are more likely to occur and to remain undetected in restless, semicomatose patients, who may tug endlessly at the drip tubing.

The practical difficulties of supervising the insulin infusion in addition to the various other lines, catheters, and monitor leads while also

perhaps restraining the patient are obvious, and it is hardly surprising that mishaps occur, even with the best nursing care and adequate staffing. Since the benefits of low-dose intravenous over low-dose intramuscular insulin therapy are marginal it would seem sensible to use the latter, safer, route in diabetic ketoacidosis. These remarks do not apply to the use of insulin infusion pumps in less critical situations, such as in the postoperative management of diabetic patients, where they are much safer and undoubtedly effective.

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Data sheets and lactation

SIR,—As authors of the articles^{1,2} on drugs and breast-feeding described by Dr C D E Morris (18 November, p 1435) as "incomplete, inaccurate, and misleading" may we comment on his letter? Dr Morris complains that UK drug data sheets contain no reference to safety of the drug for use in lactating women. However, quantitative information on drug transfer in milk is available for very few drugs. Similarly the maximum "safe" dose of almost any drug taken by a suckling neonate in breast milk is unknown. For the majority of drugs, then, their safety in this context is still a matter of judgment, the exception being those drugs which we listed as contraindicated, such as carbimazole and amantadine, where definite adverse effects have been reported. More research on drug transfer is desirable.

In this situation it is not possible for precise advice to be included in the majority of drug data sheets. In our articles we attempted to help doctors by pointing out that centrally acting drugs (anticonvulsants, sedatives, etc) have low plasma levels in relation to effective oral doses so that the concentration of drug in breast milk will generally be low also. The majority of these drugs will therefore be safe for lactating women to take, but no drug manufacturer could state this categorically in a document for which he has legal responsibility. If a statement in the data sheet is made compulsory, then most companies will play safe and recommend that the drug be withdrawn during breast-feeding.

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

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

Breakfast and Crohn's disease

SIR,—I venture to claim that the data of Dr J F Mayberry and others (18 November, p 1401) support my own¹ provided that equivalent figures are compared. In my study I took account of pre-illness habit. Their tabulated data record current habit, but they go on to tell us that 33 of the patients and 13 of the controls had stopped eating cornflakes, having previously taken them regularly. It follows that if pre-illness habit had been