and V and no significant decrease by men in socioeconomic group V or women in socioeconomic group III.

Our data do not exclude the future impact of health publicity or, indeed, of a reduction or cessation in advertising on smoking by lower socioeconomic groups, and we think it important that there should be research into and evaluation of health promotion and advertising aimed at these groups.

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Nestlé abides fully to WHO code on baby milk

EDITOR,—Andrew Radford justifies his attack on the British Paediatric Association by giving a reference to a booklet produced by the International Baby Food Action Network, *Breaking the Rules 1994*.^{1,2} He adopts his usual stance of assuming that if his organisation makes an allegation then the rest of the world must believe it to be true, even though many of the accusations are imprecise and unverifiable, have been hoarded for many months, or concern products not covered by the World Health Organisation's marketing code.

Nestlé's investigations indicate that among 455 allegations counted in *Breaking the Rules 1994* and three supporting letters from Baby Milk Action only three charges required corrective action.³ In one case this had been effected before the publication of the booklet. Not only do our investigations show the unreliability of the "monitoring" by International Baby Food Action Network but a number of independent third parties have confirmed the inaccuracy of the accusations. For example, in one case the network's monitor, an adviser on breast feeding, herself declared the accusation regarding her clinic to be "false and unfounded"; in another case the head of a maternal and child health clinic declared the allegations to be "in complete contradiction to what is happening here in the field." Investigations into the unpublished reports from Unicef similarly indicate the inaccuracy of the accusations.

The only conclusion that can be drawn from *Breaking the Rules 1994* is that the British Paediatric Association is fully justified in adopting the position it has done, and not that Nestlé is breaching the code. Nestlé has no wish to intervene in any decision that the British Paediatric Association takes with regard to commercial sponsorship. The association can, however, remain assured that Nestlé abides fully by the WHO's code and all other national agreements.

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Nocardia pericarditis

EDITOR,—S J Tabrizi lists the clinical contexts with which nocardial infection has been associated.¹ Malnutrition due to anorexia nervosa should be added to this list. We recently saw a 29 year old Greek man with a long history of anorexia nervosa who had been referred to Britain. He was receiving inpatient psychiatric and dietary treatment in a specialist eating disorders clinic when he complained of a dry cough of 12 days' duration, which became productive with bloodstained sputum. A Heaf test had yielded a positive result when he was a schoolboy. Three years previously he had weighed 92 kg, but after finishing his military service he had started to diet and had rapidly lost weight. There was no history of diarrhoea or self induced vomiting. He was tall (180 cm) and emaciated, weighing only 37 kg. His body mass index was extremely low at 11.4 (normal range 20-24).

Physical examination showed dullness to percussion over the right apical region of the chest anteriorly and oedema of the ankles. Chest radiographs, which had been normal 32 days before, showed a cavitating lesion in the right apex, and the erythrocyte sedimentation rate had risen to 156 mm in the first hour. *Nocardia asteroides* was isolated from a fibreoptic bronchoscopic lavage specimen and subsequently from three separate sputum specimens. No mycobacteria were seen or isolated by culture.

He was initially treated for tuberculosis as the most likely diagnosis and subsequently with sulphadiazine 1 g four times daily for three months. The results of liver function tests, full blood count, and erythrocyte sedimentation rate returned to normal, and the chest radiological appearances resolved. He also slowly gained weight and achieved the mean weight in a matched population.

This is the first report of anorexia nervosa associated with nocardial infection. Malnutrition is recognised as predisposing to infections with various pathogens,² including mycobacteria,³ probably owing to its effects on the function of polymorphonuclear cells,⁴ antioxidant systems,⁵ and humoral immunity. Since anorexia nervosa is fairly common it is interesting that infections such as this are not seen more often.

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Risk factors for breast cancer

EDITOR,—Peter J Lewis comments on the fact that our article on risk factors for breast cancer did not include the role of xeno-oestrogens and progesterone deficiency.¹ The aim of the ABC series is to review the current state of knowledge succinctly. The article did not mention the two factors because

the evidence linking them with breast cancer is conflicting. While some studies have linked pesticides with breast cancer, others have not.² Definitive evidence that pesticides either induce or promote breast cancer has yet to be presented.

The role of progesterone in the breast is unclear. There is a body of opinion that progesterone deficiency, leading to unopposed oestrogen action, is associated with an increased risk of breast cancer.³ Others, however, have failed to show that women either at high risk of, or with, breast cancer have abnormal progesterone concentrations.⁴ Furthermore, there is an opposing view that high progesterone concentrations may be a determinant of risk and that the hazard of a prolonged reproductive life is mediated through cumulative exposure to an excessive number of ovulatory menstrual cycles.⁵ Progesterone also seem to be mitogenic in the normal breast, with increased proliferation being found in the luteal phase compared with the follicular phase of the menstrual cycle.⁶ Proliferation is also increased in women using combined oestrogen-progesterone contraceptive pills.⁶ Against this background, the case for giving progestogens to women at high risk of breast cancer is at best unconvincing and at worst potentially hazardous.

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Trials in palliative care

EDITOR,—In their discussion of the problems and pitfalls of evaluating a palliative care service McWhinney and colleagues mentioned three published trials in palliative care services.¹ Apparently only trials with additional care services were selected, and trials on palliative treatment were excluded. In the field of additional care services we found one other trial.² Many trials in palliative cancer care report problems with patient selection, accrual, attrition, contamination of exposure, and selection of adequate outcome measures. We also conducted a randomised trial on palliative care services, for patients with disseminated colorectal cancer. Our trial compared fluorouracil as single agent by continuous infusion at home versus combination therapy with leucovorin at an outpatient clinic. Main outcome measures were quality of life, use of care services, and satisfaction with care. Quality of life was assessed with a global assessment with a linear analogue scale, the medical outcomes study's 24 item short form, the affect balance scale, the