encourage change. Although it is difficult to be certain how long it will take for risk to return completely, if at all, to baseline after stopping, the benefit of a substantial fall in risk after a mere five to nine years could provide a useful incentive for behavioural change. We have not directly studied the effect of reducing intake rather than total cessation, but results on the relation between amount and risk indicate that there is probably a decrease in risk on cutting down drinking as well.

In comparison with epidemiological studies, animal investigations have been less conclusive on the carcinogenicity of alcoholic beverages, and alcohol per se does not seem to be carcinogenic.² Furthermore, how alcoholic drinks cause cancer in the upper aerodigestive tract is still uncertain, although hypotheses have been put forward. The possibilities include action as solvents for other carcinogens, irritation of mucosa increasing cell turnover, nutritional deficiencies, depression of immune state, presence of other carcinogens in beverages, and carcinogenicity of metabolites of ethanol.^{2,12} The hitherto absence of information on the effect of drinking cessation has hindered the understanding of this issue. Our present finding of a rapid fall in risk on cessation among moderate drinkers indicates that the predominant action is likely to be on the late stage of carcinogenesis.^{13,14} In heavy drinkers the large fall in risk after less than 10 years of cessation also indicates a strong effect of alcohol on the late stage of carcinogenesis, although one cannot be certain how long it will take for risk to return completely to that in those who never drink. These findings should be helpful in determining the relative importance of the

possible carcinogenetic mechanisms and in the design and interpretation of further laboratory and epidemiological studies to elucidate the issue.

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Repeated oral vitamin K prophylaxis in West Germany: acceptance and efficacy

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Owing to concern that neonatal vitamin K prophylaxis might cause childhood cancer,¹ parenteral vitamin K prophylaxis for all newborn infants has been abandoned in the United Kingdom² and Germany.³ In its place three oral doses of vitamin K (0.5 mg in the United Kingdom, 1 mg in Germany) are now recommended for healthy neonates (at birth and during days 4-10 and weeks 4-6). We investigated whether these recommendations are being followed and whether three oral doses of vitamin K are as effective as parenteral vitamin K for preventing late haemorrhagic disease of the newborn.

Methods and results

We drew a random sample of 100 obstetric units from all 995 such units in West Germany. In August 1993 we sent questionnaires to the consultants in charge of these 100 units asking about their use of vitamin K prophylaxis.

Surveillance for late haemorrhagic disease was carried out by sending monthly postcards to heads of all paediatric hospitals in Germany.⁴ The average response rate during the observation period (West Germany) was 81%. Data from the postcards were validated by questionnaires. All cases of unexpected bleeding from severe, proved vitamin K deficiency in weeks 2-26 observed in West Germany from April 1993 to March 1994 were included in the case definition.

Ninety eight of the 100 questionnaires were returned (one unit was closed, one consultant refused to collaborate). Of these 98 units, 92 gave oral vitamin K (1 mg) twice to all healthy newborn infants in the first week of life as recommended. In 18 units intramuscular vitamin K was given for "at risk" conditions—for example, to infants delivered surgically. In 84 responding units the parents were alerted to the need for a third oral dose of vitamin K (three or more times in 45 units, twice in 27, and once in 12).

Twenty infants met the case definition for late haemorrhagic disease of the newborn (table), of whom 10 had intracranial haemorrhage. Fifteen infants had been breast fed exclusively. In five cases no additional diagnosis was known before and none was detected after the bleeding. Six infants had known conditions for which additional vitamin K prophylaxis was not generally recommended. In one of these additional mild cholestasis was found at bleeding, and one died before tests for cholestasis could be performed. In nine cases cholestasis (which remained "idiopathic" in four) was diagnosed after the bleeding.

Of the 20 infants who met the case definition, two had not received any vitamin K prophylaxis. Thirteen infants had received vitamin K according to the recommendations, but in five cases the required third dose had been overlooked. The time between the last dose of vitamin K and the occurrence of bleeding ranged between eight and 98 (median 28) days. The information about vitamin K prophylaxis was obtained from the well baby check up book (15 cases) or hospital delivery records (first two doses) plus parents' recall of the third dose given by the paediatrician at the well baby check up at weeks 4-6 (four cases).

Conclusions

Acceptance of the new recommendations for vitamin K prophylaxis was high in German obstetric units,

Case No	Bleeding		Feeding	Additional morbidity		Dose and timing of oral vitamin K†	Prophylaxis according to recommendations?
	Age	Location		Cholestasis (cause) diagnosed after bleeding	Known before bleeding		
1	30 days	Intracranial	Breast only	No		None (?)	No
7	50 days	Nose	Breast only	No		1 mg day 1, 1 mg day 3	Third dose omitted
8	50 days	Intracranial	Breast only	No		1 mg day 1, 1 mg day 3, 1 mg U3	Yes
14	61 days	Gum	Breast only	No		1 mg day 1, 1 mg U2, 1 mg U3	Yes
17	37 days	Intracranial	Breast only	No		None	No
4	53 days	Gastrointestinal tract	Formula	No	Galactosaemia	1 mg day 1, 1 mg day 5, 1 mg U3	Yes
9	69 days	Intracranial	Formula	No	Hypertrophic pyloric stenosis (on conservative treatment)	1 mg day 1, 1 mg day 5, 1 mg U3	Yes
20*	17 weeks	Skin	Breast only	No	Poor weight gain due to difficult breast feeding	1 mg day 1, 1 mg day 4, 1 mg U3	Yes
21*	14 weeks	Skin, gastrointestinal tract	Formula+breast	No	Poor weight gain due to malabsorption associated with intestinal obstruction	1 mg day 1, 1 mg day 4, 1 mg U3	Yes
5	28 days	Intracranial	Breast only	Yes (α_1 antitrypsin deficiency)		1 mg day 1, 1 mg day 6	Yes
6	43 days	Gum	Breast only	Yes (cystic fibrosis)		1 mg day 1, 1 mg day 5	Third dose omitted
2	62 days	Intracranial	Breast only	Yes (bile duct atresia)		1 mg day 1, 1 mg day 5, 1 mg U3	Yes
10	37 days	Intracranial	Breast only	Yes (cause unknown)		1 mg day 1, 1 mg day 5	Yes
12	51 days	Venepuncture site	Breast only	Yes (cause unknown)		1 mg day 1, 1 mg day 5, 1 mg U3	Yes
18	33 days	Intracranial	Breast only	Yes (α_1 antitrypsin deficiency)		1 mg day 1, 1 mg U2	Yes
19	53 days	Skin	Formula+breast	Yes (cause unknown)		1 mg day 1, 1 mg day 4	Third dose omitted
15	73 days	Intracranial	Breast only	Yes (intrahepatic bile duct hypoplasia)		1 mg day 1, 1 mg day 5	Third dose omitted
22*	20 weeks	Skin	Breast only	Yes (cystic fibrosis)		1 mg day 1, 1 mg day 5, 1 mg U3	Yes
3	30 days	Nose	Breast only	Yes (cause unknown)	Pulmonary atresia	1 mg day 1, 1 mg U2	Yes
11	51 days	Intracranial	Breast only	Not tested (death shortly after admission)	Haemangioma	1 mg day 1, 1 mg U2	Third dose omitted

*Cases occurring between weeks 13 and 26 (not included in International Society of Thrombosis and Haemostasis case definition).⁵

†U2=Well baby check up days 3-10. U3=Well baby check up weeks 4-6.

possibly because of the availability of an oral preparation. In addition, 84 of the 98 units that responded alerted parents to the need for the third oral dose. These efforts were effective: in 10 of 14 cases that occurred after week 6 the infants had received their third dose of vitamin K.

Even with a dose twice as high as that recommended in the United Kingdom, however,^{2,3} the efficacy of repeated oral vitamin K prophylaxis was unsatisfactory. Eighteen of 20 infants who met the case definition had received at least two oral doses of vitamin K and 13 of the 20 had received the recommended prophylaxis.

During the observation period a maximum of 550 000 babies were given the recommended oral prophylaxis. Had they been given 1 mg vitamin K at birth the expected number of bleedings between weeks 2 and 12 would have been seven.⁵ The number observed was 10.

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ONE HUNDRED YEARS AGO

M. ROCHEFORT AS MEDICAL STUDENT.

Dr Cabanès has found out that M. Henri Rochefort was once a medical student. As a schoolboy, at the Lycée St. Louis, Rochefort composed a five-act play entitled *Andreas Vesalius, Creator of Anatomy*. His love for medicine was very great, but he was too nervous. He collapsed at the mere description of an operation for the repair of a perforating ulcer of the palate, and could not be revived until ether had been freely administered to him. He wrote to Dr. Cabanès a letter in March, 1892, stating that when a student his nerves soon told him that he must not think of adopting medicine as a profession. M. Rochefort as a student took some interest in the case of a companion who

died from the effects of syphilis inoculated experimentally. He made certain communications in consequence to Ricord and others. M. Rochefort's exit from the profession seems to have been involuntary after all. He lost his patrimony and tried to get pupils. Two presented themselves, but they only brought him in about thirty-two shillings monthly. In consequence he was only too glad to get, after some solicitation, an under clerkship in the French Patent Office at 1,200 francs per annum, or about £4 a month. This is how M. Rochefort was lost to medicine. Unfortunately, other promising men who have, unlike the well-known politician, succeeded in conquering their own nerves, have failed as he did in overcoming the other obstruction. (*BMJ* 1895;ii:440.)