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The Adolescent Breast

SIR,—Your leading article "The Adolescent Breast" (7 August, p. 324), emphasizes several important points in relation to this seldom-considered subject. You rightly mention that in the early stages, development of the breasts is often unequal, this inequality disappearing as development proceeds; rarely significant inequality persists and becomes a source of considerable distress. The first manifestation of inequality may be breast swelling on one side only, and you stress that if this is regarded as an abnormality and exploration and biopsy are performed, the result will be removal of most or all of the breast tissue on that side. I have encountered a sad case of this kind.

Most breast anomalies seen while development is actually in progress correct themselves, as you say, before the girl becomes adult, but they do not all do so. Moreover, persistence of an obvious physical breast lesion may be extremely embarrassing to an adolescent, and I have known several girls greatly disturbed emotionally by hypoplasia, inequality, or gross hypertrophy. Your otherwise excellent article seems to lay insufficient stress on these psychological problems and appears to me to overstate the case by suggesting that surgical treatment for developmental breast anomalies should "seldom, if ever" be undertaken before the age of 20. I accept your view that intervention should wait until adult form has been reached, but this may be the case several

years before the age of 20. Observation for continuing breast growth will be wise for a time, but if, after a year or so, there is no change of any kind in a patient with inequality or hypoplasia, surely consideration should be given to surgical treatment, if oestrogen treatment seems unlikely to improve the situation. Only if there is clear evidence of ovarian hormonal deficiency will this be the case. In a patient with gross adolescent breast hypertrophy emotional disturbance may be profound, and to withhold help for several years would seem to me more serious than a plastic procedure to reduce breast size at an earlier age.

An important point in management may be to make it clear to the patient at an early stage that surgical treatment is possible, even if this may have to be delayed for a while for optimal surgical results to be obtained. In this way, psychological disturbances during the waiting period may be reduced, and the girl can judge more easily whether her anomaly is truly causing her sufficient distress to justify treatment of this kind. If the possibility of surgical correction is not mentioned, however, the apparent hopelessness of the situation may greatly aggravate the emotional disturbance.—I am, etc.,

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suffering from night blindness, which passed into xerophthalmia due to vitamin A deficiency. I saw several cases of hypoprotinaemic oedema, marasmus, and only one typical case of African type kwashiorkor with oedema, flexural eczema, black varnish peeling, lacklustre hair, and general peevishness. All these cases, however, were due to malabsorption secondary to diarrhoea-dysentery. I did not observe a single case of protein-calorie malnutrition due primarily to an inadequate diet.

The incidence of the dysenteries at one point of time was very high: 4% of the population of a camp of 5,000. This figure was based on dispensary attendance; the true incidence was probably higher. The cause was obvious—the open trench latrines, which could not be improved upon as a breeding place for flies.

It seems highly unlikely that this opinion would be widely accepted in the present emotional propaganda-orientated talk of famine. An appeal for the digging of bore hole latrines would bring in less than an appeal for baby foods. No doubt these are necessary, but if my clinical observations are correct, are of only secondary importance to proper sewage disposal.

The time seems opportune for the W.H.O. to send out a nutritionist to evaluate the true situation.—I am, etc.,

J. BARNES

Dublin

Nutrition in Refugee Camps

SIR,—The *Guardian* of 14 August states that famine "worse than Biafra" was rampant among Pakistan children in the refugee camps in India.

During the months of July and August I examined 3,800 refugee patients in the Garo Hills area and saw only one single case of primary malnutrition in a teenage girl

Infertility in 1909
SIR,—In your report of the proceedings of the Annual Representative Meeting held at Leicester (*Supplement*, 7 August, p. 86) it is stated that Mr. D. B. Brown, to support one of his arguments, quoted figures on the