Diarrhoea at the Olympics

SIR,—As one of the medical officers to the British athletes in Mexico City, I read with interest your leading article on "Diarrhoea at the Olympics" (12 October, p. 69). At the Rome, Tokio, and here at the Mexico Olympics we have given the British athletes prophylactically one tablet of Streptotriad twice daily, starting two days before arrival. The number of cases of diarrhoea has been negligible. This is very gratifying, particularly in Mexico City, where "travellers' diarrhoea" is so prevalent.—I am, etc.,

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Amateur Boxing Association,
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SIR,—It was gratifying to read your reminder (12 October, p. 69) that there is no evidence to support antibacterial action of iodochlorhydroxyquinoline (Entero-Vioform). This compound is taken widely to combat "travellers' diarrhoea" in its various geographic guises, although, except in regions where amoebiasis is prevalent, no significant benefit can be expected.

A point which is seldom appreciated is that the organic iodine of this compound is only slowly excreted, and will vitiate both radioactive iodine studies of thyroid function and the chemical estimation of protein-bound iodine for many months after ingestion.[1] In spite of direct questioning many appear unable to recall having taken Entero-Vioform, and the high serum iodine level may become evident only after both tests have been performed and incompatible readings obtained. While other tests of thyroid function which are not affected by exogenous iodine are available it is often advisable to have confirmatory tests if abnormal readings are obtained, and the time may not be far off when those who require such studies will have to wait at least six months before the tests can give a reliable result.

Anti-diarrhoea remedies are, of course, readily available without prescription, but may we ask through your columns that when medical advice is sought as to the most suitable compound those containing iodine should not be prescribed unless there are definite indications for their use?—We are, etc.,

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REFERENCE

1 Kirkpatrick, H. F. W., *Lond. Clin. med. J.*, 1962, **3**, 11.

When is a Placebo?

SIR,—A placebo in one clinical situation may not be a placebo in another. In your leading article (12 October, p. 69) "Diarrhoea at the Olympics," the writer quotes a clinical trial on the treatment of travellers' diarrhoea in which the placebo (lactose) was associated with a higher incidence of diarrhoea than either of the treatment groups.

Lactose may be a valid placebo in a trial of analgesics but not in a situation involving alimentary symptomatology. Acute alimentary infections are associated with disturbance in small bowel structure and function. Lactase, the enzyme necessary for the digestion of lactose, is the disaccharidase most susceptible to impairment in activity. Impaired digestion of lactose is itself a cause of diarrhoea. Therefore, in the paper quoted, the administration of lactose, far from being placebo therapy, could actually have augmented the symptomatology of the control group, leading to erroneous therapeutic conclusions.

May I suggest that you invite someone to write a paper or give a lecture on the title "The Science and Psychology of Placebos." One man's placebo may occasionally be another man's poison.—I am, etc.,

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Prognosis in Tetraplegia

SIR,—I hope many of your readers beside myself will see the manifold merits of the paper by Dr. J. R. Silver and Mr. N. O. K. Gibbon (12 October, p. 79). They rightly stress the need for immediate admission of traumatic tetraplegics to a spinal centre; the need for equipment for intensive care in such a centre; systematic all round rehabilitation from day one to discharge; the startling range of possibilities for independence and work opened up by R. Maling's invention of Possum, a control-system making use of the minimal residual power of the most severely disabled; and the shameful lack of permanent accommodation for those of the—often young—tetraplegics who can work and enjoy life in a properly equipped and conducted hostel, as at Stoke Mandeville, but quickly deteriorate and die when discharged to an unsuitable home or institution. Administrators, please note. Pressure of space, no doubt, prevented the authors from differentiating among the incompletely paralysed between those who on discharge had subtotal, medium, or only slight neurological deficits.

The one really important point not made in their paper concerns the impact of bowel-function on prognosis. Even if reliably trained and dealt with while in a centre, bowel function is often neglected at home and in institutions. Too few people, relatives, general practitioners, and consultants not in this field, realize that the overloaded "neurogenic" bowel, not unlike the bladder, is responsible for much respiratory distress through pressure on the diaphragm, for urinary complications from retention via reflux and hydronephrosis to stone-formation, or even for volvulus of the sigmoid. That constipation is second only to contractures in reflexly aggravating spasticity is the simple truth, too simple for the sophisticated, but true all the same, as those who have looked after a few thousand "neurogenic" bowels know only too well.

A neurologically trained physician and a neuro-urologically experienced surgeon have given us an example of teamwork at its best.—I am, etc.,

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Suppressing Rh-immunization

SIR,—Your otherwise excellent leading article (19 October, p. 135) is misleading in one respect—namely, that routine use of anti-D immunoglobulin in the "United Kingdom" is determined by the finding of foetal red cells in maternal blood. In Scotland Rh-negative primiparae who give birth to an Rh-positive, ABO compatible infant are given anti-D immunoglobulin irrespective of the number of foetal red cells in maternal blood. The 200-μg. dose is injected even when no foetal cells are detectable. In practice most laboratories engaged in this work in Scotland do not perform acid-elution tests for foetal cells. Only the essential blood grouping tests are done.—I am, etc.,

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Inhibition of Lactation with Quinestrol

SIR,—Quinestrol, the cyclopentyl enol ether of ethinyloestradiol, has been shown to effectively inhibit lactation.[1-3] Its particular advantage over other oestrogen-like preparations is that "one tablet" therapy orally is all that is necessary. Each mother in a random series was prescribed one 4.0-mg. tablet of quinestrol (Estrovis) within 24 hours of her delivery. Twenty-three of the 26 (88%) so treated required no further treatment. None of the patients suffered any more than mild breast engorgement, which always occurred on the fifth or sixth day of the puerperium. It is possible that two further patients, each of whom left hospital 24 hours after delivery, might have achieved equally successful lactation suppression on the one tablet, but unfortunately their family doctors gave them stilboestrol at the first sign of breast discomfort, which appeared on the fifth day in each case. Only with one patient was quinestrol treatment considered to be completely unsuccessful.

Eighteen of these patients were multipara, and it is interesting that 11 of them had previously breast-fed their babies. Yet every one of these 11 had lactation successfully inhibited with the one tablet of quinestrol. Of the other seven, two had previously had lactation suppressed, and one, who had been delivered of a stillborn baby, had been treated similarly. In the notes of the remaining four no history as to the method of feeding was given.

Experience of this trial has convinced the medical and nursing staff of the efficacy of this treatment. They have found it quite unnecessary to be alarmed if a patient's breasts become slightly uncomfortable on the fifth or sixth day post partum. Certainly in the majority of cases the discomfort has subsided rapidly, without the need to give either a further quinestrol tablet or any other oestrogen therapy. Only very exceptionally will a patient's breast become excessively uncomfortable and leak milk from the nipple, and for such a patient it is suggested that a further 4.0-mg. quinestrol tablet should be taken at about the fifth or sixth day—and it might even be necessary to give yet a third 4.0-mg. tablet another 48 hours later. The very success of this preliminary quinestrol trial has determined the staff's decision to