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six months. (3) Introduce other foods together with continuing, so-called "prolonged" breast-feeding (after 6 months) from four to six months, together with the normal locally appropriate technological contraceptives which has no adverse effect on lactation (for example, especially excluding oestrogen preparations).

Breast milk production from six months to two years has been shown to supply a small but very important nutritional supplement. Conversely, breast-feeding alone and unsupplemented into the second year of life has long been recognised as a problem in parts of India12 and Bangladesh, leading to "late marriage". From a more flexible perspective, the appropriate age at which technological contraceptives are needed to reinforce the waning effects of breast-feeding varies with the community and the many details of local infant feeding practices, essentially with their influence on sucking stimulation and prolactin secretion. There is in fact a gradient from the Kung to the partially breast-fed to the entirely bottle-fed.

In breast-feeding communities the usual length of lactation amenorrhoea in the particulary young women two months seems a reasonable rule-of-thumb for introducing technological contraceptives, allowing for the well recognised anovulation that can occur before menstruation. Indeed, it is our view that the bacteriologically and endocrinologically dangerous interval for introducing foods other than human milk, and hence the need for technological contraceptives, may often be later than currently believed. This ultimately hinges on a balance of risks and benefits.

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On reading the research by Professor Jelliffe and colleagues, the value of sulpiride to improve lactation performance by increasing prolactin secretion (24 July, p 249) is a valuable contribution to knowledge of substances which can enhance lactation (galactogogues). Throughout the ages methods to improve lactation have been used. Sulpiride (Sulpro, Leche League) (30 mg, twice a day) significantly increased milk production (although the benefits to the community in financial terms are evident.) The political aspect should not be ignored, however. Taking politics in its widest sense as relating to power and control, successful breast-feeding managed and supported by women places power in the hands of women. Dependence on drugs for the maintenance of lactation places power (and money) in the hands of corporations. It is worth thinking about.

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Sulpiride improves inadequate lactation

Sin.—On reading the research by Professor O Ylikorkila and others (24 July, p 249) I was surprised to find that tests with drugs are being considered useful in improving breast-milk production. A usual method used by these mothers—that is increasing the number and frequency of nurseries—was not mentioned.

The significant factor in the study—the number of nursings a day—was not mentioned in the table. None of the babies in the test group was nursed more than seven times a day, and some as few as four times a day. The average was 5.3 ± 0.3. There are some babies who can maintain their mother's milk production even when they are not given enough milk in nurseries, on nursing as infrequent as this, but they are rare and should not be considered the norm.

In countries where breast-feeding is unrestricted babies may nurse every hour day and night with little disturbance to the mother. In the less supportive culture of the West embarrassment, ignorance, and the habit of bottle-feeding combine to separate mother and baby and restrict the number of feeds given in the 24-hour period. Still many mothers find it quite possible and very restful and relaxing to nurse their babies upwards of eight times a day.

Mothers often find it helpful to discuss with a group of other mothers the practical problems involved in arranging sleeping quarters so that mother and baby can sleep close together, choosing clothes for discreet nursing away from home, and so on. The emotional support of a friendly peer group can also provide the key to successful lactation in a non-supportive culture. The self-help movement for breast-feeding has been urged by Leche League (Box BM 3424, London WC1V 6XX), is particularly useful in this context.

This raises the question of why the medical community should be investigating the effects of drugs on lactation rather than the simpler but cleaner management techniques used by women. Doubtless the answer is partly technical, since measurement of breast-milk quantities in the intimacy of successful lactation is impossible. Parity no doubt it is financial since no-one stands to make a profit out of successful breast-feeding (although the benefits to the community in financial terms are evident.) The political aspect should not be ignored, however. Taking politics in its widest sense as relating to power and control, successful breast-feeding managed and supported by women places power in the hands of women. Dependence on drugs for the maintenance of lactation places power (and money) in the hands of corporations. It is worth thinking about.

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1 Platt BS, Gin SK. Arch Dis Child 1983;58:432-5.
3 Davies DP. Lancet 1979;i:541-2.

Postmenopausal osteoporosis

Sin.—Your leading article on postmenopausal osteoporosis (28 August, p 585) highlights the pain and suffering that new mothers in women that are the result of this process and emphasises the great cost of treatment. That prevention is possible by the administration of oestrogens is now accepted, but whether it will be easy to persuade postmenopausal women to take oestrogens and progestogens with the nuisance of monthly withdrawal bleeding remains to be seen. Perhaps those who have undergone hysterectomy would be more willing to take oestrogens, probably with progestogens, for fear that the fear of breast cancer can be dispelled.

The main difficulty will be to reverse the adverse publicity regarding the risks of thromboembolism, believed to be associated with the ordinary combined oral contraceptive. It is very galling for the practising gynaecologist to have one of his most effective drugs rejected by his patient because of the fear of thrombosis and myocardial infarction; this is especially so when the older woman takes an oestrogen/progestogen preparation not greatly different in dosage for menopausal symptoms.

The dose of oestrogen that may help women depends, I believe, on their biological age. The younger woman requires a reasonable amount to suppress ovulation; her elderly sister needs a little less; while the middle-aged woman might continue to take a perimeno-
pausal pill to control dysfunctional bleeding and hot flushes. If this was an accepted prophylactic many women would avoid hysterectomy for dysfunctional bleeding. Then after the age of 52 the postmenopausal pill containing even less oestrogen would, could and would have to be taken for many years to reduce the chances of myocardial infarction and osteoporosis. All this is I suppose contingent on women giving up smoking.

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Sin,—I would like to comment on two aspects of the leading article by Dr J C Stevenson and Dr M I Whitehead (28 August, p 585). They strongly advocate the use of long-term oestrogen preventive treatment and accuse doctors of managing the condition “too conservatively.” It is important to try to balance the risks against the benefits of treatment.

Benefits although real may not be so great as is claimed. We have at present only three patients out of a practice population of 8300 suffering from disabling clinical osteoporosis: two secondary to rheumatoid arthritis and one to prolonged treatment with corticosteroids. Links between are much commoner, and perhaps half of these could be prevented by oestrogens.

Against these benefits must be set the possible complications of treatment. I do not agree that “The risks of oestrogen treatment have been overstated.” A multicentre long-term surveillance of mortality and cancer incidence is in progress under Professor Vessey of the department of community medicine and general practice, Oxford. Most family doctors would prefer to await the conclusions of this research before exposing their patients to unknown risks.

Calcium supplements offer an alternative form of treatment which is probably safer and certainly cheaper. Two studies have shown that calcium is at least partly effective in the treatment of osteoporosis. One of the references quoted by Dr Stevenson and Dr Whitehead in fact showed that calcium was intermediate in effect between oestrogen and placebo. A further study supports this view.

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Sin.—Two of the recently suggested aetiological factors and possible agents for treatment of osteoporosis not mentioned in the article by Dr J C Stevenson and Dr M I Whitehead (28 August, p 585) are copper and vitamin K.

The link between copper and osteoporosis has been suggested by animal and human data. Copper deficiency in animals has been shown to lead to increased absorption of bone and histological changes similar to those found in patients with osteoporosis.1 Similarly, bone changes have been noted in infants with copper deficiency, and these revert to normal on copper replacement.2 Although no study so far has looked at copper in patients with postmenopausal osteoporosis, it has been suggested that such a link should be investigated.3

The importance of vitamin K in osteoporosis is suggested by the fact that vitamin K is an essential cofactor for the microsomal enzyme carboxylase, which converts glutamic acid to γ-carboxyglutamic acid,4 which is present in the matrix of the bone.5 The γ-carboxyglutamic-acid-containing protein in the bone, osteocalcin,6 has calcium-binding sites.7 In vitamin K deficiency it has been shown that glutamic acid is not carboxylated and the non-carboxylated sites exhibit a weak reaction with calcium ions.8 The facts which support its use in osteoporosis are: (1) vitamin K reduces calcium excretion in patients with osteoporosis; (2) increase in osteocalcin results in increase in bone density9; (3) osteoporosis of old age or that associated with steroid treatment exhibits increased urinary γ-carboxyglutamic acid, which reflects increased breakdown of osteocalcin, the vitamin K-dependent protein.10

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Biofeedback, salt restriction, or a combination thereof is most effective depends in part on the individual as well as the practitioner. Factors such as patient expectation, level of compliance, motivation, etc, comprise important variables which are considered all too frequently when treatment is planned. In short, the individual to whom the treatment is administered. This would include the integration of various treatment packages with individual patient characteristics. Of course, such a procedure requires more time, but improved effectiveness would, no doubt, be the net result. Whether this question of cost effectiveness is worth while is undoubtedly left up to the individual physician. After all, treatment of choice must be integrated with his or her personality as well.

Evidence supporting the individualization of treatment in areas outside hypertension, along with the authors’ firm conviction that treatment is enhanced through the consideration of personality variables1-3 (both of the patient and the physician), provided the impetus for this letter.

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Do alcoholics recover?

Sin,—As Dr W H (7 August, p 443) points out, surely the question is not “Do alcoholics recover?” (3 July, p 3) but “How do (a considerable proportion of) alcoholics recover?” Clearly alcoholics “Do not . . . inevitably slide downhill . . . with few if any recovering”; but even nowadays (though less so in the past) this utterly false stereotype still contributes to the lack of interest of doctors in the fate and management of alcoholics. Not surprisingly therefore many doctors may indeed “seldom recovering,” but those doctors, much as the members of the British Doctors’ Group, referred to by Dr E D McConnell (7 August, p 443) who assist problem drinkers and, of course, also the members of Alcoholics Anonymous all meet a great many recovered alcoholics. I have been privileged to observe the steady progress of quite a number of alcoholics treated in the Waringham Park Unit in the 1950s1-3 who have maintained their sobriety and with it a healthy, contented lifestyle (to the great benefit also of their families) for nearly three decades. Incidentally, the treatment results of these patients—one-third recovered, one-third improved, one-third unchanged—are very much in line with those various studies referred to in your leading article.

It is undoubtedly some alcoholics recover without treatment or, as reported by Orford and Edwards,4 with the help of detailed, judicious, and informed advice—although these authors’ finding that (mainly outpatient) treatment gave no better result than expert “advice” was obtained in a special group of alcoholics—that is, still living with their wives. Whether such results also apply to prognostically less.