populations who are heterogeneous with regard to risk susceptibility. The patient with above average susceptibility may develop risk factors, though his or her behaviour may not be aberrant in statistical terms.

The first approach confirms the importance of individual prevention and care, whereas the second shows that prevention is necessary also at the level of populations.

We thank Ms G Cohier, M Lagrost, C Chabert, H Eydoux, C Marcoul, and S Perles for collecting the survey data and Dr B Krajevitch for examining the children.


(In Accepted 9 December 1987)

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Intrauterine growth and neonatal weight gain in babies of women with anorexia nervosa

Babies of women with a low weight before pregnancy are smaller than average and have an increased perinatal mortality.1 This report describes the outcome of seven pregnancies in women with anorexia nervosa who conceived despite remaining low in weight.

Patients and results

Six of the 327 patients who started to attend the eating disorder clinic at Maudsley Hospital over the past three years conceived while their body mass index was low (median 16.8 kg/m²; range 14.9-18.1 kg/m²). Only one of the seven pregnancies in these six women was induced (with clomiphene).

All six women had had anorexia nervosa for a long time (median 15 years, range 11-17) and were relatively old at the time of pregnancy (median 31 years, range 28-36). None smoked. Four women were primiparous, two had had earlier pregnancies terminated, and one had had a 3200 g baby before developing anorexia nervosa. Their average weight gain during pregnancy was 8 kg (range 5-14); this compared with the minimum recommended weight gain of 11 kg.

Fetal growth was determined by serial ultrasonography in five patients. The rate of growth of the abdominal circumference of the five fetuses was diminished during the last trimester, and the abdominal circumference of all seven babies was below the third centile at birth. Nevertheless, accelerated growth was seen in all these babies during the first few months after birth (figure). Five of the six women had difficulty breast feeding and introduced bottle feeding in the first few weeks.

Comment

Several points of interest arise from these findings. Firstly, women with chronic anorexia nervosa may menstruate and even conceive despite maintaining their weight at suboptimal levels. This confirms previous reports.1 Secondly, the poor fetal growth during the third trimester probably reflected a degree of intrauterine malnutrition, but “catch up” growth was evident in the neonatal period. This is contrary to findings in other babies, who failed to thrive in their first year and showed poor catch up growth.3

Long term follow up will be required to ascertain whether these small for gestational age babies are at risk of impaired growth and neurodevelopmental

Intrauterine and postnatal growth of babies of anorectic mothers. Intrauterine growth is represented by median abdominal circumference (and range) in five fetuses as measured by ultrasonography. Postnatal growth is represented by weights from birth to six months (median and ranges refer to seven babies, except at four weeks (one baby) and after 20 weeks (three babies)). Heavy lines and shaded areas indicate mean (2 SD) values in normal populations.

sequelae.4 Mothers with anorexia nervosa may underfeed their children, although this is probably not the case. The children of four patients attending our clinic had been investigated for poor growth, which was attributed to poor feeding.5


(In Accepted 23 December 1987)

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An unusual complication of removal of a nasogastric tube

We describe a previously unreported complication of removal of a nasogastric feeding tube.

Case report

A 21 year old man with cerebral palsy was admitted with an empyema, which was treated by decortication. Postoperatively he required enteral feeding. A narrow bore (9 French gauge) Silastic tube with a bolus weighted with tungsten (Vionmedex) was passed through the right nostril into the stomach, and its position was confirmed radiographically. Nasogastric feeding was stopped after 15 days, and attempts were made to remove the tube. It became stuck with a few centimetres still in the nose. Gentle manipulation failed to move the tube in either direction, and on gentle traction the tube became detached from the tungsten bolus, which remained in the nostril. The bolus had become impacted behind a septal spur and become buried beneath the mucosa. It was removed under general anaesthesia. The patient recovered without further incident and was discharged soon afterwards.

Comment

Soft, small bore tubes have replaced large bore ones for enteral feeding because they are more comfortable and cause less irritation of the nasopharynx and oesophagus, reducing the risk of stenosis. Two types of narrow bore tube are commonly used: those with a weighted bolus at the distal end and those without, which are passed over a guidewire. Complications associated with passing these tubes include oesophageal perforation.