Inhibition of Lactation by Oestrogens

Sir,—There is clear evidence today that more than 70% of parturients do not propose to breast-feed their infants, and will require inhibition of lactation. In 1963, in a double-blind trial that stilboestrol showed a significant superiority to a placebo in inhibiting lactation. No patient was restricted in her fluid intake, nor were the breasts bound. All had had normal pregnancies and spontaneous deliveries.

In stilboestrol given in an eight-day course, with dosage reduction every second day, a total of 195 mg being administered. Lactation was inhibited successfully (when assessed on day seven) in 89% of stilboestrol-treated cases, compared with 32% of placebo-treated cases. However, when followed-up for 42 days, permanent inhibition of lactation only occurred in 55% of the stilboestrol-treated group, and 30% required a further course of stilboestrol because of the recurrence of painful lactating breasts. Hodge has shown the superiority of stilboestrol over a placebo, using a dose of 105 mg. stilboestrol over three days, and assessing the patient on the fourth day, and found substantially similar results (stilboestrol cases, 88% successful; placebo-treated cases 32% successful). Stirrat et al., using 105 mg. of stilboestrol on the first three days, compared the “immediate” success rate of stilboestrol when compared with a placebo, but noted that over a 21-day period of follow-up (as judged by “painful lactation”), occurred in 38% of the stilboestrol-treated patients, and suggested “it may be that a higher level of oestrogen circulating for a longer period would be more effective.”

These three studies confirm that inhibition of lactation is best effected by oestrogens, but suggest that shorter courses, in lower dosage, as suggested by Professor T. N. A. Jeffcoat and others (5 October, p. 19), may be inefficient. The relationship between oestrogen used in the puerperium to inhibit lactation and puperial thromboembolic disease is substantiated the use of other hormone combinations (such as a mixture of oestral valerate and testosterone enanthate) may be advisable in “high-risk” women. Meanwhile it must be stressed that the incidence of thromboembolism is very low, and in the abnormal woman inhibition is best treated of, I am, etc.,

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Rickettsial Endocarditis

Sir,—Your report of four cases of rickettsial endocarditis (5 October, p. 40) prompts us to report two further cases from the north of Scotland.

A man, aged 45 years, had consulted his practitioner for an acute attack of pain in his left leg and calf which was worse on exercise. He had a lump in his groin and it was thought that he had inguinal adenitis. This condition was very slow to resolve. Fourteen weeks later, prior to admission, he had a similar pain in his left leg and a recrudescence of pain in his right limb. Coincidentally he noticed haematuria for the first time. There was no other relevant medical history.

On admission he looked ill, his right leg was cold and he had an unequal swelling. There was a tender swelling in his right femoral triangle. He had hard discrete enlarged glands in his left axilla and his spleen was enlarged to three fingers below the right costal margin. There was no jaundice. His appetite was poor and he had lost about one stone (6.5 kg) in weight. Leukaemia was suspected, and blood examinations, x-rays, arteriograms, and lymph gland biopsies were undertaken at this stage. Confirmation of the block to his right femoral artery was obtained, but since the diagnosis was still in doubt he was seen by one of us (J.K.). The low-grade fever which had developed, finger clubbing, together with the detectable cardiac murmurs suggestive of aortic and mitral valve disease, suggested subacute bacterial endocarditis. Four negative blood cultures were negative. The complement fixation test for Q fever carrier was found at this time to show a titre of greater than 1:1,000 (Phase I). Subsequent testing for Phase I antibodies showed these present to a titre of 1:4,096. In the light of this he was treated intensively with tetracycline; his temperature gradually returned to normal and his general condition markedly improved.

Both patients are awaiting transfer to cardiac units. It is hoped to publish fuller details, together with the results of the epidemiological investigations undertaken, at a later date.—We are, etc.,

H. Williams,
J. Knox,
W. Lancaster.

Sin.—I was delighted to read the report of the clinicopathological conference on "Four Cases of Rickettsial Endocarditis" (5 October, p. 40) and to see you still honoured Ricketts. But I was sorely disappointed when you and those who assisted in preparing the report later allowed the organism to be called Coxiella burnetii.

Howard Taylor Ricketts (1870–1910), of Findlay, Ohio, discovered in 1907 that the Rocky Mountain spotted fever is transmitted by the wood-tick (Dermacentor occidentalis), and in 1910 (with F. P. Wilde) that Mexican typhus (tabardillo) is transmitted by the body-louse (Pediculus vestimenti). This had already been demonstrated for European typhus by Charles Nicolle.

Ricketts died in 1910 from tabardillo, louse-borne typhus. It is idle to speculate what further advances he would have made. Derrick isolated the organism in 1937 and called it Rickettsia burnetii because Burnet and Freeman had classified it as a rickettsia. This is not to decry Cox’s valuable work in isolating Rickettisias in stock holders and slaughterhouse workers, his cultivation of the organism, and the preparation and standardization of rickettsial vaccines. H. R. Cox in papers published in 1938, 1941, and 1948 consistently uses the word "Rickettsia." Let us do likewise and give eponymous immortality to a medical martyr.—I am, etc.,

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Sniffing of a Shoe-cleaner

Sir,—A group of teenagers in two schools in this area have been sniffing from handkerchiefs a proprietary brand of liquid cleaner for leather shoes which is retailed in two-ounce (50-ml) bottles by a well-known chain store, and which is therefore presumably widely available. The preparation consists of a mixture of trichlorethylene, perchloroethylene, and methane chloride, with smaller quantities of dipropylene glycol and methyl alcohol, and is described on inhalation a feeling of pleasant elation for about 10 minutes, followed by severe headache.

This self-induced narcosis seems likely to be the explanation for cases of hitherto unexplained headache which have been occurring in the affected schools.—I am, etc.,

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Chronic Lead Intoxication Mimicking Motor Neurone Disease

Sir,—In many cases the diagnosis of lead poisoning is obvious, in others the possibility may never suggest itself. 115 These words remain as true today, as has been shown in your columns recently (1 January, p. 117, and 29 September 1968). The inevitably progressive course and poor prognosis of idiopathic motor neurone disease is