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. 

Stilboestrol was given in an eight-day course, with dosage reduction every second day, a total of 195 mg. being administered. Lactation was inhibited successfully (as 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 53% 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 over six days, compared the "immediate" success rate of stilboestrol when compared with a placebo, but noted that over a 21-day period of follow-up failure (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. Jeffercoate and others (5 October, p. 19), may be ineffective. It is reasonable to assess the relationship between oestrogen used in the peripuerium to inhibit lactation and puerperal 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 abnormally woman inhibition of lactation still-becomes the treatment of choice. —I am, etc.,

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REFERENCES


Ricketsia 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, just 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 had a left ankle swollen. 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 the limit of the left 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, a swelling of the trunk, together with the detectable cardiac murmurs suggestive of aortic and mitral valve disease, suggested subacute bacterial endocarditis. Four negative blood cultures were followed by the demonstration of Rickettsia burnetii complement fixation titres 1:1,024 (Phase I) and greater than 1:10,000 (Phase II).

Intensive treatment with tetracycline produced an excellent response, and the patient's condition very markedly improved.

The second case was a man who first came under our medical supervision in 1959 at the age of 28 years, after a negative chest x-ray examination. He was referred to a cardiology clinic, where he was found to have aortic stenosis and incompetence, now in a moderate degree, together with the detectable cardiac murmurs of aortic and mitral valve disease, suggested subacute bacterial endocarditis. Four negative blood cultures were followed by the demonstration of Rickettsia burnetii complement fixation titres 1:1,024 (Phase I) and greater than 1:10,000 (Phase II).

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 trichloroethylene, perchloroethylene, and methylene chloride, with smaller quantities of dipropylene glycol and methyl alcohol and is tributary to inhalation a feeling of pleasant elation for about 10 minutes, followed by severe head-ache.

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. These words remain as true today, as when they have been in your column recently (13 January, p. 117, and 20 January, p. 222) and to any degree of the inevitably progressive course and poor prognosis of idiopathic motor neuron disease is