Correspondence

Contentment in the breast-fed baby

Sir,
We were somewhat disturbed by Evans and Davies's Short Report (*Archives*, 1977, 52, 974). With the lack of proper nutrition and lactation education in medical and nursing schools (in the USA), the power of the infant formula industry, and tendency of the poor to emulate richer people's past misconceptions (Evans *et al.*, 1976; Jivani, 1978) it is a shame that these doctors promulgated this misinformation. Although well intentioned, their report is not going to help make breast feeding a successful venture in clinical settings where providers are first beginning to deal sensitively with this important form of nurturing.

It was interesting how all 4 cases displayed a tendency to accept long periods between feedings. Ribble (1965) described a definite variance in sucking needs—some babies suck all the time and never seem to be satisfied while others often seem disinterested in sucking. We have also observed this phenomenon with bottle-fed babies! The La Leche League International (1977) described breast-fed babies who are 'good' babies and need to be fed more often because demand feedings are not enough. We have observed babies whose sucking need seemed normal but after nursing briefly, preferred self-gratification with the thumb.

We agree that infants should be monitored for weight gain at regular 'well-baby' visits, but has anyone taken a feeding history or observed the actual feeding of the mother-infant dyad? By observing the feeding we discovered that quite a number of these 'poor gainers' have sucking defects. We noted problems like tongue sucking, flutter sucking (rapid and weak motions), and a lack of drawing the nipple far enough into the mouth (the baby falls off the breast easily).

Our first approach, therefore, is to step up the number and length of feedings. This is often all that is needed, together with some instilling of confidence, combined with reassurance for the mother. When this fails, we attempt to correct the poor sucking. We teach the mother how to monitor and stimulate the sucking in order to get the baby acclimated to a constant pattern of good sucking (Frantz *et al.*, 1978). If this fails we use a device called a 'lactaid supplementer' (Avery, 1973) which gives additional milk and corrects the sucking pattern without the use of a bottle.

Human milk is so important to infants (especially between 2 and 3 months of age, the age at which three babies had their supply curtailed), that there is virtually no reason to exclude the rapidly growing infant from breast milk (except, of course, in cases of cancer of the breast, acute infectious tuberculosis, drug abuse, or serious psychiatric illness). The mothers of these babies

feel like failures if the infant is switched to the bottle, when perhaps the problem was exclusively the baby's. What significance would this change of nurturing have on mothering and nursing future infants? Many of the mothers of these troubled dyads whom we have assisted to continue breast feeding successfully have had subsequent children who did well at the breast without any problems.

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Drs Evans and Davies comment:

We do not understand why Ms Frantz and Dr Magnus think we have promulgated misinformation about breast feeding since they agree, (1) that there are some breast-fed babies who need to be fed more often and that others are disinterested in sucking, (2) that infants should be monitored for weight gain at clinics (although we also emphasised the additional requirement of a clinical estimate of fat folds with the infant naked), and (3) that in the management of underfeeding at the breast, increasing the number of feedings is important.

In preparing our paper we were aware that problems did exist in breast feeding and now, nearly 2 years later, we are if anything even more convinced. In fact it is our experience that failure to thrive because of breast feeding difficulties is an important and a not uncommon reason for admission to hospital. We believe this to imply that difficulties are being encountered not only by mothers but also by doctors, nurses, and other health workers who are giving advice about infant feeding. The DHSS report on

infant feeding practices (Department of Health and Social Security, 1974) strongly recommended a return to breast feeding and there is now little doubt that far more mothers wish and are attempting to breast feed. It is none the less a fact of modern life that many of our doctors and nurses were brought up and trained in a tradition of bottle feeding and are therefore unaware of important principles and practices of breast feeding.

Is it therefore wrong of us to draw attention to the problem of failure to thrive in breast-fed babies? We think not. In trying to understand more about the physiology, both basic and applied, of breast feeding, problems would be better understood and far from being to the detriment of breast feeding this better understanding will perhaps help to promote the practice.

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Diaphragmatic hernia and pleural effusions

Sir,

Dr Chilton *et al.* (*Archives*, 1978, 53, 600) reported two infants with a right-sided diaphragmatic hernia which presented as a pleural effusion. A similar case was reported in an 11-month-old Collie dog (Claveau *et al.*, 1973). The fluid in the thorax appears to have been related to the strangulation of part of the liver which had to be resected. Bacteriological studies were negative except for the isolation of *Pasteurella multocida* from the trachea and pharynx.

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Insertion of sewing needle as a form of child abuse

Sir,

Insertion of a sewing needle into the body has been hitherto unreported in the UK as a form of child abuse, although two such cases have been reported—from

America (Stone *et al.*, 1976) and France (Arcadio *et al.*, 1969). A 23-month-old girl was referred by Social Services because she was found to have many bruises on her body when attending a day nursery on a Monday morning. These bruises had not been present on the previous Friday. The family was known to the Social Services department as being on the 'at risk' register. According to the parents, these bruises were sustained when she fell from a push-buggy during the weekend. On examination, apart from being dirty, she was otherwise well nourished and healthy. There were multiple bruises of different sizes and ages all over her face and body. It was obvious that not all of them could have been caused by a fall from the push-buggy.

Figure Site of sewing needle.

A skeletal survey showed no soft tissue injuries or fractures, but a sewing needle was found to be deeply embedded in the right gluteal region (Figure). Re-examination of the gluteal region in the light of the x-ray finding showed no pin prick marks or inflammation, nor was the needle palpable. It was felt unlikely that a needle could have worked its way through into her buttock accidentally without anyone being aware of its presence. The needle in this case would have been missed altogether but for the skeletal survey. While insertion of pins and needles into a child's body would appear to be an easy form of injury to inflict, it has rarely been reported.

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