Correspondence

Prolonged exclusive breast feeding and heredity as determinants in infantile atopy

Sir,

The observation in the Finnish study that prolonged breast feeding is associated with a higher incidence of infantile atopy, heredity being its only reliable predictor, is not surprising and warrants some additional considerations. Dr David's commentary omits some of the basic biological aspects.

In many studies atopy is assessed by the onset during infancy of certain clinical signs possibly caused by atopy. Whether breast feeding can or cannot delay the onset of these signs is not the same question as whether or not atopic disease itself can be prevented. In a number of inherited metabolic disorders—phenylketonuria, for example—a suitable diet can prevent symptoms from developing, but cannot eliminate the underlying congenital disorder.

Furthermore, we are a long way from knowing whether and to what extent atopic signs and symptoms during infancy are antigen or host dependent. From findings in animals and in cultured fetal intestinal tissues, various factors available in breast milk have been shown to stimulate the gut surface, possibly exaggerating the infant's immune responses, as recently reported by Raloff. In addition to heredity factors, breast feeding could even enhance the host's capability of eliciting a reaginic response with consequent earlier clinical presentation of atopy, an argument invoked to discourage the combination of breast and formula feeding.

Some foods ingested by the mother pass into the milk and can sensitise the infant. Also, various milk proteins from the mother may have immunogenic power due to the frequent occurrence of polymorphic variants genetically arranged in different structural forms. They include the not strictly alimental milk proteins like immunoglobulins, blood group, and HLA specific glycoproteins and transferrin, and also specific milk proteins, like casein. The traditional statement that mother's milk proteins are homologous for her infant is contradicted by the presence of allologous proteins which have potential immunogenic capacity when they come into contact with the immune system of an infant differing from the mother for that allotype.

It is not surprising that prolonged breast feeding may be associated with a higher incidence of infantile atopy when compared with limited breast feeding because of the more prolonged exposure to maternal allotypes and possibly because of its adjuvant effect in the sensitisation process. The same explanation might apply to the observation that by withholding certain sensitising foods from the lactating mother's diet the incidence of atopic symptoms is lowered, but not avoided.

These observations indicate the biological uniqueness of breast feeding that appears to be an exclusive way for the developing infant's immune system to be instructed and adapted to react through exposure to dietary antigens which, unlike all others, will never be encountered again in the course of life.

References

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Congenital dislocation of the hip: to screen or not to screen

Sir,

The personal experience of Mr Dwyer1 confirms my view that most abnormal hips may be safely and effectively diagnosed and treated at birth.2 The excellence of his results reflects credit on him and on his team including the physiotherapists who I understand do the primary screening in his hospital.

In only one aspect does Mr Dwyer's practice differ appreciably from that recommended recently by the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee.3 The success of clinical screening in the neonatal period in his hospital seems to have suggested to him that follow up screening is not required beyond the age of three months. While this may be the case if screening is undertaken by 'a dedicated, experienced and skilful team', the availability of such support is difficult to achieve and maintain. For this reason the SMAC/SNMAC guidelines stated that 'it is essential to reassess the possibility of this condition until a child is seen to be walking normally'. Their report recommended that the hips of all children should be routinely surveyed not only at birth and on discharge from neonatal care, but also at 6 weeks, at 6–9 months, and between 15 and 21 months of age. This advice is surely sensible. Late cases of established congenital dislocation of the hip still occur even in the best centres and—as is well recognised—the later the diagnosis the more difficult the treatment and the more likely is the occurrence of avascular necrosis of the head of the femur.
Liaison psychotherapy in a hospital paediatric diabetic clinic

Sir,

Drs Josse and Challoner’s paper highlights the importance of liaison psychotherapy in the management of diabetes, an illness with recognised psychological components.

Our experience over the past seven years has suggested that a psychotherapist’s skills are useful in a wide range of paediatric work. A member of the ‘team’ who is not involved in day to day management can define the psychological impact of illness, dying, and handicap on the child and his family and on those who care for him, and can help them.

In our hospitals, in addition to working with individual children and their families, the liaison psychotherapist holds two weekly staff groups for nurses. One group is in a specialised setting—a special care baby unit—and the other is in a general paediatric ward. The work of each group is aimed at augmenting the care of patients by helping the staff to find constructive means of working with the various amounts of stress present and to facilitate a greater understanding of the psychological aspects of child and family functioning by means of implementing this in treatment. A psychotherapeutic approach to liaison work needs not only a knowledge of family systems theory but also an understanding of the various dynamic forces at work in the psyche, for example, unconscious conflicts and anxieties and the association between these and child development and family functioning. His training in therapeutic techniques, both individual and family, can help provide paediatric staff with additional ways of working with patients and their families.

An integral part of any team is the medical social worker who provides among other things a link with the community, necessary statutory work, and the tackling of multifarious social problems. Many social workers are skilled in the techniques of supportive counselling and family treatment and provide a valuable service. Their work is complementary to the psychotherapist’s whose lengthy specialised training enables him to work quickly at a depth which can bring about effective change.

Constructive paediatric psychotherapeutic liaison can only take place, however, if the psychotherapist is able to take a common sense approach to working with medical staff. It is necessary to find ways in which their skills can be practically used in paediatric work. This precludes the superimposition of metapsychological theories and their accompanying jargon, which are wholly impractical and understandably alienating in this field.

We feel that liaison paediatric psychotherapeutic work has much to offer the National Health Service and more effective training, including fieldwork, is required.

Mercury as a health hazard

Sir,

Curtis et al reminded us that pink disease still occurs and mercury remains an occasional environmental hazard, but were all their cases of pink disease due to mercury poisoning? Certainly this toxic metal causes the severe disease, but the similarity between mild disease and the appearance of some severely disadvantaged children with ‘deprivation hands and feet’ has been noted. After reviewing reports of the disease it seems to me that the diagnosis of pink disease was often made on clinical grounds alone without laboratory confirmation. The condition was most frequent among the poorer sections of the community and many children responded to close follow up and support at out patient clinics, displaying weight curves that latterly would fit catch up growth where social circumstances have improved. Perhaps mild pink disease was simply a marker for social deprivation and unrelated to mercury poisoning?

Would senior paediatricians who manage the disease like to comment on this hypothesis?

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References