Duodenal Ulcer and Priority Foods

SIR,—I was interested in Dr. A. H. Morley's letter on duodenal ulcer and priority foods (Nov. 8, p. 745) and would say a word on the other side of the picture. It is agreed, of course, that many duodenal ulcers are cured, temporarily or otherwise, or lie dormant for long periods, but surely it is also agreed that the only rational way to treat an ulcer subject is to keep him well, and that a bland diet, especially with regard to the protein intake, is a very important factor, if not an essential one, to that end. He is advised—and rightly, I believe—to avoid tough meat, stews, cheese, sausage, salty and spiced foods, yet the bulk of his rationed food will come fairly under these categories. He does better on white fish, but that is sometimes short, often of poor quality, and can be extremely monotonous. I am informed that an extended course of this can destroy the appetite and undermine the character, that an addict is liable periodically to break out into homicide, divorce, or a debauch of liver and onion, curried beef, kippers, or other flavoursome but deadly comestibles.

No doubt there are some who may not require these priority foods, but I am of opinion that any general curtailment of these would result in an increase, and probably a large one, in the incidence of ulcer breakdown. It is well to remember that such a breakdown may be regarded in these days as a small national disaster. Ambulatory treatment is seldom satisfactory, and the subject, to have any real prospect of cure, must lie up for weeks or months in the care of others at home or in our hard-pressed hospitals.

I feel exception should be taken to Dr. Morley's statement that duodenal ulcer "has, indeed, become a somewhat popular malady—and no wonder!" If this means anything, it implies an unfortunate innuendo. Surely the patient does not elect to have an ulcer—the diagnosis is with the physician. Any claim by an unknown patient can be readily checked as a rule. I have not found that ulcer patients consider themselves fortunate. Dr. Morley's estimation that this priority milk would float a battleship may be accurate, but surely this alternative use need not be considered at the present time. Our old friend Chad has just peeped over my pile of milk certificates with a startled comment on our naval establishment.—I am, etc.,

Sutton, Surrey. J. CRAWFORD.

SIR,—It must surely cause some astonishment that there are medical men who hold the view expressed by Dr. R. Stuart (Nov. 22, p. 842) that "the symptoms of chronic duodenal ulcer are chronic, recurring at regular intervals every day and every night throughout many years." Can he have in mind some atypical condition such as an ulcer extending to and constricting the pylorus? It is, after all, the alternating bouts and the much longer intervals of freedom from symptoms which constitute so invaluable a diagnostic feature of the disease. In this connexion I would quote Sir Robert Hutchison, when he says in his *Lectures on Dyspepsia* (1927, London): "The History is in many cases perfectly clear and sufficient alone to base a diagnosis upon. It is as follows: The patient will tell you that, often for years back, he has been subject to attacks of indigestion *which have been intermittent*, that is they have cleared up and he has been well between them." And again, to quote Sir James Walton in his *Surgical Dyspepsias* (1930, London): "When once the disease is well established one of its most characteristic features is the periodicity of the symptoms. This is more marked than is the case with gastric ulcers, and indeed *than in any other disease*. There will be attacks of acute symptoms persisting for some three or four weeks, which are followed by periods of complete freedom. These periods will nearly always last for some months and may persist for nearly a year."

In regard to the other point in Dr. Stuart's letter, although it may be conceded at once that regulation of the patient's habits—frequent small regular meals, avoidance of irritants and tobacco, worry and fatigue, and so forth—is of great importance in prolonging the periods of freedom from symptoms, a rigid regime of diet is considered by many authorities to be unnecessary. Dr. A. H. Douthwaite (July 12, p. 43) expressed this view.

This brings me to my original contention, to which I adhere, that to lavish 10 pints (5.7 l.) of milk a week (five times the allowance for the ordinary consumer at present) and priority in eggs on the chronic duodenal ulcers is indeed squandermania—an expressive word, for which I thank Dr. Stuart. It fits admirably.—I am, etc.,

London, N.W.7. A. H. MORLEY.

Vitamin-D Requirements in Pregnancy

SIR,—Dr. L. J. Harris is to be congratulated on his admirable survey (Nov. 1, p. 681) of the present state of our knowledge as to vitamins. I venture, however, to question the accuracy of one of his statements: "For nursing and expectant mothers 1,000–2,000 i.u. [vitamin D] daily may be prescribed. . . ." I made a search of the literature on this subject about a year ago; I found only vague and contradictory statements. The following two quotations from recent authoritative textbooks are typical: McCune[1] states that during pregnancy "an amount of vitamin D equal to that contained in 5 teaspoonfuls of cod-liver oil—that is, 1,700 i.u.—may be required in addition to a high calcium intake to prevent a negative balance and guarantee calcium retention." Shohl[2] writes: "400 units of vitamin D and 1 quart of milk daily should be included in the diet of pregnant women." No experimental evidence is brought forward in support of either of these statements.

I have recently completed a four-year survey of normal pregnancy in the out-patient department of the City of London Maternity Hospital. Some of the biochemical findings have been published.[3] They cover 226 48-hour calcium and phosphorus balances at various stages of pregnancy. They would seem to show that doses of vitamin D smaller than 10,000 i.u. per day have no influence whatever on calcium and phosphorus metabolism and that doses considerably larger than this (up to 36,000 units per day) exert a definite influence only if the calcium intake is above 1.5 g. per day in the early months and later 2 g.

This subject is a difficult and complex one. My findings, to be conclusive, must be confirmed on a larger number of cases. But this is not a matter of purely academic interest. It concerns us all—vitally. Until further experimental evidence, adequate and incontrovertible, is made available, I submit that we should play for safety. In a climate like that of England every pregnant woman should be given a supplement of vitamin D in doses of not less than 10,000 i.u. per day in the first 7 months, and 20,000 i.u. during the 8th and 9th months.—I am, etc.,

Como, Italy. E. OBERMER.

REFERENCES

1 McCune, D. J., in *Dietotherapy* (Editor, Wohl, G. W.), Philadelphia, 1945, p. 317.
2 Shohl, A. T., *Mineral Metabolism*, New York 1939, p. 344.
3 Obermer, E., *J. Obstet. Gynaec. Brit. Emp.*, 1946, **53**, 269, 362; ibid., 1947, **54**, 432; ibid., 1947, **54**, in press.

H.T.S.T. Pasteurization

SIR,—As far as we are aware no report has been made of the efficiency of the H.T.S.T. method of pasteurizing milk on a commercial scale. The results of tests carried out by Dr. Porteous of St. Mary's Hospital on samples taken from three of our plants using this process therefore may be of interest outside our own organization.

One hundred and twenty-nine samples of the raw milk used gave a positive guinea-pig test for tubercle bacilli. The 129 samples of commercially pasteurized milk corresponding to the above raw were all negative in the test. All these pasteurized milk samples also passed the official phosphatase test.

The samples covered a period of two years from January, 1945, to January, 1947.—I am, etc.,

E. B. ANDERSON,
Chief Chemist,
United Dairies, Ltd.

*** This matter is discussed in a leading article at p. 914.—ED., *B.M.J.*

Thiouracil

SIR,—It is with great interest that I have read the review by Dr. H. Cookson and Dr. F. H. Staines (Nov. 15, p. 759) on their experience with thiouracil. With increasing experience in thiouracil therapy it is evident that the risk of immediate toxic effects is diminishing. I note, however, that the length of treatment is given as "a year or two and may be even more." That this chronic therapy with a drug which poisons the thyroid is not altogether without risk of far more serious consequences is shown by the work of Purves and Griesbach,[1] who produced