

We wrote to the cookery editor of each publication asking whether it had a policy on publishing recipes that required raw or lightly cooked eggs; three responded. One admitted that the publication did not publish warnings but intended to introduce them in future for high risk groups. The second claimed that a caption was printed next to high risk recipes. The third said that the publication printed a warning to vulnerable groups alongside recipes containing raw egg; we could find no such warning.

Clearly, many editors still do not appreciate the risk of salmonella infection from eating raw eggs. There seems to be some misapprehension that only high risk groups such as very young or elderly people may be at risk. Many of the people affected in outbreaks in which raw egg has been implicated have been young, previously fit adults.

Cookery writers are well placed to educate the public and to develop alternatives for recipes that require inadequately cooked eggs. Some alternatives, such as dried or pasteurised eggs, are not always easily available in retail outlets. If these products were widely promoted in recipes the increased demand would widen their availability and encourage safe cooking practices.

LORRAINE LIGHTON  
LINDSAY GREENWOOD

Tameside and Glossop Health Authority,  
Hyde,  
Cheshire SK14 1DB

- 1 Department of Health. *Salmonella and raw eggs*. London: DoH, 1988. (PL/CO(88)9.)
- 2 Advisory Committee on the Microbiological Safety of Food. *Report on salmonella in eggs*. London: HMSO, 1993.
- 3 Public Health Laboratory Service Communicable Disease Surveillance Centre. *Foodborne disease surveillance in England and Wales: 1989-1991. Communicable Disease Report Review 1993;12:R159-73.*

## Health promotion advice in the private sector

EDITOR,—An 86 year old female patient of mine was given a cardiovascular risk assessment as a Christmas present by her family. This was done at a local private hospital and cost £50. The report does not mention her existing angina or osteoporosis as two major health problems. For her £50 she had her total cholesterol concentration measured (7.3 mmol/l, her body mass index calculated (26), and her blood pressure tested (160/90 mm Hg). She was told that she should lose 6.4 kg in weight and given detailed dietary advice on reducing her fat intake. Following this advice would not have lengthened her life but would certainly have made it more miserable. She was greatly relieved when I told her that she could ignore this and eat what she liked.

How can any sensible, coherent, and consistent health promotion advice be given to the general public when messages like this emanate from the private sector?

J JUSTICE

Medical Centre,  
South Harrow,  
Middlesex HA2 8RS

## Study leave difficult to fund

EDITOR,—Like many college tutors I am wrestling with the task of designing an educational scheme for my department's trainees that is compatible with time that they are available and with service demands. The senior house officers and registrars work the equivalent of a 72 hour on call rota. The mathematics of this means that there are occasions when they have complete days free of a service commitment. They may well be recovering from a busy night on call.

Senior house officers and registrars are entitled to up to 30 days' study leave each year. This, however, originated when the normal working week for trainees was frequently over 100 hours. Therefore the time that they could commit to training was considerably less than it is now. The hourly working week now is perhaps two thirds what it used to be. Has the time come to reduce the annual allocation of study leave to senior house officers and registrars to 20 days? I am sure that my department is not alone in finding it impossible to meet the financial demands of 30 days' leave with expenses.

DAVID P COATES

Directorate of Anaesthesia,  
Bristol Royal Infirmary,  
Bristol BS2 8HW

## Failure to thrive

### Define it carefully

EDITOR,—Harvey Marcovitch's review of failure to thrive was flawed in its failure to define the term satisfactorily.<sup>1</sup> In the wider sense failure to thrive can be defined as the failure of a child to fulfil his or her potential in terms of physical, social, and emotional growth and development. In the somatic sense, the term failure to thrive is usually applied to infants and preschool children to denote a failure to gain weight at an appropriate rate. In other words, the child is thin; typically, head growth is preserved relative to linear growth, and linear growth is preserved relative to body weight.

By contrast, short stature simply means height below the third centile and makes no assumption about the normality or otherwise of the child. Clearly, a child who is particularly short but proportionate will be below the third centile for weight as well as height without in any sense failing to thrive.

Growth failure can be defined as failure to achieve a height velocity appropriate for age and stage of development. A classic example of this is seen in acquired primary hypothyroidism (for example, Hashimoto's disease), in which initially at least the child will not necessarily be short and certainly will not be thin.

Failure to thrive, short stature, and growth failure may coexist but are separate entities that should not be confused. For example, in box 1 in Marcovitch's review (differential diagnoses in children who may be failing to thrive) a normal child with short stature cannot by definition be failing to thrive.

With regard to mid-parental heights, I agree that parents should be measured whenever possible but disagree that parents "tend to overestimate own height." Though men almost always do this, women usually underestimate it.

MALCOLM DONALDSON

Department of Child Health,  
Royal Hospital for Sick Children,  
Glasgow G3 8SJ

- 1 Marcovitch H. Failure to thrive. *BMJ* 1994;308:35-8. (1 January.)

### Persevere with breast feeding

EDITOR,—We believe that the information on managing failure to thrive in a breast fed baby given in box 6 of Harvey Marcovitch's article warrants further discussion.<sup>1</sup> If other causes have been excluded there is little point in test weighing the baby. This procedure is notoriously inaccurate<sup>2</sup> and will not assist in the management. It is essential to observe a breast feed.

To feed efficiently the baby needs to make a teat from both the nipple and the breast. If the baby is trying to feed from the nipple alone he or she will fail to compress the lactiferous sinuses underlying

the areola and will obtain most milk via the letdown reflex. The baby will thus fail to obtain the high fat (high energy) milk that comes at the end of an efficient feed.<sup>3</sup> The mother's breasts may respond to inefficient use by either increasing or decreasing the volume, but unless the quality of the baby's "mouthful of breast" is improved the feeds will continue to be low in fat.

Discussion with the mother may establish that she is removing the baby from the breast after a set time rather than allowing the baby to terminate the feed by spitting out the nipple when satiated. (Until recently, mothers were told not to allow the baby to feed at one breast for longer than 10 minutes.)<sup>4</sup> Such a practice can also lead to the baby failing to obtain the hind milk.<sup>5</sup>

In both instances the mother will indeed need "practical nursing advice"—that is advice on how to nurse her baby. Marcovitch's instruction to "discuss with the mother how important she regards breast feeding" seems to imply that she should be discouraged from continuing unless she is adamant that she wishes to do so. In view of the overwhelming benefits to the baby of receiving his or her mother's breast milk, surely the emphasis should be on helping the mother to solve her problem. The instruction shows what little confidence health care professionals now have in their ability to help a woman breast feed successfully.

JO ALEXANDER

Midwifery Education Department,  
Princess Anne Hospital,  
Southampton SO9 4HJ

CHLOE FISHER  
SALLY INCH

Breastfeeding Clinic,  
Women's Centre,  
Churchill John Radcliffe Hospital,  
Oxford

- 1 Marcovitch H. Failure to thrive. *BMJ* 1994;308:35-8. (1 January.)
- 2 Whitfield MF, Kay R, Stevens S. Validity of routine clinical test weighing as a measure of the intake of breastfed babies. *Arch Dis Child* 1981;56:919-21.
- 3 Woolridge MW, Fisher C. Colic, "overfeeding" and symptoms of lactose malabsorption in the breast-fed baby: a possible artifact of feed management? *Lancet* 1988;ii:382-4.
- 4 Culley P, Milan P, Roginski C, Waterhouse J, Wood B. Are breastfed babies still getting a raw deal in hospital? *BMJ* 1979;ii:891-3.

## Risk factors for salmonella infection

### Loss of gastric acid linked to candidiasis

EDITOR,—Keith R Neal and colleagues report that recent treatment with H<sub>2</sub> antagonists and gastric surgery predispose to salmonella infection, presumably as a result of reduced production of gastric acid.<sup>1</sup> A protective effect of gastric acid against the non-typhoid salmonellosis has been suspected.<sup>2</sup> Another potential infective complication of reduced secretion of gastric acid is candidiasis.

There have been anecdotal reports of both local and systemic candidal infections after various interventions that produce gastric hypoacidity, including partial gastrectomy, vagotomy, and treatment with H<sub>2</sub> antagonists<sup>3</sup> and proton pump inhibitors.<sup>4</sup> Because local candidal infections—for example, of the oesophagus—are often asymptomatic the risk of infection after inhibition of secretion of gastric acid is difficult to quantitate by case-control studies. Data from patients with systemic sclerosis suggest, however, that a combination of impaired oesophago-gastric motility and reduced production of acid may particularly enhance susceptibility: candida was found in oesophageal brushings in 44% of untreated patients but in 89% of a subgroup of patients treated for oesophagitis with high dose ranitidine (> 300 mg/day) or omeprazole (40 mg/day).<sup>4</sup> Such observations have prompted the suggestion that