

reminded of a 51-year-old woman who received octreotide because of daily losses of 6 L of fluid through her jejunostomy. After the first dose of 100 µg she developed upper abdominal pain and serum amylase rose to 18 µkat/L. After stopping concomitant codeine treatment the patient tolerated further injections of octreotide well. The duration of pancreatitis, lasting for days, in two patients after the single dose of octreotide is consistent with retention of activated pancreatic enzymes due to outflow obstruction.¹

Octreotide and natural somatostatin inhibit secretion of pancreatic juice and release of hormones relaxing the sphincter of Oddi. However, while somatostatin has a relaxing effect on the sphincter of Oddi, octreotide seems not to.¹ After octreotide spasm can be induced in susceptible patients.² Pancreatitis occur, more often after octreotide than placebo when administered before ERCP³ and the papilla can be more difficult to cannulate.³

Our third patient did not develop pancreatitis during treatment with codeine before nor with octreotide after her single attack of pancreatitis. The tendency of codeine to contract the sphincter of Oddi may have made her susceptible to the contractile effect of octreotide. Thus, the concomitant treatment with both drugs probably induced spasm of the sphincter of Oddi and pancreatitis.

We suggest that this side-effect of octreotide should be part of the drug information for octreotide, both available to the authorities and when the drug is promoted to doctors.

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Iron supplementation and cognitive function

SIR—Ashby (Oct 12, p 973),¹ commenting on a study of the effects of an iron supplement given to iron-deficient adolescent girls,² in which benefit was evident in only one of the four end-points investigated, emphasises the need for trials to ascertain whether any benefit can be realised in actual practice, such as in school performance. This need is especially apposite in the African setting, where the huge mass of the people are impoverished, and moreover, where most have non-dietary as well as dietary disadvantages, including iron-deficiency anaemia. Among children, we may wonder whether a benefit from iron supplementation would be manifest, say, in school examination results. Lozoff,³ has called for long-term studies to evaluate factors such as poor school achievement, vocational versus academic career tracking, absenteeism, school drop-out tendencies, and behavioural problems.

We believe that the benefits of supplementation should be scrutinised in all instances of nutritional shortfalls. Among black Africans, there is the intriguing situation of very low

calcium intake and the apparent absence of deficiency stigmata.⁴ Daily intake of calcium is usually half or less of the recommended dietary allowance. The intake of elderly black African women is very much less than the 1000-1500 mg now recommended for the avoidance of hip fracture. To comply with the dietary guidelines, all such Africans would require supplements, but this is not really practical. Besides, do Africans really need the intake of calcium recommended? Breast milk has a satisfactory composition, as shown in extensive studies in the Gambia;⁵ calcium-deficient rickets is very rare; rural African children have excellent teeth; and in South Africa, the frequency of hip fracture in elderly black African women is still about one tenth of that in white women. In the particular context described, it is not unreasonable to question the merit of including calcium in the dietary recommendations for this population.

While the developed countries are reducing their public funding of health services, in developing states the effects of funding restrictions are even more acute, as frequently described in *The Lancet*. In the context of poverty, we need to know what the minimum intakes of nutrients consistent with reasonable health performance and wellbeing really are. In situations in which specific supplementation is called for, the benefits to be gained must be clear, and—to secure funding—the proposed supplementation must be able to compete, in terms of cost-benefits, with other interventions, dietary and non-dietary, in the quest for disease avoidance and the maintenance of health.

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SIR—Ashby's¹ commentary on Bruner and colleagues'² report is important. Her warning that long-term follow-up of clinically relevant endpoints should be included and long-term safety should be carefully considered in all intention-to-treat approaches needs to be applied to the recommendations for iron supplementation in healthy and patient populations. There is a need of public health efforts to detect hereditary haemochromatosis and to prevent the consequences of this common but under-recognised genetic disorder.

Feder and colleagues³ reported two easily detectable mutations in the novel HLA-H gene; one of these was homozygous in 83% of 178 patients with hereditary haemochromatosis. Their findings offer the possibility for screening carriers of the defective gene and preventing the development of severe disease which often has a fatal outcome. Little⁴ points out some doubts about the candidacy of HLA-H to be the hereditary haemochromatosis gene, and underlines the importance of investigating recombinants by familial analyses. Barton and colleagues and Little⁵ explain the extraordinarily high

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frequency of this disease by the selective advantage of heterozygous child-bearing women to impart greater quantities of iron to their offspring. This argument is based on an as yet unproven hypothesis, and unfortunately reinforces the widespread and routine use of unselective iron medication for pregnant women and infants.

In 1984 a joint symposium of the International Society of Haematology, International Society of Blood Transfusion, and WHO initiated investigations to determine adequate iron stores in periods of increased cell proliferation, and launched a campaign against indiscriminate iron supplementation that would interfere with physiological adaptations at such times. Many investigations and clinical trials have corroborated the validity and the public health importance of these aims, but have not changed the prevailing clinical practice in most countries.

Iron supplementation during pregnancy will increase the circulating red-cell volume, leading to reduced blood flow, enhanced platelet-vessel wall interaction, and platelet aggregation. These changes would raise the risk of thromboembolic complications in the physiologically hypercoagulable state of pregnancy, combined with a rise in femoral venous pressure as a result of compression of the vena cava by the enlarging uterus. Additionally, iron-catalysed release of free radicals is involved in mediating immunodeficiency and increased mutagenesis in the highly proliferative tissues of the fetus, especially in the presence of viral infections or any other oncogenic factors. Since malignant diseases arise as a result of multistep mutations the consequences of interuterine damage may be manifested after several decades of latency. It seems probable that hypoferraemia during pregnancy is an important physiological adaptation for the prevention of these risks to mother and fetus.⁵

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The superficial femoral vein: a cause of therapeutic error

SIR—There is general agreement about the need to prescribe anticoagulants to patients with deep vein thrombosis (DVT), in order to prevent pulmonary embolism and ameliorate post-thrombotic syndrome. In addition, the rapid achievement of adequate anticoagulation with heparin has an important prognostic influence.¹ However, we have recently seen two patients admitted to hospital with suspected pulmonary embolism, who were not anticoagulated urgently despite an ultrasound scan of the lower extremities reporting "signs of thrombosis of the superficial femoral vein". We asked the junior doctors who first attended those patients about the reasons for not prescribing immediate anticoagulation. They explained that they knew the necessity of anticoagulation in DVT, but they thought that the superficial femoral vein was indeed a superficial vein, not a deep one.

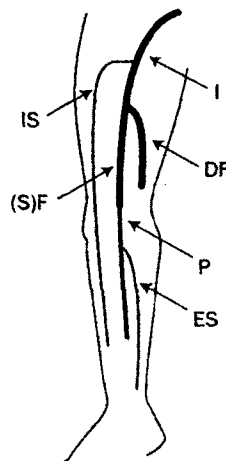


Figure: Schematic diagram of main veins of leg. Superficial veins (thin lines): IS, internal saphenous; ES, external saphenous. Deep veins (thick lines): P, popliteal; (S)F, femoral, also known as superficial femoral; DF, deep femoral; I, iliac. The segment of the femoral vein proximal to the confluence of the deep femoral is sometimes called the common femoral vein.

To find out if this was a common misinterpretation, we passed a questionnaire to 34 junior doctors in family medicine (8), general internal medicine (7), or internal medicine subspecialties (19). Only 9 (26%) considered anticoagulation indicated for thrombosis of the superficial femoral vein. However, all adequately answered that anticoagulants should be prescribed for thrombosis of the iliac, femoral, common femoral, or deep femoral veins. All but one (97%) would also anticoagulate popliteal vein thrombosis, whereas only two (6%) would anticoagulate external saphenous vein thrombosis.

These results clearly indicate that the failure to anticoagulate patients with thrombosis of the superficial femoral vein was not due to ignorance about proper therapy of DVT, but to a misinterpretation of the term superficial applied to the femoral vein. In fact this seems to be a common worldwide mistake.² The denomination superficial femoral for the vein segment joining the popliteal and iliac veins is frequent in ultrasound publications and patient reports (figure). However, since it seems to be a common cause of clinicians' confusion, it should be abandoned. The more easily interpreted term femoral (which is also more adequate from an anatomical point of view) should be used instead of the potentially dangerous superficial femoral.

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DEPARTMENT OF ERROR

An air stewardess with puzzling diarrhoea—In this Case Report by Greaves and colleagues (Nov 30, 1996), the second author should be R L Bown, not R L Brown.

CHD prevention in clinical practice—A line was lost from panel 1 in Professor Pyörälä's contribution to the supplement on Coronary Heart Disease (*Lancet* 1996; 348 (suppl 1): s26-s28): the middle section (modifiable biochemical or physiological characteristics) should have included raised plasma triglycerides.