Selectuve serotonin reuptake inhibitors in anorexia

Sir—Hobohm suggests that there is a discrepancy between our figures 2 and 3 which provide data on total and event-free survival. As we indicate in figure 4, the main advantage of radiotherapy is to prevent loco-regional recurrence, which, as other randomised trials have shown, does not greatly influence survival. This difference in loco-regional control is indicated in figure 3, which also includes death without disease and distant disease as endpoints. It is relevant that in this figure the curve representing the proportion of women given radiotherapy who are alive and free of disease is almost identical to that of total survival shown in figure 2: this would not be the case were radiotherapy causing harm. The only events excluded from the life-table analyses were 12 living patients with new primary tumours at various sites, seven of which were in the radiotherapy arm of the trial.

We agree with Kunkler that there is further need to examine the role of radiotherapy related to age, although from studies other than the Milan trial there is evidence that elderly women are no less at risk from relapse after local excision alone than are younger women.1 The operation that the Milan group describe as quadrantectomy was planned to include 2–3 cm of normal breast tissue surrounding the tumour and a large portion of the overlying skin and underlyig pectoral fascia.2 In view of the small size of the tumours in the Milan trial (upper limit 2·5 cm) compared with our trial (upper limit 4 cm), their procedure was considerably more radical.

In the report of the CRC trial1 of primary tamoxifen therapy in women aged over 70 years, the frequency of loco-regional recurrence in 120 women treated by local excision of an operable (presumably less than 5 cm) tumour and tamoxifen 20 mg daily was 16·7% at median follow-up time of 34 months; this has reached 20·8% at 4·4 years (T Bates, personal communication). These loco-regional recurrence rates are more in keeping with those in women over 60 years in the Scottish trial and are perhaps more representative of practice in the UK.

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1 Forrest AP, Fentiman IS. Breast cancer: principles of management.


Blood pressure and cholesterol in fish-eaters versus vegetarians

Sir—Pauletto and colleagues (Sept 21, p 784)1 assert that freshwater fish consumption by Tanzanian Bantu villagers (the Lugalawa study) is associated with lower blood pressures and plasma cholesterol concentrations as compared with a separate community of vegetarian villagers. By contrast, T horogood and colleagues2 had shown that plasma cholesterol concentrations were lower in strict vegetarians than in fish-eaters.

A previous publication from the Lugalawa study indicated that the non-fish dietary components of the two groups of villagers were dissimilar.3 Although the present study mentions that the vegetarians ate maize and rice inter alia, the previous study indicated that their diet consisted of maize, beans, potatoes, bananas, and low-alcohol beverages; the fish-eaters, on the other hand, were said to have derived almost half their total calories from a cassava root preparation.4 This difference may be important, since there is experimental evidence that cassava root may have both hypcholesterolaemic5 and hypotensive6 properties—along with some less desirable effects. Therefore, the high cassava intake by the fish-eaters may account for the lipid and blood pressure findings.

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Authors’ reply

Sir—We believe that comparison of our data from Lugalawa with the data of T horogood and colleagues,1 as proposed by Lavin, is not appropriate. Fat intake of the fish-eaters studied by T horogood was much higher than that of the Bantu fishermen (32·4–40·5% vs 12% of the energy). Supplementation studies5 have shown that intake of n-3 polyunsaturated fatty acids may increase low-density lipoprotein cholesterol if dietary saturated fat supplies greater than 10% of the individual’s energy requirements.

Our dietary study was based on individually recalled data, as well as on a family-based questionnaire. The first approach provided more details about diet composition, but there were discrepancies between individual recollections, family-supplied information, and our own observations. Although not reported by them, tapioca (a cassava root preparation) was present in the homes of vegetarian villagers. Fish-diet villagers did not usually report their consumption of potatoes, rice, and other vegetables. With the family-based questionnaire, our estimate of cassava consumption by the fisherfolk was 150–350 g per day (theoretically, 15–70% of calories, depending on their overall calorific intake, and the method of food preparation). Among the vegetarians, who had a slightly lower overall calorie intake, cassava consumption exceeded 50 g per day, on average.

Although cassava consumption was higher in the fishing community than among the vegetarians, it seems unlikely that this difference consistently affected the cholesterol and blood pressure profiles we obtained through our Lugalawa investigation. As mentioned by Lavin, there is experimental evidence that cassava derivatives may reduce circulating cholesterol and lower blood pressure. A comparison between cassava-consuming and non-consuming populations in Tanzania3 showed slightly lower cholesterol concentrations in the former than in the latter (3·7 [SD 0·91] vs 3·8 [0·97] mmol/L in men; 3·9 [0·94] vs 4·1 [0·88] in women). However, malnutrition was more often present among the cassava consumers, and this condition may have affected their cholesterol concentrations. Data on blood pressure were not reported by Swai and colleagues,7 nor by M clarty and colleagues,8 who investigated the prevalence of diabetes in cassava consumers. Finally, it is worth noting that our Lugalawa study found an inverse relation between plasma n-3 polyunsaturates and blood pressure* (ie, the higher the former the lower the latter); this, we believe, sustains the view that the fish diet was the main determinant of the findings on cardiovascular risk factors we reported.

*Data available from T horogood and the authors, on request.

* P Pauletto, M Muoto, C Galli, on behalf of the Lugalawa study group

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