the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD

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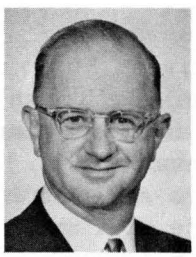

Dr. Robert Mendelsohn

This month, two events occurred which illustrate how much scientists still have to learn about the brave new world they've created. First, from Tennessee, came reports of several cases of sudden infant death following closely upon the babies having received DPT (diphtheria, whooping cough, tetanus) vaccine. I had hardly digested this news and gone on to talk to the doctor who had reported these findings when news broke of the radiation leakage at the Three Mile Island nuclear power plant near Harrisburg, Pennsylvania.

Both of these terrible events seem to me to be linked: Man has found the power to control much of his own planet, but he still lacks the knowledge to make that power absolute. In this month's Newsletter, I am giving you my reaction to these two happenings, along with the caveat that the more we know, the less we know.

Radiation: Why not evacuate?

By the time you read this, the nuclear leakage from the accident at the Three Mile Island power plant near Harrisburg, Pennsylvania, will hopefully be ended. However, it seems to me that there are some important lessons to be learned for the next leakage which nuclear engineers in other parts of the country have already stated could certainly happen.

When I joined my assistant, Vera Chatz, the morning of March 29, 1979, to write my medical column, her first and startling question to me was, "Why aren't they evacuating Harrisburg?" And even though officials gave the usual assurances that the radiation level was safe, her question started off a chain reaction in my mind. After all, didn't our country take the extreme precaution of inoculating 80 million people just in case there might be a swine flu epidemic? Aren't entire communities evacuated when trucks overturn and noxious fumes and other dangerous substances are released?

Since the media reports were so scanty, we decided to do a little research on our own. Ms. Chatz telephoned the Harrisburg Patriot and Evening News where she learned that 20 millirems per hour of irradiation had been detected in Goldsboro, Pennsylvania, a town opposite the island on the river on which the nuclear power plant stands, about one mile away. This alarmed us since for more than 20 years, federal scientific panels have established the maximum safe dose of manmade radiation at 170 millirems per year. An ordinary chest x-ray delivers from 20 to

500 millirems, yet the people of Goldsboro were being exposed to 480 millirems every 24 hours! Low-level radiation (and these levels from this accident are not so low-level) is generally agreed to be much more dangerous than originally thought. In addition to the risks of cancer and leukemia, particular hazards to the pregnant woman and her unborn fetus concern me as a pediatrician. The link between radiation to pregnant women and later mental retardation in their offspring, first proposed by Dr. Ernest J. Sternglass, professor of radiological physics at the University of Pittsburgh, leads me to predict that 20 years from now, Goldsboro and Harrisburg will be fertile areas for scientists doing research on intelligence tests. But why wait for these retrospective studies? Why not adopt the prudent approach, as in other emergencies threatening health and life, of ordering (or at least recommending) immediate evacuation?

In future similar accidents, we must regard those invisible radiation particles as being as capable of causing disease as we now regard the epidemics caused by invisible viruses and bacteria. This is the lesson I think we can learn for the future.

Previously, I gave my recommendation for the first line of defense against radiation damage from future nuclear plant accidents. I advised the prudent approach of immediate evacuation. At that time (March 29, 1979), it took government officials an additional 48 hours before they counseled even the halfway measure of removing pregnant women and preschool age children from a five mile area surrounding the Three Mile Island plant. Even as I write today (April 2, 1979), no further evacuation, even of adult women who might unknowingly be pregnant, has been suggested.

Although many statements, often conflicting, have been heard from physicists and other scientists, to date there has been an almost total silence on the part of physicians. The Department of Health, Education, and Welfare, so outraged by cigarette smoking and saccharin, has voiced not a peep about radiation-induced leukemia and cancer. The health officials of the State of Pennsylvania have said nothing about radiation-caused fetal malformations.

Seeing this vacuum of medical leadership at the highest levels, I will humbly offer my own prescription for the second line of defense (under no circumstances any less important than the first line of defense), namely breastfeeding rather than bottlefeeding in areas of high radiation.

Appearing on television on the east coast following the nuclear accident, La Leche League International president Marian Tompson cited evidence from the British medical journal, Lancet ("Absorption, Excretion, and Retention of Strontium by Breastfed and Bottlefed Babies," Elsie M. Widdowson, et al, University of Cambridge, October 29, 1960) that breastfed babies excrete more strontium (a radioactive substance) then they ingest. If born with five milligrams of strontium (or strontium 90) a breastfed baby would be free of the material within three months. However, the bottlefed baby would have twice as much strontium as he was born with after about one month. The difference was attributed to the high content of strontium in cows' milk and the low phosphorus content of human milk. When phosphorus was given breastfed babies, the excretion of strontium was reduced. Thus, the likelihood is that strontium would not be retained by babies as long as they are fully breastfed.

Even though strontium may not be yet identified as a significant element in the present Three Mile Island leak, the above scientific finding shows the "survival selectivity" of breast milk. Other pieces of

evidence, such as differential absorption of iron, support this characteristic of breast milk. Tiny amounts of iron in breast milk are fully utilized by nursing babies, preventing iron-deficiency anemia, while cows' milk is well-known to inhibit the absorption of iron, thus requiring iron supplementation in formula-fed babies. In PCB-PBB scares of past years, even though these chemical contaminants were measured as being higher in breast milk than in cows' milk, not a single baby has been shown to have suffered any harm. (In the present Pennsylvania nuclear accident, high levels of radioactive substances have already been reported in cows' milk.)

Breastfeeding has a particular advantage for the babies now being evacuated, being always available, always fresh, and always sterile. In contrast, it may be very difficult for mothers in transit to simulate the kind of conditions present when they prepare and refrigerate formulas in their kitchens. Thus, the danger of bacterial contamination and subsequent infectious disease, long associated exclusively with Third World countries, is increased right here.

My advice to breastfeed in the face of nuclear accidents is important not only during this immediate crisis but also for many months to come, particularly along the east coast where the nuclear drift may endanger both the physical and intellectual development of children already born and those yet to be born.

Sudden infant death and DPT vaccine

The day that the deaths of four Tennessee infants were reported within 24 hours of receiving DPT (diphtheria, whooping cough, tetanus) vaccine, I phoned Robert Hutcheson, M.D., Director Communicable Disease Control, Tennessee State Department of Health. Dr. Hutcheson provided me with vital pieces of information left out of the sketchy newspaper reports. In response to my questions about why these deaths seemed to occur only in Tennessee, Dr. Hutcheson described the unique vaccine-monitoring system which he initiated years ago as state epidemiologist.

Unique among the 50 states, Tennessee has provided a 24-hour toll-free telephone number for parents of immunized children to phone in order to report reactions from immunizations. Parents of children who receive inoculations at public clinics are given an "important information form" mandated by federal regulations which describes the benefits of immunization, some of the reactions, and the toll-free telephone number. Thus, the reporting of reactions in Tennessee is not exclusively dependent on physicians.

Because of this parent participation, Tennessee is in an unusual position vis-a-vis other states. It should be pointed out that patients who are immunized by private physicians do not necessarily receive this special form; however, in Tennessee 70 per cent of children are immunized in public clinics. Because of this excellent early warning system, Dr. Hutcheson had sufficient data to order immediate withdrawal of the suspicious vaccine on March 9, 1979.

In response to my next question about the failure to publicize the suspect batch numbers of vaccine, Dr. Hutcheson informed me that thus far the only manufacturer implicated is Wyeth Laboratories, and the batch numbers are 64-201 and 619-87,-88,-89,-90,-91. One hundred and fifty thousand doses of these suspect lots were withdrawn from use in Tennessee, but there were an additional 300,000 doses in the rest of the country.

In response to my next question about the statistical methods used in implicating this batch of triple vaccine, Dr. Hutcheson reported

that his biostatisticians had used the same statistical analysis (binomial distribution tests) as were used in establishing the causal connection between the swine flu vaccine and Guillaine-Barre paralysis.

Some claim that these four infants simply had the Sudden Infant Death Syndrome (SIDS), and the time relationship with the immunizations was only coincidental. But this makes the arm of coincidence very long indeed. The possibility of a linkage between immunization and sudden infant death should not be casually dismissed. After all, the administration of DPT (and usually polio) immunization (two to six months) coincides almost exactly with the age of SIDS infants. Furthermore, at least one of the components of DPT, i.e. whooping cough (pertussis) vaccine, has a very bad reputation from the standpoint of causing convulsions and other neurologic damage. Routine pertussis inoculation was withdrawn in 1974 in Hamburg, West Germany, and a furious battle on this subject has been raging for years in Great Britain. Dr. Gordon T. Stewart, a Scottish physician, has charged that whooping cough has declined to the point where the risks of vaccination now outweigh its benefits (Wall Street Journal, March 31, 1977). Furthermore, the diphtheria component of DPT has been questioned for years since there has been little difference in recent epidemics in terms of both death and severity of illness between children who were vaccinated and those who were not.

My advice to scientists and government officials is:

1) Declare an immediate moratorium on all DPT immunization nationally until the suspect batches can be totally removed from physicians' offices.
2) Institute the Hutcheson monitoring system in all states for both public and private patients.
3) Investigate further the possibility of a causal relationship between some immunizing agents and sudden infant death. A good place to begin might be to compare the incidence of sudden infant death in those nine states that as of 1975 did not require preschool immunization -- Arizona, Idaho, Indiana, Iowa, Utah, Vermont, Washington, Wisconsin, and Wyoming--with those states which do require it. Another fertile area for investigation of immunization practices might be Finland where the rate of sudden infant death is one-quarter that of Great Britain.

My advice to parents is:

1) When you next take your baby in for a DPT shot, ask the doctor if his vaccine carries any of these suspect batch numbers.
2) Discuss with your physician whether your child should receive the triple vaccine.
3) If you're a private patient, try to get at least as much information on possible reactions as is made available to patients at public clinics.
4) Keep a record of the batch numbers and manufacturer of any immunization given your children.

Q My 5-year-old son has an undescended testicle. Today he was examined for the second time by a urologist (referred to us by our general practitioner), who explained that the first step to bring down a testicle is hormone injections, which rarely work in cases where the testicle has never appeared. If the hormone treatment doesn't work, the urologist recommends surgery. And even that may not work if my son was born with only one testicle.

I'm writing in the hope that you can tell me if it is truly important for a child to go through surgery because of one testicle.

Being female, I don't know. I do know that he can be fertile with only one testicle. I have no qualms about operations, but I don't want one performed unnecessarily.--Mrs. A.M.

A

Undescended testicle

Unlike you, I have plenty of qualms about operations, especially unnecessary ones.

I was taught that an undescended testicle should be brought down into the scrotum either by hormone treatment or surgery, primarily to achieve a decent "locker room" appearance.

I was also taught that there is a remote danger of cancer developing in an undescended testis, but the passage of years has demonstrated that the danger of surgery far exceeds the extremely rare instance of tumor development.

And I am not impressed with the farfetched argument that injury to the remaining testis may result in infertility. With one testis a man could repopulate the world (assuming all other conditions were right).

An ongoing argument is whether this surgery should be performed at age 2, 5, 9, or 12. The most fundamental question is whether the testis is truly undescended or a phenomenon sometimes caused by the cold fingers of the most warmhearted physician and by other techniques of examination.

I am extremely skeptical of the value of hormones or surgery in the treatment of an undescended testis. Perhaps your urologist will have more convincing arguments. But keep in mind, if you're thinking of taking the child in for further examinations, that long and frequent examinations of a child's genitals may tend to produce an undue concentration on that area of the body by the child and his parents.

Q

My 4-year-old son has a speech problem. What kind of treatment should he get?--C.P.

A

Speech problem

So much speech therapy is being done today that my answer may sound a little old-fashioned. Nevertheless, the opinion of the University of Chicago's Dr. Joseph Wepman and of other outstanding authorities in this field is that most speech variations in young children disappear spontaneously by the time they reach 8 or 9 years of age. Treating a condition that is almost certain to improve spontaneously adds unnecessary expense and may create possibly stressful situations.

In the small percentage of children who still have problems by the time they are in second or third grade, short-term speech therapy almost always is very effective. One exception to this general rule must be made in the case of a young child who cannot be understood; this kind of rare case merits immediate attention. Unless your child falls into this category, forget about his speech problem. Enjoy him as he grows out of it by himself.

Q

My son and daughter-in-law plan to take their two sons, aged 10 and 16, on a three-week biking trip through Great Britain this summer. I feel that the 10-year-old, who is a big boy for his age and a few pounds overweight, isn't old enough for such sustained exercise--35 miles a day or more. He tires rather quickly, and a nurse friend of mine told me that when muscles are strained and overheated, the load on the heart

--especially a 10-year-old one--is increased, possibly to a dangerous level. My grandson is active, but he participates in no sports other than swimming.

Wouldn't my family be better off using a car to get from place to place and do their walking and biking within villages and cities?--M.K.S.

Biking trip for 10-year old

I don't have to be a grandparent to agree with you. A person's physical capabilities are not simply a result of individual health and ability, important as these factors obviously are. Familial patterns and cultural background play a large role in physical strength--a fact that is often overlooked in our society. For example, everyone is aware artistry on the high wire tends to run in families.

Your assessment, based on a recognition of the limitations of muscle activity characteristic of your family, deserves the most serious consideration. Unless your son and daughter-in-law can offer compelling arguments to the contrary, I would agree with you that the automobile is preferable to the bicycle for this year's trip. Reserve that bike trip for future years when the 10-year-old has developed muscular capabilities in other sports as well as in swimming.

My daughter is 6 years old. Her health is excellent and she is a lovely child. But how should I handle her nightly bedwetting?

So far, we have kept her in diapers because I feel it's terrible for a young child to sleep in a wet bed. I don't want to resort to drugs or appliances unless I'm convinced they work, and from the little I've been able to find out from other parents, they don't.

My child is not punished for wetting, and she is not at all bothered by it. She even takes her diapers along when she stays overnight at a friend's house.

Doctor, what do you think her prognosis is? How long will this bedwetting continue? How else should I approach the situation?--K.W.

Bedwetting

It's a pleasure to hear from a mother who is handling a difficult situation with such intelligence. You might have listened to the advice of experts who are eager to prescribe such remedies as electrical devices, pills, cystoscopy and psychiatry.

Instead, you have managed to influence your daughter with such finesse that she is able to cope adequately with an overnight stay at a friend's house, a challenge that often assumes gargantuan proportions for children with bedwetting problems (enuresis).

I congratulate you most of all because you have avoided all the wrong approaches to a condition in which some treatments are more disabling than the enuresis itself.

Check with family members to see if they had similar problems (familial aspects are common in bedwetting), and see how long it took them to outgrow it. Bedwetting at 6 years is not all that unusual, and the vast majority of children so afflicted has dry beds within a short time.

Is your family physician satisfied with your child's condition? Has he taken simple urine tests, which have proved negative? If so, heed his advice and continue to behave just as you have toward your child.

Two years ago, when our daughter was 8, she wanted to go on a five-day trip with her classmates. This presented quite a problem since she had a severe bedwetting problem. Because she so desperately wanted to take

that trip, we visited the doctor who said there was a safe medication--Tofranil--that would help her.

The medication worked beautifully. She took it for six weeks before the trip without wetting her bed. But after her trip, we found her speech very difficult to understand. The problem got worse as the summer continued. Our doctor, a consultant and a specialist who took x-rays of her head were all puzzled as to why our daughter, who had spoken clearly from babyhood on, now had almost incomprehensible speech.

Shortly after our unproductive visit to the specialist, I began to wonder if Tofranil might be the cause of her speech problem. I took her off the pills, and although her bedwetting resumed, her speech cleared up within two weeks. I called the doctor who told me never to give her the medication again. He said he had never heard of the drug causing these problems.

Now, two years later, the bedwetting is ceasing to be a problem. I hope this will help some other family whose child takes Tofranil; we had to go through a lot of worry, expense, and exposures to x-rays before we connected the drug with our daughter's speech difficulty.--Mrs. K.T.

A Although speech disturbances are not specifically listed among the adverse reactions to Tofranil, other effects that may affect speech incoordination, dry mouth, nervousness, and tiredness--are listed. Congratulations on using your good common sense to figure out the cause of your daughter's speech problem.

Q I send my children to private school, and the principal is bugging me about getting them immunized. What can I do?--G.K.
P.S. Perhaps what we need is a "People's Lawyer!"

A You may be interested in the following statement contained in the Illinois State School Code (27:8): "Pupils objecting to physical examination or immunizations on constitutional grounds shall not be required to submit themselves thereto if they present to the school boards or Board of Governors of State Colleges and Universities a statement of such objections signed by a parent or guardian of the child."

Compulsory immunizations

Although I'm not a lawyer, I have been informed that this type of clause exists in the codes of most states.

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Another View

by Marian Tompson
President, La Leche League International

"All I did was encourage her to breastfeed and now I feel responsible for all that's happened." The telephoned words came from a La Leche League leader, the sister of Iowa firefighter Linda Eaton. You remember that Linda became instantly famous when she insisted on breastfeeding her baby during her private time at the firehouse. It took a court hearing and an investigation by the Iowa Civil Rights Commission to determine that she really had that right.

Last summer, another mother, Barbara Damon of New York, found herself in trouble when she nursed her two-month-old son as she sat beside a toddler pool keeping an eye on her two older children. Although a large beach towel wrapped around Barbara's shoulders covered the nursing baby, two women objected and Barbara now is in the middle of a lawsuit. She's suing the community for $1,000,000 because she lost her pool privileges for nursing in public.

In Colorado, a mother took her four-month-old baby for a well-baby check. The doctor praised Karen on how strong and healthy the baby was and then asked about the foods the baby was getting. When Karen replied that the baby still was totally breastfed, the doctor became angry and said that he was going to write officially on her chart that the baby was being abused and neglected because its mother was ignoring his advice about starting solid foods. He announced that he intended to monitor the situation through one of the public agencies. A week later, a public health nurse appeared at the family's home to investigate the matter!

Breastfeeding, it seems, can be a radical and dangerous act even when it's done by the nicest people. And all this is happening despite the fact that the American Academy of Pediatrics and the American Medical Association have come out strongly in support of breastfeeding.

I realize that the problem lies in the time lag between our intellectual acceptance of an idea and our getting used to the reality of what that acceptance means. For if we were to truly encourage breastfeeding, we would applaud and support the commitment of a mother who chose to nurse her baby even though she had to return to work. Better yet, we might work out a system of baby bonuses which might mean she could stay home during those early years. We would accept breastfeeding in public. Most women are very discreet about it, and it is totally unrealistic to expect mothers who have other children to care for and obligations to fulfill to always arrange to be in a secluded area when nursing--babies' needs just aren't that predictable. And we would make it mandatory for every doctor involved with families to be educated not only about the advantages and techniques of breastfeeding but also about the larger implications of this special mother/baby relationship.

We would expect every pregnant woman to be given the facts about the differences in breastfeeding and bottlefeeding. She would be prepared for a drugless delivery in a setting of her choice and her baby would be given to her right after birth and would remain with her. Supplementary bottles would not be given, nor would they be needed. And most important, the mother would be assured of receiving the practical help she needed day-to-day until her baby was weaned.

No doubt it will take time for some of these changes to come about. But if we are serious about upgrading the health and well-being of our mothers and babies, we have an obligation to start making those changes.

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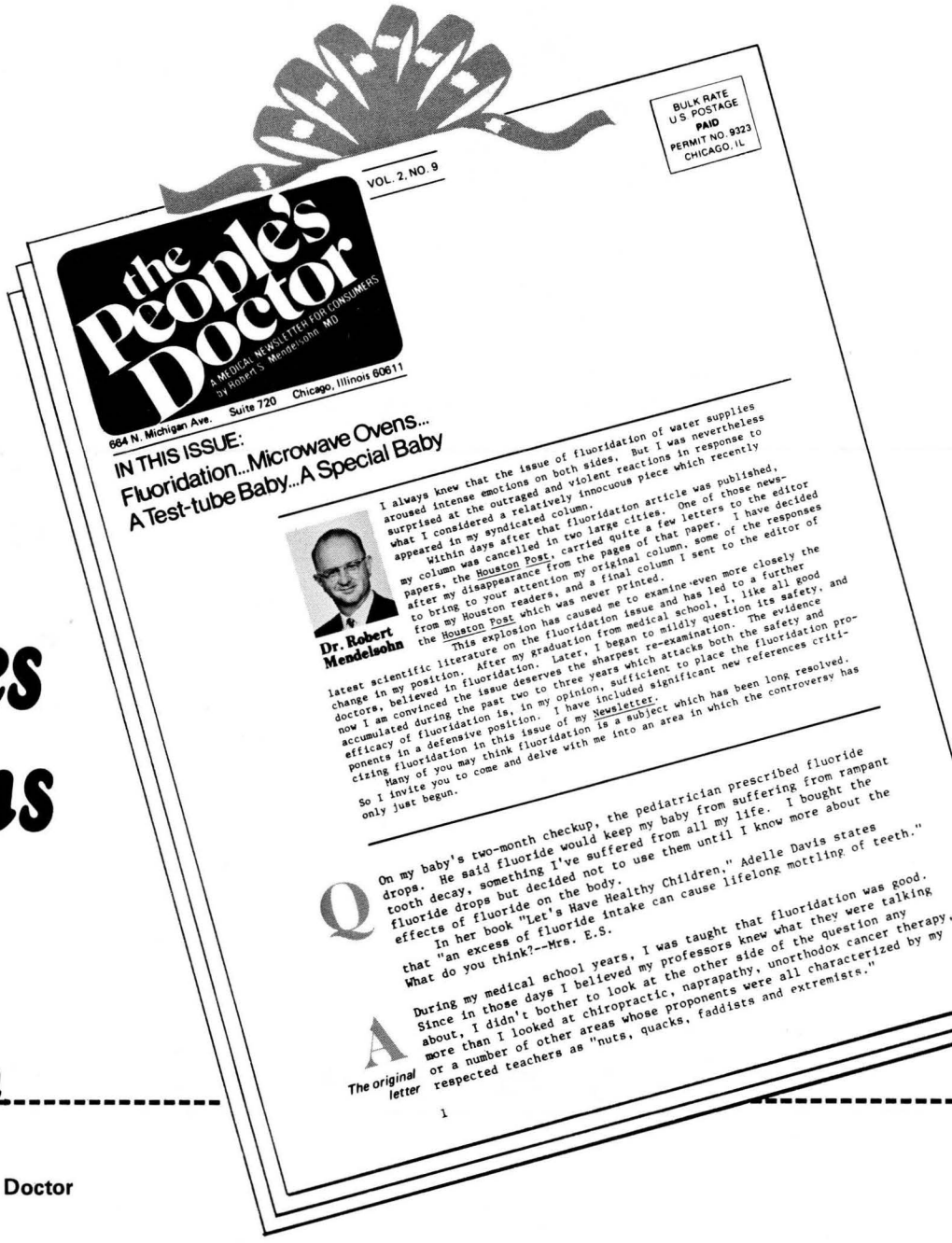

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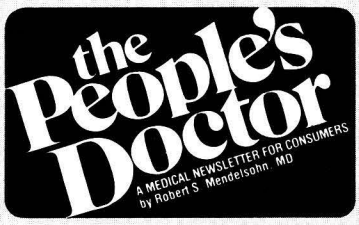

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