

sponses to symptoms and, as such, are not indicators of the construct of interest in this study—perimenstrual symptom experiences. By definition, symptoms are subjective phenomena, and investigators should not automatically discount their validity. Instead, studies can be designed to explore sources of bias, thus contributing to a more sophisticated understanding of the generation of symptoms.

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Comment on Eye Sensitivity and Vitamin C

Dr. McIntosh's letter in the December Journal¹ raises two important issues. Her experience of idiosyncratic symptoms from exposure to newsprint, photocopy, and exhaust fumes has been reported by others. This form of sensitivity to chemicals has been documented in both case studies² and in double-blind challenges.³⁻⁵ Dr. McIntosh's use of pharmacological doses of vitamin C prophylaxis is intriguing. Anecdotal success using vitamin C to treat acute sensitivity reactions to chemicals and also to foods has been reported,⁶ although, to my knowledge, there has been no attempt at double-blind verification. I am not aware of other reports using vitamin C as a preventive for idiosyncratic reactions to chemicals or foods.

Because of the unverified claims which have been made for vitamin C, one tends to maintain scepticism. However, Vitamin C, in high doses, has been reported to have biological effects, including, for example, an ame-

liorative effect on experimentally induced asthma.⁷ Therefore, reports such as Dr. McIntosh's should be given consideration. However, at a dose of 500mg per day it may be that we are more likely seeing a pharmacological effect rather than a replacement of nutritional deficiency.

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Breastfeeding among Hispanics

I was glad to note that the Four-State border study by Smith, *et al*,¹ corroborated what I had previously pointed out concerning the dearth of breastfeeding among Los Angeles Hispanics.² Unfortunately, Smith and his colleagues concluded nebulously that "ways to encourage and support the practice of breastfeeding in this group (border Hispanics) need to be developed." Perhaps federal monies used in gathering statistics to demonstrate unmet need would be better directed toward effective (existing) programs which can prevent the "dissolution of the lactation bond among the population least apt to breastfeed. . . . Whereas the middle and educated classes have begun a resurgence of breastfeeding, this renaissance is missing among the poor."²

Some of the cost-effective ways to promote breastfeeding are:

1) Breastfeed or lactation infant clinics (or early well-baby clinics) as operating in University of California San Diego and Los Angeles County University of Southern California medical centers, respectively. At the latter, "pediatric and obstetrical staff referred infants and mothers to the clinic for a follow-up visit seven to ten days postpartum. The clinic seeks to determine and solve any breastfeeding problems the mother/baby dyad are having, support and give guidance to those mothers who are not having problems, and teach the physician-nurse house staff the management of breastfeeding problems."³ Much of this could be done as well in the private physician's office, the public clinic, the WIC program, by the visiting nurse, or the support group milieu (e.g., La Leche League) by asking and observing a feeding.⁴

2) Peer advocates can counsel lactating women (and non-supportive men) of similar socio-cultural backgrounds, thus creating a "doula-type" support system for nuclear families to dispel myths and encourage proper techniques. Respected cultural leaders can be part of the support system.

3) Breastfeeding teenagers can lecture on sex education and infant nutrition to high school peers. Health education teachers can include lactation as a direct extension of placenta-tion in classwork. Lactation is often neglected as a scientific and nutritional resource topic.

4) Billboards in inner cities can depict nursing supportive dyads and their approving man; USDA advertisements can be placed in supermarkets, newspapers, radio, and TV.

5) Discontinue giving a discharge pack of formula to parents as they leave the hospital. Prescribe no formula or glucose-water supplements to healthy breastfed neonates post-delivery, thus avoiding possible nipple confusion.⁴

Sensitive nurturing counseling is important prenatally, perinatally, and postnatally to ensure "appropriateness" of infant feedings—to encourage breastfeeding.²

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Author's Affiliation Clarified

I would like to bring to your attention an omission which occurred in the author identification of the article, "The Implementation of Model Standards in Local Health Departments," (*AJPH* 1982; 72:1230). The article was cited as being "From the California State Department of Health Services." In fact, Jane Boggess, PhD, the second author and the primary analyst and evaluator for the Model Standards project, is from the Health Officers Association of California, 926 J Street, Suite 201, Sacramento, CA 95814. The three other authors are, or were, from the California State Department of Health Services.

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On the Cost of Providing Services under Connecticut Medicaid

In combination, a recent article in the *Journal*, "Cost of Providing Dental Services to Adult Mentally Retarded: A Preliminary Report," and the accompanying editorial,^{1,2} suggest that developmentally disabled persons residing in community settings may be exposed to a community health care system that is equally inadequate in meeting their needs as the institutional programs that the population relied on prior to deinstitutionalization.

The article singled out poor reimbursement under Medicaid as being a major weakness in delivering dental care, and made an important finding relative to the actual cost of providing services, and what is reimbursed under the Connecticut Medicaid program. However, caution should be used in making generalizations about these findings. In a 1982 survey of state dental Medicaid programs, done by the American Dental Association, Connecticut was ranked 37th out of the 44 reporting states in the average cost per recipient for dental benefits. Total payments for all Medicaid dental services was only \$4.2 million, substantially below that paid by comparable states. These statistics call for more detailed information in future reports before any generalizations should be made.

In addition, it should be pointed out that increasing reimbursement to community practitioners may do very little if the practitioner is not trained to care for the person; if the office is not equipped; or if an organized system of case finding and referral is not in place for the vocational or residential programs that serve the clients.

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Investigations of Health Effects in Populations Living Near Nuclear Installations

A recent *American Journal of Public Health* report addresses health risks from "low-dose ionizing radiation."¹ Similar reports were prepared for the Nuclear Regulatory Commission (NRC) and the US General Accounting Office.²⁻⁴ Nine "candidate

populations" for investigations of radiation effects are listed, but the authors judge that "no single population can be recommended for study on purely scientific grounds since the largest group offers only a small chance to obtain a definitive result." Such recommendations may have the effect of doctrine when supported by several federal agencies, and the field of radiation protection is too young to be burdened with doctrine. Epidemiological investigations must continue to be initiated in populations around nuclear plants, even if on an empirical basis.

One such "candidate population," the Denver Standard Metropolitan Statistical Area, downwind from the Rocky Flats nuclear plant (RFP) which reprocesses plutonium and uranium and manufactures weapons components,⁵ is inaccurately depicted, and the exposures sustained are grossly underestimated by Dreyer, *et al*,⁶ who base their population radiation dose estimates on an average air concentration of 0.37 femtocuries per cubic meter (fCi/m³) of plutonium 239 measured in 1975 at the Department of Energy (DOE) Environmental Measurements Laboratory (EML) sampling site #4, east of RFP.^{1,7} The authors overlook a number of important references which add information essential to such estimates.⁸⁻²⁸ For example, the ERDA (now DOE) Environmental Impact Statement (EIS) reports (2-175) "as of 1975 the total site releases from RFP have been reduced nearly 1,000 times from 1965 levels,"⁸ and so air concentrations of plutonium in 1965 would have provided a more conservative data base for estimating exposures to people in the Denver area. In toto, there are about 20 omissions, oversights and errors in the chain of assumptions developed by Dreyer, *et al*.

More important than the routine releases are the large releases due to accidents^{5,10} such as the fire and explosion in 1957 which blew out all 620 industrial filters in the main exhaust system at RFP.¹²⁻¹⁵ The filters had not been changed in the four years of the plant's operation and a single filter could accumulate more plutonium than the EIS acknowledges RFP releasing throughout 24 years of the plant's operation.^{14,15} Most of the plutonium on the