

Letters to the Editor

Fatty Acid Content of Margarines and Other Table Fats

Dear Sir:

In regard to the recent Letters to the Editors about the fatty acid content of margarines (in your March 1963 issue), I wish to mention that the Bernfeld, Homburger and Kelley paper entitled "Fatty Acid Content of Margarines and Other Table Fats" in the December 1962 issue of the Journal omitted what I consider to be a pertinent reference to previous work.*

I would also like to point out that the data as given by Bernfeld et al. are not easily usable by dietitians and practical nutritionists, since

* OSTWALD, R. Fatty acids in eleven brands of margarine. *J. Am. Dietet. A.*, 39: 313, 1961.

no values for fat or water content are listed. Therefore, the amounts of a given fatty acid per unit weight of margarine cannot be calculated from their data (also see*).

This is not to detract from the additional valuable data offered by Bernfeld et al. It is hoped that an increasing number of such investigations will provide the consumer with valid and meaningful information about the composition of the foods he buys.

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Chorionic Gonadotrophin in the Treatment of Obese Women

Dear Sir:

May I refer to the article "Chorionic Gonadotrophin in the Treatment of Obese Women," by Leela S. Graig et al. published in your March 1963 issue?

That twenty obese women maintained on a diet of 550 calories over a period of forty days, with or without chorionic gonadotrophin, have shown an average loss of only 9 pounds is entirely contrary to all experiences so far recorded. Evidently, as the authors themselves admit, the diet was not scrupulously controlled and observed. The diet described by the authors is hardly as they claim "a modification" of the one used by Simeons, Sohar, Lebon and others. In caloric value and composition it differs considerably from the diet I have recommended for use in association with human chorionic gonadotrophin.

It does, moreover, seem a little wayward to conduct an elaborate double blind experiment when the most important factor, the diet, is poorly controlled. If the authors had excluded from their series all the cases in which they had doubts about the strict observance of the diet throughout most of the treatment, the value of their study would have been enhanced. As it stands, their work on the use of human chorionic gonadotrophin is rather like testing the value of insulin in diabetic patients whose carbohydrate intake is unestablished.

Before a new method is tested one does rather expect the student to have first fully acquainted himself with the technic under investigation. Had these authors done this, they would have excluded from their series all the patients who required vitamins, thyroid and diuretics "for other conditions" which are

not explained, knowing as they then would that such additions drastically alter the mechanism of weight reduction with human chorionic gonadotrophin.

What so many investigators seem to overlook is that human chorionic gonadotrophin as such has no weight-reducing action whatsoever, nor has this ever been claimed to be the case. In fact, those quite exceptional patients who have the willpower to stay on a 500 calorie diet for forty days without human chorionic gonadotrophin often lose more weight than those who are receiving it; but they look drawn and haggard and regain their weight rapidly as soon as they stop dieting, because they have depleted normal fat reserves. The function of human chorionic gonadotrophin is exclusively to make drastic reduction over a short period of time safe, comfortable and entirely confined to abnormal fat deposits. It is the latter peculiarity which accounts for the relative ease with which patients can hold their weight after this treatment, a fact which Dr. Craig's paper confirms.

Unless the student is fully familiar with this interesting action of human chorionic gonadotrophin in obesity, he completely fails to recognize its absence when patients reduce their weight by diet only. The experienced worker, on the other hand, sees the marked difference within the first week of treatment and cannot, therefore, carry out a double-blind experiment. He can always pick out the control subjects

who are receiving the placebo long before the end of treatment, since they have trouble with the diet, look weary and completely lack the bright exhilaration which obese patients receiving human chorionic gonadotrophin almost invariably experience. Moreover, the excessive measurements do not regularly decrease at the rate of at least 1 cm. per kg. of weight lost as is usual in patients on a reducing diet and human chorionic gonadotrophin.

We treat patients from most parts of the world, among them many Americans. We hardly ever see a loss of less than 20 pounds, while many patients on a forty day diet lose over 30 pounds. We have little trouble with the diet even in ambulatory patients who eat at home. Perhaps this is because we consider it worthwhile to investigate even the slightest gain which, with the exception of premenstrual water retention, is always due to a dietary error. Once the reason for the gain has been elicited, the error is rarely repeated.

May I use the hospitality of your *Journal* to say how much we would welcome a visit to our clinic from our critics so that they may be in a position to compare their results with those of our standard technic before condemning a method which gives us, and others who follow it strictly, such consistently satisfactory results?

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