

Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Oral Diuretics in Pregnancy Toxaemia

SIR,—We would like to draw your attention to what we consider to be a misuse of a most valuable new series of drugs. We have now seen five cases of intrauterine death following the use of diuretics of the chlorothiazide type in toxaemia of pregnancy.

The first two cases occurred in our own department after we ourselves had prescribed moderate doses of this drug. The oedema lessened, the blood pressure became lower, and the foetus died. We have now seen three cases referred to us from general practitioners outside, with the same sequence of events.

We believe that two valuable signs of toxaemia of pregnancy are minimized or lost, while the toxaemic process continues. The warning to rest the patient more completely or to induce labour being absent, the correct measures for the control of the toxaemia are delayed. We have not yet seen any dire effect on the mother following the use of oral diuretics, but the loss of five babies in three months makes us consider that further research into the action of oral diuretics in the toxaemia of pregnancy should be carried out before manufacturers claim that it is a useful drug in this serious condition.—We are, etc.,

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Familial Intestinal Polyposis

SIR,—I was very interested to read the leading article on familial intestinal polyposis (May 28, p. 1627). It is a most useful summary of the present position of these diseases. I do, however, disagree with the opening sentence, which states that adenomatous polyps are not uncommon in childhood. Superficially this is true, but the article does not point out that there is a definite clinical, and I believe pathological, entity, the congenital polyp. This is quite unlike the adenoma seen in the adult rectum and colon at sigmoidoscopy, which has the same appearance as that seen in familial polyposis coli and has the same predilection for malignant change.

The congenital polyp is compact and not lobulated, it is a much brighter red (not plum-coloured), and shines on account of adherent mucus. It is more commonly single, though it may be multiple, and it is usually on a short pedicle. It does not undergo malignant change. Congenital polyps commonly cause bleeding in early childhood, but it is uncommon to see them in the adolescent. They tend to fall off, and it seems probable that many are never found for this reason: the more profuse bleeding which takes the child to the doctor has occurred as the polyp has been shed.—I am, etc.,

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IAN P. TODD.

SIR,—In your otherwise excellent leading article on familial intestinal polyposis (May 28, p. 1627) you state in your opening paragraph that adenomatous polyps of the large intestine are not uncommon in childhood and that the polyp is usually single. I do not think this statement should be made without some reference to

the so-called congenital polyp of the rectum and colon, which is not uncommon in childhood, and is often confused with true adenomatous proliferation. Moreover, I would suggest that true adenomata of the large intestine other than those seen in familial polyposis are very rare in children.

The congenital polyp is usually single. It may be multiple and is a cause of bleeding from the rectum in both children and adults. It is round, with a smooth surface, whereas the adenoma is a lobulated tumour in its developed state. The cut surface appears cystic, and under the microscope is composed of rectal tubules lined by well-differentiated mucus-secreting epithelium lying in a stroma of connective tissue resembling primitive mesenchyme. The tubules tend to become dilated with excess mucus secretion, which explains the cystic appearance on inspection of the cut surface. The amount of stroma in proportion to the epithelial element is much greater than in an adenoma. The congenital polyp of children and young adults is probably a malformation, a hamartoma rather than a true neoplasm, and should not therefore be regarded as precancerous. These polyps are not directly related, as far as we are aware, to any of the forms of familial intestinal polyposis mentioned in your article.

There is also considerable histological evidence that the polyps in the Peutz-Jeghers syndrome are malformations or hamartomas rather than true neoplasms, which would account for the very low risk of carcinoma in patients with this disease. The polyps are composed of well-differentiated epithelium covering a stroma composed of smooth muscle, which probably represents a malformation of the muscularis mucosae. The appearances are quite unlike those seen in adenomatous proliferation. Personally I do not think there is yet sufficient evidence for regarding Peutz-Jeghers polyps as a precancerous lesion. Apart from the risk of malignancy being very low, the histological transition from an obviously benign appearance through the changes of "carcinoma *in situ*" to frank invasion of adjacent tissues has not been demonstrated.—I am, etc.,

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BASIL MORSON.

Intestinal Fat-absorption

SIR,—We read with interest the article by Mr. W. F. Walker, Dr. W. K. Stewart, Dr. H. G. Morgan, and Mr. J. McKie (May 7, p. 1403) on intestinal fat-absorption, in which they suggest a rapid screening-test based on the urinary excretion of ^{131}I in the first 24 hours after ingestion of radioactive fat. For nearly four years, this department has routinely employed the radioactive fat-absorption test as described by Lubran and Pearson¹ and Veall and Vetter,² which depends on faecal collections. In our preliminary studies on patients and controls both faecal and urinary collections were made. The results are shown in the Table and it will be seen that one patient with marked malabsorption of fat excreted a small percentage (10%) of radioactive ^{131}I in the urine in the first 24 hours, two patients with normal absorption excreted less than 30% of the radioactive ^{131}I in the urine in the first 24 hours, and two patients with equivocal results (6.7 and 7.8% in the faeces) and one with a normal faecal excretion excreted less than 50% in the urine in the first 24 hours. Another patient with an equivocal result (6% in the faeces) excreted 65% in the urine. In view of these results the