

colleagues and of the Law. Nevertheless, in the eyes of the medical profession as a whole the prestige of the specialty is not everywhere as high as it ought to be. This is not, as some believe, an emotional matter of minor importance, but one that adversely affects recruitment and thus is a matter for public concern. We believe that the very existence of a college of anaesthetists would influence this situation.

A college is of importance to anaesthetists. Those academically inclined will turn to it for support and guidance in the furtherance of education and research at all levels. Consultants will see their problems of maintaining a high standard of anaesthetic service to the community receiving the attention they deserve. Many work in circumstances of intolerable strain in which only their devotion and skill are effective in limiting what might otherwise be a serious level of morbidity and mortality. Trainees, general practitioners, and medical students will all detect the changed climate in anaesthesia and will look on anaesthesia as a career with new interest. Those who become part of the college will have the satisfaction of knowing that they are helping to build their own physical and professional home.

The Royal College of Surgeons has encouraged our development for 25 years and our debt to it will never be forgotten. However, the specialty of anaesthesia is now large enough and vigorous enough to stand by, and to speak for, itself.—We are, etc.,

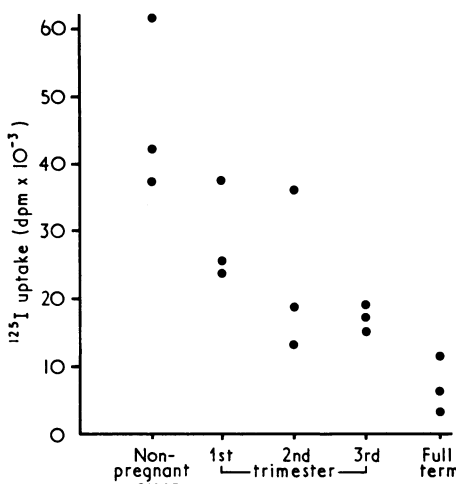
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### Lymphocyte Reactivity in Pregnancy

SIR,—We were interested to read that Dr. Ronald Finn and others suggest in their paper (15 July, p. 150) that phytohaemagglutinin-induced lymphocyte transformation is reduced during pregnancy. Their results obtained using a morphological assay were supported by *in vivo* tuberculin testing, and they apparently confirmed the results reported by Purtilo, Hallgren, and Yunis<sup>1</sup> who used <sup>3</sup>H-thymidine uptake to measure lymphocyte transformation.

In this laboratory lymphocyte reactivity to phytohaemagglutinin (PHA) is assessed by measuring the rate of <sup>125</sup>I-5-iodo 2'-deoxyuridine (<sup>125</sup>IUDR) uptake into DNA. We have found that the serum of pregnant women frequently reduced the phytohaemagglutinin response of washed lymphocytes obtained from normal healthy donors when compared with normal human serum. Moreover, the inhibitory effect increases as pregnancy progresses and reaches a maximum at term (see Fig.). Maximum inhibition was observed at phytohaemagglutinin concentrations of 5-7 µg/ml culture, while at higher concentrations of phytohaemagglutinin (more than 15 µg/ml culture) the inhibition was overcome. Inhibition of lymphocyte reactivity by serum taken from mothers at the time of childbirth has been observed in one-way mixed leucocyte, vaccinia, and phytohaemagglutinin cultures.<sup>2</sup>

Non-specific serum inhibition of the phytohaemagglutinin response has been widely reported and in some cases the inhibitory substance has been identified—for example, an α globulin fraction in normal human serum.<sup>3</sup> In pregnancy the increasing levels of circulating oestrogen and proges-



Effect of pregnancy sera on the PHA response. Cultures contained 0.57 x 10<sup>6</sup> TC199 washed lymphocytes from a normal healthy donor (group 0), 2 ml of medium (TC199/20% serum), and 7 µg/ml PHA (Difco PHA-P, control 551099). After 67 hr incubation at 37° <sup>125</sup>IUDR (2.1 x 10<sup>3</sup> mg) was added in a 1 hr pulse period. Control responses (no PHA added) were subtracted.

terone may result in an impaired phytohaemagglutinin response.<sup>4</sup> Another possible inhibitory substance is α fetoprotein which also occurs with increasing concentration in maternal serum as pregnancy progresses.<sup>5</sup> It would be interesting to know whether the cases with greatest reduction of phytohaemagglutinin response in Dr. Finn's study were from the later stages of pregnancy.—We are, etc.,

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- Cooperband, S. R., Davis, R. C., Schmid, K., and Mannick, J. A., *Transplantation Proceedings*, (1969), 1, 516.
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### Cataracts after Renal Transplantation

SIR,—Though Mr. R. Porter and others (15 July, p. 133) incriminate only steroids in the causation of posterior subcapsular cataracts after renal transplantation it appears from their data that cyclophosphamide administration could also be associated with this complication. Unfortunately we are not clear what statistical analysis they employed in coming to their conclusion.

In respect of cyclophosphamide treatment our understanding of their data could be summarized as shown in the Table.

	With Cataract	Without Cataract	Total
Treated with cyclophosphamide	7	2	9
Not given cyclophosphamide	2	28	30
Total	9	30	39

An exact test on this 2x2 contingency Table shows the probability of there being no relation between cyclophosphamide administration and the development of cataracts to be less than 0.0001. So it appears that cyclophosphamide should not be entirely exculpated in this regard.—We are, etc.,

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### Contact Eczema in Agricultural Workers

SIR,—Within the past year we have seen five patients who developed a severe contact eczema while handling commercially prepared animal feeding meals. Three of the patients were male and two female. We believe that the allergen was quinoxaline dioxide which had been added to the meals as a growth factor. In all our patients pig farming, particularly the breeding and rearing of piglets, was the principal work carried on. The rash was maximal in, but not restricted to, light exposed areas. The lesions had a rather dry appearance and there was a tendency for fissuring to develop easily.

We carried out patch tests with samples of meal, both containing and not containing quinoxaline dioxide, also with quinoxaline dioxide 0.5% in white soft paraffin and copper sulphate 0.5% in aqueous solution. The test with copper sulphate was included as many of the meals were labelled to contain additional copper as well as quinoxaline dioxide. The concentration of copper was of the order of 100 to 200 p.p.m., according to the labels. The concentration of quinoxaline was of the order of 20 to 50 p.p.m. Our choice of concentration for patch-testing was empirical, but was made bearing in mind that preliminary tests with samples of meal had given negative or doubtful results. We therefore assumed that a much higher concentration of the allergen in question would be required to detect sensitivity by patch-testing than was necessary to produce clinical eczema, as is known to be the case, for example, with neomycin and dichromate sensitivity. Standard and photo patch tests were carried out on each patient. The standard patch tests were left in place for 48 hours, then removed, read at once and again at 72 hours. The photo patch tests were removed after 24 hours and the sites irradiated with a predetermined dose of ultraviolet light (approximately half the minimal erythema dose), using a mercury vapour arc lamp. Readings were made at 48 and 72 hours after application.

Two patients showed faintly positive results with meal containing quinoxaline dioxide. The results were slightly stronger with the photo patch tests than with the standard patch tests. In the other three patients testing with samples of meal gave negative or doubtful results. A very strong positive result was obtained with all the 0.5% quinoxaline dioxide patch tests. The results were again rather stronger with the photo patch tests than with the standard tests. In one patient the standard patch tests were all negative immediately on removal, but several hours later a strong positive result developed at the site of the 0.5%