a gastrojejunal rather than a gastroduodenal anastomosis, since the former may create a blind loop and shunts food directly into the proximal jejunum. Occasionally gross diarrhoea, steatorrhoea, and loss of weight follow inadvertent anastomosis between the stomach remnant and the terminal ileum in mistake for the proximal jejunum, or result from the development of a gastro-jejuno-colic fistula.

Most patients after a partial gastrectomy complain of a sensation of fullness during meals and an inability to eat as much as other members in the family. In many cases these troubles clear up completely, but some patients continue to complain of them. They are apparently a consequence of the small gastric reservoir and are particularly likely to occur when a high resection of the stomach has been carried out. It would seem that the single most important cause of failure to regain or maintain weight after gastrectomy is diminished food intake. Indeed, I. D. A. Johnston and colleagues showed that if the patient can be persuaded to eat sufficient food his weight will increase. They estimated in a group of patients who were below weight after gastrectomy that reduction in food intake had provided almost a quarter less calories than was theoretically necessary to maintain normal weight.

A recent paper by H. S. Hillman, from Prince Henry's Hospital, Melbourne, provides a detailed study of 30 patients who had undergone partial gastrectomy for peptic ulcer a year or more previously and who were 6 kg. (13 lb.) or more below the usual preoperative weight. Twenty-eight had undergone Polya partial gastrectomy and two a Billroth I procedure, but this could merely be a reflection of the popularity of the former operation. There was often an appreciable delay of many months or even years before loss of weight became apparent. Associated with this weight loss was an invariably increase in faecal fat, though only 14 of the patients had diarrhoea. Fourteen patients had a haemoglobin level below 13-5 g. per 100 ml. and three of them were below 10 g. per 100 ml. An inquiry into the diet taken showed that 14 had a poor diet and four a very poor one. Twelve of the patients had what was considered an adequate intake. The constant presence of steatorrhoea suggested that pancreatic insufficiency could be a constant factor, and a therapeutic trial with pancreatic enzyme was carried out. All patients gained some weight, the range being 0-2 to 22-2 kg. and the mean weight gain 6-73 kg. Faecal fat follow-up estimations were carried out on 23 of the patients, and 20 showed a reduction in the degree of steatorrhoea ranging from 18.8 to 98.8%.

As a result of this study Hillman considers that both dietary deficiency and defective absorption played a part in the loss of weight of these patients.

Other well-recognized causes must always be borne in mind, and indeed among these 30 patients one had evidence of intestinal stasis and another subsequently developed a gastrocolic fistula. Hillman considers that pancreatic disease rather than merely disturbed function of poor mixing was the basis of the pancreatic insufficiency, and evidence of intestinal malabsorption was absent in most cases. Among factors which may predispose to the development of pancreatitis or pancreatic atrophy after gastrectomy are direct trauma to the pancreas at the time of surgery, interference with its blood supply, and an increased tendency to duodenal reflux and disuse atrophy owing to the loss of the gastric stimulus to pancreatic secretion. Alcohol was thought to be aggravating the symptoms in four of the cases.

### Pregnancy Prurigo

Many of the common dermatoses, such as psoriasis, acne, and alopecia areata, are influenced by pregnancy, either for better or worse, but in a somewhat capricious and unpredictable way. Moreover, several rashes are more specifically associated with pregnancy. None of these can yet be explained in terms of the known hormonal, metabolic, or immunological changes associated with pregnancy, so that distinction between them must be purely descriptive. Patients may suffer from pruritus, prurigo, urticaria, erythema multiforme, and less commonly the distinctive papular eruption described by A. S. Spangler and colleagues, the bullous eruption usually called herpes gestationis, and the very rare pustular eruption impetigo herpetiformis. Often cases show mixed features and cannot readily be assigned to these groups.

Apart from simple pruritus, which is common, prurigo is the commonest of these rashes of pregnancy, occurring in 2–3% of all pregnancies. The term prurigo has no uniformly accepted definition and probably includes more than one pathological process. It is used to describe the clinical picture of tiny (1–2 mm.) intensely itchy papules. Such lesions are always quickly excoriated, but it is probable that small inflammatory lesions do precede the scratching.

D. S. Nurse has recently studied 40 cases of pregnancy prurigo. Onset is usually in the middle trimester of pregnancy or later, with irritable lesions on the proximal parts of the limbs and upper part of the trunk. A different pattern may be seen in the last week or two of pregnancy, when itching of abdominal striae and an irritable rash spreading on to the rest of the trunk may occur. The eruption can cause considerable discomfort, sometimes for several weeks, but usually improves spontaneously before term or rapidly after delivery. The rash may recur in subsequent pregnancies but far less regularly than with the papular dermatitis of pregnancy or the bullous eruptions. When recurrences do occur they are usually in the same form. In other rashes of pregnancy the pattern may sometimes differ with subsequent pregnancies—for example, erythema multiforme succeeded by herpes gestationis. Pregnancy rashes may recur in a minor form when contraceptive pills are taken.

Perhaps the most important question is whether there is an association with some abnormality of the pregnancy itself. In pregnancy prurigo Nurse was unable to find evidence of an increase in toxemia, foetal mortality, or other complications, and few reported series have contained enough unsolicited cases from which to draw valid conclusions, though G. Bourne found a high incidence of abnormality, including especially postmaturity. Though pre-eclamptic toxemia may be associated with the prurigo it seems best at present to consider the two processes as not directly related. A
higher incidence of complications of pregnancy is associated with the less common and more severe eruptions—for example, herpes gestationis and the papular dermatitis of pregnancy.¹

Differential diagnosis must include scabies and, perhaps even more difficult, infestations with other mites which are not able to burrow in human skin, such as those derived from pets. The problem of sensitivity to a drug has always to be considered, but drugs seldom cause prurigo. They are more likely to confuse the diagnosis in cases of urticaria and erythematous eruption. Omission of possible offenders may then be the only way to reach a diagnosis.

Fortunately most pregnancy prurigo can be adequately controlled by simple measures like rest, administration of trimeprazine or sedatives by mouth, and the application of calamine or oily calamine lotion. A steroid cream should be used when there are superimposed eczematous changes. Progesterone (norethisterone 10 mg. twice a day) has helped some cases.² Systemic corticosteroids are only seldom required for the treatment of prurigo in contrast to herpes gestationis and the papular dermatitis of pregnancy. In these conditions they are commonly needed and are effective in palliating the symptoms and reducing the increased hazards to mother and foetus.

**Gynaecomastia in Chronic Renal Failure**

The prolongation of life by regular haemodialysis of patients with end-stage renal failure has resulted in changes in the natural history of many of the complications of uraemia. One example is gynaecomastia. It has been recorded in only a few patients with chronic renal failure untreated by dialysis,¹ but, as recent reports show,³ affects a large proportion of patients on regular dialysis treatment.

Enlargement of the breasts is usually bilateral, often tender, and ranges from minor to "impressive." The onset is usually one to two months after the start of dialysis, and spontaneous regression occurs in most cases within a year. Histological confirmation of true gynaecomastia has been obtained in patients at necropsy.

The aetiology is uncertain, but among possible causes of gynaecomastia which may be eliminated are digitalis and methyldopa administration, neither of which has been common to all affected patients, and liver dysfunction, which is usually minimal or absent. Gynaecomastia may complicate prolonged malnutrition, but its development has also been observed after the resumption of an adequate diet by previously malnourished patients.⁴ The somewhat similar nutritional state of patients with chronic renal failure, whose appetite has been restored by dialysis and their protein intake improved, suggests that their gynaecomastia may be of the "reefeeding" type. In patients with malnutrition pituitary and gonadal function is suppressed. Feeding them up results in rapid recovery, with an increase in the excretion of gonadotrophin and oestrogen to a rate temporarily greater than normal—a situation akin to normal puberty, in which transient gynaecomastia frequently occurs. Some support for the suggestion that a similar hormonal mechanism may be the cause of the gynaecomastia of patients on dialysis is provided by the observation that libido returns in some of them at about the time that the gynaecomastia develops⁵ and by their reasonably normal testicular interstitial cells.⁶ Endocrinological investigation of these patients has been impeded by their inadequate renal function, but the application of recently developed methods for the assay of pituitary and gonadal hormones in plasma⁷ ⁸ would be likely to elucidate this and the other endocrine problems of patients on regular dialysis treatment.

**Proper Information**

Professor Keith Simpson has attacked the *BMJ*. for publishing an advertisement for a nursing-home which stated it was registered under the Abortion Act. He is reported (p. 437) as saying that this was "a disgraceful advertisement" which the journal should "be called to answer for."

The *BMJ*. is a medical journal for medical readers, and advertisements are one of the ways in which a journal conveys information to its readers. Nursing-homes are places where doctors practise, and therefore information about their availability and the facilities they provide is of proper interest to medical readers of a medical journal. The Abortion Act 1967 requires that private premises used for therapeutic abortion must be approved by the Health Ministers. Doctors are entitled to be informed in an advertisement for a nursing-home that it is one in which they may treat or arrange for the treatment of a patient who needs an abortion under the provisions of the Act.

People may express opinions about legalized abortion and about the way the Act is being interpreted. The *BMJ*. has itself commented on the matter.¹ An editor has a duty to check the accuracy of advertisements he publishes, but neither we nor Professor Simpson have a duty to censor, or to urge the censorship of, information of legitimate interest to doctors. We hope that, on reflection, Professor Simpson will modify his views on the *BMJ*.s action.

¹ *Br. med. J.*, 1969, 1, 199.