Parents for the Parentless

The Adoption of Children Act 1926 introduced the idea of adoption as a process “confering the privileges of parents upon the childless and the advantages of having parents upon the parentless”1. As a description of adoption today it is only partially true, because there are people who want not because they are childless but from a sense of social responsibility and concern for deprived children. Indeed, adoption is one method of providing substitute parents for children whose natural parents are unable or unwilling to look after them, and it should be part of a comprehensive social service.

In England and Wales 23,803 adoption orders were registered in 1969,2 the last year for which official figures are available. Many but not all the children were infants, and approximately 35% of them were adopted by one or both biological parents. Evidence3 from children's departments and voluntary societies shows that adoption placements continued to rise until 1967, but there was a fall of 15% in the following two years. It is reasonable to suppose that the Abortion Act and increasing contraceptive advice to single girls have had more effect on those who would have offered their babies for adoption than on other unmarried mothers. Nevertheless, there will be a continuing need for adoption in the foreseeable future.

In July 1969 the Home Secretary and the Secretary of State for Scotland appointed a departmental committee under the chairmanship of Sir William Houghton to consider law, policy, and procedure on adoption. Its medical members are Dr. Christine Cooper, who is the secretary of the Medical Group of the Association of British Adoption Agencies, and Dr. F. H. Stone, a consultant child psychiatrist with wide experience of medical work in adoption. Recently the committee published a working paper4 containing its provisional proposals for comment and criticism. The basis of their recommendations is that in adoption law the long-term welfare of the child should be the first and paramount consideration.

The Houghton Committee has noted that “there are changes in the pattern of adoption, with fewer healthy babies and more children with special needs requiring placement.” Theoretically any child has the right to adoption, no matter how handicapped he or she may be. In practice most would agree that adoption is rarely suitable if the child is mentally subnormal or has a disease that is likely to lead to early death. Whether or not it is advisable for any particular infant with a disability or the risk of one to be placed with prospective adopters is a matter for informed judgement of the whole situation and should not be determined by arbitrary rules. It is not the function of doctors to say that any child is “passed” or is “not passed” but rather to make the most accurate health prognosis possible and to relate this to the offer of the adopters. The objectives of the adoption medical examination of the infant have been rightly summarized5 as being “to ensure his medical welfare, to give some protection to adoptive parents against being misled about the probable health of an infant whom they are considering for adoption, and to give adoptive parents any medical advice necessary about a child whom they propose to adopt.”

A suggestion in the committee’s report is that legal criteria of eligibility should be distinguished from professional assessment of suitability to adopt and in particular that professional judgements should not be fettered by precise legal criteria such as the present minimum age limits. Many doctors will have reservations about removing these safeguards, particularly in view of the present inadequacies of the social services. There is a firm recommendation that independent placements for adoption by non-relatives should not be allowed, and the report deprecates in addition the adoption of his or her own child by a natural parent. It envisages an extension of custody under the Guardianship of Infants Acts to provide legal recognition and security for their relationship to the child.

A new procedure for mothers to give consent for adoption is proposed, and it would enable them to relinquish parental rights and duties at a separate court hearing, often though not necessarily before the child has been offered to adopters. This should help to eliminate the distress caused by mothers changing their minds after their babies have been placed with adopters, though placement before final consent will remain possible. An interesting suggestion is that “family courts” dealing with adoption should have discretionary power to appoint doctors and other qualified people either to inquire into cases and report back to the court or to advise and assist the court as expert assessors of information before it.

The working paper affirms the necessity of a comprehensive medical examination of the adopters and of the baby before placement and again subsequently for the purpose of the adoption application to the court. It makes the welcome suggestion that there should be full medical examinations before applications to adopt by relatives and foster parents. The medical group of the Association of British Adoption Agencies has recently published6 inquiry and examination forms which, if widely used, will help towards establishing good standards of medical examination in adoption practice.

Collagenous Sprue

In temperate regions the commonest cause of malabsorption in conjunction with a flat intestinal mucosa lacking villi is coeliac disease.1 The definition and diagnosis of this disease depends on proof of its association with gluten, and it is treated by exclusion of this cereal protein from the diet.2

However, some patients fail to improve on a gluten-free diet, and the failure rate may be as high as 30%.3,4 This is in contrast to children with coeliac disease, nearly all of whom respond to the diet. Failure to improve may be due to failure to adhere to the diet, or it may indicate a faulty diagnosis owing to misinterpretation of the biopsy. Occasionally therapeutic failures may be due to the presence of a second disorder, such as pancreatic insufficiency, or to a complication of coeliac disease, such as lymphoma or intestinal ulceration.5 6

Many patients with coeliac disease commit dietary indiscretions, but luckily there are wide variations in gluten sensitivity from patient to patient, and many suffer no clinical effects. If a patient fails to respond to exclusion of gluten from the diet, and careful review of the diet discloses no obvious intake of it, he should be admitted to hospital so that the diet can be more carefully controlled. If there is still no response, failure may be due to minor indiscretions by a person very sensitive to gluten, or the patient may have another disease.

W. M. Weinstein and colleagues10 recently described a middle-aged man with malabsorption and a flat jejunal mucosa on biopsy who progressively deteriorated in spite of all treatment and died 42 months after the onset of symptoms. Serial intestinal biopsies showed amorphous hyaline eosinophilic material, identified as collagen, in the lamina propria immediately below the enterocytes. This collagen was not present initially but began to appear in the twentieth month of the illness and was first recognized as such in the thirty-fifth month. They called the condition collagenous sprue.

Does progressively worsening malabsorption unresponsive to a gluten-free diet and associated with subepithelial fibrosis represent a new syndrome? Most authorities now accept that a flat mucosa on biopsy (subtotal villous atrophy) is not confined to coeliac disease and that a convoluted mucosa (partial villous atrophy) has an even wider range of possible causes.11 12 As study of the small intestine becomes more fashionable, new causes of villous atrophy will be described. A recent example is the report from Singapore of a case of subtotal villous atrophy secondary to pulmonary and intestinal tuberculosis, with mucosal recovery as a result of chemotherapy.13 Are the collagen deposits specific? Hyaline eosinophilic material with some of the staining properties of collagen was first described at necropsy in two cases of refractory malabsorption.14 After the advent of jejunal biopsy D. O'B. Hourihan15 noted foci of subepithelial collagen in 35% of biopsies, and it was a prominent feature in his one fatal case. Moreover, W. T. Cooke and colleagues1 reported similar material in 42% of their biopsies, though it was not identified as collagen. It therefore appears that eosinophilic deposits are frequent and non-specific.

But their presence has recently been emphasized in three unusual cases of malabsorption. The first patient initially responded to exclusion of gluten from the diet but relapsed after taking a gluten-containing preparation and thereafter ran a downhill course complicated by vasculitis and cryoglobulinemia.16 The second patient also had vasculitis and failed to respond to a gluten-free diet until steroid therapy was introduced.17 The third patient had a fatal malabsorption syndrome, though differing from the other two because certain features militated against the diagnosis of coeliac disease, but the issue wasclouded because she had been on a gluten-free diet for some months. Her jejunal biopsy showed diminution of overall mucosal thickness, the enterocytes were normal, and the rate of loss of enterocytes into the intestinal lumen was diminished.18

Collagenous sprue may therefore turn out to be a mixed collection of diseases rather than a single entity, and this and other problems may be better understood by the application of an elegant new in vitro technique. Dividing cells may be labelled by tritiated thymidine, which is incorporated into DNA. Once the cell has matured, the label remains unchanged for the rest of its life, and its progress can be followed by autoradiography. Attempts to label the enterocytes of human jejunal biopsies in this way have failed in the past owing to difficulties in tissue culture techniques, but J. S. Trier and T. H. Browning19 have succeeded in maintaining the cells in good condition for up to 24 hours. In cases of untreated coeliac disease they found increased numbers of labelled nuclei in the crypt of enterocytes, and they showed that a column of labelled cells spread up more rapidly from the base of the crypt to the tip of the villus than in healthy tissue and had usually reached the villous surface by 24 hours. This confirms earlier indirect studies which had suggested that the mucosa is hyperactive in coeliac disease, with acceleration of both cell proliferation and migration. A hyperactive mucosa would suggest an alternative diagnosis. Moreover, the enterocytes became histologically normal within 24 hours, as they had been cultured in a gluten-free medium. However, this rapid improvement was not reflected in the biopsy specimens from patients who had been on a gluten-free diet for 6 to 12 weeks, since the rates of proliferation and migration of the enterocytes had not yet returned to normal.

Is there any practical advantage in diagnosing collagenous sprue? When a patient fails to respond to a strict gluten-free diet further treatment should be tried in addition to the correction of any nutritional deficiency. The following measures have been beneficial on occasions: steroids, broad-spectrum antibiotics, milk-free diet, low-fat diet, pancreatic enzymes, folic acid, and vitamin B12. Serial jejunal biopsies may disclose the evolution of a new or specific histological lesion, but for the moment the finding of subepithelial collagen can do no more than suggest a poor prognosis, though even this is not certain.

5 Shiner, M., American Journal of Digestive Diseases, 1963, 8, 969.