Vaginal Cytological Findings in Pregnancy in the Mothers of Three Anencephalic Babies

<table>
<thead>
<tr>
<th>Case No.</th>
<th>E.I.</th>
<th>K.I.</th>
<th>Vaginal Flora</th>
<th>Clumping</th>
<th>Other Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Just above normal</td>
<td>High</td>
<td>Variable</td>
<td>Occasional parabasal cells</td>
<td>Occasional parabasal cells</td>
</tr>
<tr>
<td>2</td>
<td>Just above normal</td>
<td>High</td>
<td>Moderate to severe</td>
<td>Occasional parabasal cells</td>
<td>Nil</td>
</tr>
<tr>
<td>3</td>
<td>Variable; mainly normal</td>
<td>Variable but high (up to 40%) in 3rd trimester</td>
<td>Variable</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

E.I. = eosinophilic index
K.I. = karyopyknotic index

was having difficulties in accepting the diagnosis, and karyotyping of mother and baby was deferred. MacNaughton reviewed the evidence that mothers of such babies may have an abnormal steroid metabolism. An increased output of dehydroepiandrosterone has been reported in young mothers of mongoloid children but this has been questioned by others who doubt the possibility that the differences present are due to translocations being present in only some of the mothers while others have a normal karyotype.

The presence of non-specific, unexplained, persistently abnormal hormonal cytological patterns in pregnancy in groups at risk may alert the clinician to the possibility of certain congenital defects being present and indicate the necessity for further investigations.

I would like to acknowledge the encouragement of Dr. W. L. C. Langley and a research grant from the United Manchester Hospital.

D. K. SEN
Department of Obstetrics and Gynaecology, University Hospital, Kuala Lumpur, Malaysia


Can I Have an Ambulance, Doctor?

Str.—The article by Dr. T. C. Beer and others (9 February, p. 226) provides some very disturbing facts, not so much about the use of the ambulance service but about physiotherapy. What it reveals is that a treatment centre attached to one of the most modern hospitals in the country provides such a low level of treatment that the author’s comments about the effectiveness of outpatient physiotherapy are almost bound to be correct. The last sentence is really the important one: “Doctors ordering [physiotherapy] should remember that it may be merely a potentially socially disruptive placebo.”

The facts revealed in the article showed that 75% of the patients treated were receiving no more than one hour of physiotherapy per week. I find it incredible, at a time when rehabilitation services are being reassessed and recommendations made, that the Implementing the Tunicbridge Committee report and when consultants in rehabilitation are being appointed, that such a very low level of treatment with a modern rehabilitation centre which treats patients on a full-time basis—that is, the patients attend for a 57-hour working week and treatment is devoted to active exercise or effective forms of physiotherapy and recovery time is reduced to an absolute minimum thereby.

I wonder if this article is in fact illustrating a norm for patient after-care because, if it is, no wonder the rehabilitation services are in such urgent need of reappraisal and reorganization. I am, etc.

D. E. FORD
Medical Rehabilitation Centre, London N.W.1

High-dose Frusemide in Renal Failure

Str.—With reference to the paper by Professor F. Cantarovich and others (24 November 1973, p. 449) and the subsequent letter from Dr. D. Ganeval and his colleagues (9 February, p. 244) I should like to report my experience of the use of high-dose frusemide in the treatment of acute tubular necrosis and exacerbations of chronic renal failure.

In my series 10 patients were treated with frusemide, initially 1g intravenously and rising gradually to 3g over a period of seven days if no response was obtained; a control group of 10 patients were treated conventionally, without frusemide. The patients were allocated to the two groups at random and were evenly matched for age and diagnosis.

I found that in the group treated with frusemide the period of oliguria was shorter and the diuresis was greater than in the controls, so fluid retention was not a problem; there was no life-threatening hyperkalaemia and the patients were discharged earlier (mean seven days). The most practical factor was that in the control group seven patients required peritoneal dialysis, while in the group receiving high-dose frusemide only one patient required peritoneal dialysis. I am, etc.

S. KARAYANNOPoulos
Renal Unit, Firaion General Hospital, Piraeus, Greece

Str.—I have read with interest the paper by Professor F. Cantarovich and others (24 May 1974, p. 278).