Diagnosis of Toxoplasmosis

Dr. H. J. A. Longmore illustrates (12 April, p. 94) the frequency with which clinical toxoplasmosis may be diagnosed in general practice when the appropriate serological tests are carried out. He also unintentionally illustrates one of the pitfalls in making a diagnosis. His second case, in a newborn infant, appears to have been diagnosed as one of congenital toxoplasmosis on the strength of a dye-test result of 1/512. However, in 23 cases of proved congenital toxoplasmosis shortly to be published we observed that the titre was 1/1024 and the titres in most cases did distinctly higher than the geometric mean for all cases (1/790). These findings were similar to those of other workers. Supporting our doubt about the diagnosis is the negative dye test at 18 months. Though the dye-test result might be expected to fall over a period of years, perhaps encouraged by the early use of specific chemotherapy, we have never encountered a case becoming serologically negative in this way, nor to our knowledge has it been reported in the literature.

Now that a test for specific toxoplasma IgM antibody is becoming increasingly available it would be rash to diagnose toxoplasmosis in the newborn without this test giving a satisfactory positive result. The test can also be useful in suspected acquired cases, particularly where the dye-test titre is rather lower. In such a case a negative IgM test is evidence against the current illness being due to toxoplasmosis. Our rather brief experience on this has been that titres of 1/256 in current illnesses are usually accompanied by a negative or very weak IgM test, indicating that the dye-test titre is probably due to a past infection rather than the one in question.

Toxaemia of Pregnancy and Plasma Prolactin

SIR,—Dr. C. W. G. Redman and his colleagues (8 February, p. 304) have clearly demonstrated that among hypertensive women in the third trimester of pregnancy those with rising plasma urate levels had elevated plasma prolactin.

We have examined prolactin levels in hypertensive women (blood pressure (>130/90 mm Hg) between 32 and 40 weeks pregnant) who had not been taking any medication apart from oestrogen. None of the patients were taking hypotensive drugs; nearly all were having small doses of barbiturates, diazepam, or nitrazepam. The findings were compared with those in normotensive women having antenatal rest and similar sedatives for other reasons. Blood was taken at 09.00 hours from resting patients. Serum prolactin was measured by the double antibody radioimmunoassay, with 1/512 Trasylol (Friesen) as standard, prolactin VLS No. 1 (N.I.H.) for labelling, and rabbit antiserum 65-5 (Friesen).

There was a considerable between-patient variation, serum prolactin ranging from 48 to 273 μg/l, but values for an individual patient were relatively consistent (S.D. ± 33 μg/l) and showed no trend between 32 and 40 weeks. The mean prolactin levels were: normotensive, 174 ± 45 μg/l (five patients); hypertensive, 176 ± 16 μg/l (12 patients). The standard errors cited represent between-patient variation; the difference between the two groups was not significant.