IgA levels remain high in DH patients regardless of diet. We have also found that IgA synthesis in organ cultures of jejunal mucosa in DH patients may be reduced but is not absent (unpublished observations). It is perhaps unfortunate that the published photomicrograph of jejunal mucosa following gluten withdrawal shows very little of the lamina propria, making it difficult to compare the number of IgA-containing cells with the "pretreatment" section.

The findings imply that the three patients have selective mucosal IgA deficiency without deficiency of the circulating IgA and that this defect is only revealed following withdrawal of gluten from the diet. While it is well recognised that the numbers of the IgA-containing cells in the mucosa may be influenced by antigenic stimulation, I am not aware of any previous reports that mucosal IgA cells disappear following withdrawal of one only of the multitude of antigens which assail the intestinal surface.

In view of the troublesome problems of non-specific staining and autofluorescence of non-lymphoid cells, especially eosinophils, in studies of intestinal mucosa I feel that the present observations, although intriguing, should be interpreted with some caution.

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¹ McClelland, D B L, *et al*, *Lancet*, 1972, **2**, 1108.
² Lancaster-Smith, M, *et al*, *Gut*, 1974, **15**, 371.

Amniotic fluid AFP in multiple pregnancy

SIR,—We share the concern of Dr A T Letchworth and his colleagues (12 March, p 689) on the interpretation of amniotic fluid alpha-fetoprotein (AFP) levels in multiple pregnancy. The possible confusion arising from maternal serum AFP screening when the levels are known to be raised will be clarified sooner if values of amniotic fluid AFP in twin pregnancy can be established. When multiple pregnancy is diagnosed before planned amniocentesis it is unusual to proceed unless the risk is exceptionally high. Hence information about values in uncomplicated pregnancy is hard to obtain.

In about 2000 amniotic fluid samples derived from mid-trimester diagnostic amniocenteses over the past three years we have encountered samples for nine multiple pregnancies. With the exception of two cases all

AFP values were within normal limits as defined for singleton pregnancies (see table). In case 3 and case 8, the sac of the unaffected fetus showed an AFP level which exceeded the mean +2 log SD limit, but did not reach the +4 log SD discriminant value. This modest elevation of AFP can be presumed to have arisen by diffusion from the anencephalic twin.

It is likely that in the patient reported by Dr Letchworth and his colleagues there was actual or impending fetal death before the amniocentesis and, as in our patients with an anencephalic fetus, high levels were obtained in the other sac. There seems no evidence as yet that twins per se cause higher liquor levels of AFP, but further information on this point is required.

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Lumbar disc surgery

SIR,—I was interested to read Mr Arthur Naylor's paper on the surgical treatment of lumbar disc protrusion (26 February, p 567) and Mr Roger Austin's subsequent letter (19 March, p 778) concerning postlaminectomy backache.

In patients whose dominant symptom is backache a less widely practised surgical procedure for degenerate lumbar disc lesions is that of anterior excision of the disc and interbody fusion, and this may be done via a transperitoneal¹ or a retroperitoneal approach,² the latter being technically less difficult.

Excellent symptomatic relief is reported by these authors, but there is as yet no certain evidence that the anterior approach is superior to the posterior approach with fusion in the long term. Anterior disc excision and fusion may be a useful salvage procedure in some patients with persistent backache following previous posterior surgery.

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¹ Freebody, D, and Bendal, R D, *Journal of Bone and Joint Surgery*, 1971, **53B**, 617.
² Hodgson, A R, and Wong, S K, *Clinical Orthopaedics and Related Research*, 1968, **133**, 56.

Amoxycillin rash

SIR,—We have seen a typical "ampicillin rash" in a patient with a glandular fever-like illness for which he was prescribed amoxycillin.

A 48-year-old man while travelling abroad developed a sore throat, fever, and malaise, and was given amoxycillin. The day afterwards, on arriving in England, he developed a universal erythema. Examined a week later his throat was very red, he had minimal lymphadenopathy and splenomegaly, and his face was grotesque with swelling from the non-scaly, diffuse erythema. This was an obvious cutaneous vasculitis in the erythema multiforme pattern, purpuric in places, on the ankles and in the groins and subgluteal folds. There was a past history of some sort of eczema and his father also had dermatitis and asthma. The eruption faded over the next 10 days, scaling profusely.

Our conclusion is that just as ampicillin plus infectious mononucleosis syndrome equals a rash in nearly every case, the same equation may apply to amoxycillin.

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Induction of labour and perinatal mortality

SIR,—Dr P W Howie and his colleagues (9 April, p 974) accuse us of missing the central point of their article (5 February, p 347)—namely, "that the value of induction of labour cannot be assessed adequately from total perinatal mortality." The text of the original article and its summary both suggested that "increased use of induction of labour has contributed to the improved perinatal mortality rate" and this aspect seemed to us to be the one to discuss first, since our reading of their figures suggested that there was no improvement in perinatal mortality rates. If anything, an earlier falling trend had been interrupted during the years with high induction rates.

Concerning "causes," and assuming that steps were taken to avoid possible bias in classification, their figures certainly show an immediate and sustained fall in the death rate in the category "mature, cause unknown" from the year the induction rate went above 30%. This rate was 2.4 per 1000 in 1969 and 0.5 per 1000 in 1975. However, deaths categorised as "premature, cause unknown" were higher than in 1969 in four of the six subsequent years and those categorised as

Amniotic fluid AFP in multiple pregnancy

Case	Indication for amniocentesis	Gestation (weeks)	AFP concentration (mg/l)			Normal singleton AFP concentration (mg/l)		Karyotype	Outcome
			Sac 1	Sac 2	Sac 3	Median	+2 log SD		
1	Maternal age 40 years	17	32	—	—	15	33	46 XY	Normal binovular twins, 1 male, 1 female
2	Balanced translocation in one parent. Known multiple pregnancy	17	16	23	—	15	33	(1) Balanced translocation (2) Unbalanced translocation	Triplet pregnancy terminated
3	Hydramnios	24	81	27	—	7	14		(1) Anencephalic female (2) Normal male
4	Anencephalic twin suspected ultrasound								
5	Previous neural tube defect (NTD)	16	24	—	—	18	35		(1) Normal male (2) Papyraceous fetus
6	Family history of NTD	15	16	—	—	19	37		Normal binovular twins
7	Hydramnios	24	7	—	—	7	14		Normal binovular twins
8	Hydramnios	26	5	—	—	6	10		Normal binovular twins
9	Previous NTD	15	42	—	—	19	37		(1) Normal male (2) Anencephalic male
	Previous NTD	14	39	—	—	22	42		Normal binovular twins