I have recently cared for a 37-year-old patient in my practice, para 3+0, who had no antibodies at booking or in previous pregnancies. In this, her fourth pregnancy, she had an amniocentesis to exclude chromosomal abnormality, but no anti-D was given as the Kleihauer test was negative. At 32 weeks her anti-D titre was 1/512 and amniocentesis showed the bilirubin level to be in the severely affected category. The baby was delivered by caesarean section at 33 weeks but did well.

It has now become policy in Oxford to give anti-D to all rhesus-negative mothers having amniocenteses and to increase the dose if the Kleihauer test is positive. This policy is also recommended by the Department of Health and Social Security.¹

Amniocentesis is performed in early pregnancy to reduce the incidence of abnormal children. To cause an otherwise normal pregnancy to result in a handicapped child as a result of the test would be a tragedy. Anti-Rh(D) immunoglobulin is very effective and safe. It should surely be given in all cases, whether the Kleihauer test is positive or not.

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¹ Department of Health and Social Security, Standing Medical Advisory Committee, *Haemolytic Disease of the Newborn*, revised version, para 4.7. London, DHSS, 1976.

Vitamin B₁₂ for vegans

SIR,—Your expert errs in stating (11 June, p 1525) that "there are no measurable amounts of vitamin B₁₂ in any known plant." Seaweeds, including those growing round our shores, are good sources,^{1,2} about 100 g a day furnishing the daily requirement of the vitamin (as well as useful amounts of vitamins A and B₂ and arachidonic acid). The nodules on the roots of nitrogen-fixing plants are very rich sources of Vitamin B₁₂,³ although they are not usually eaten. Yeast from wine-making contains the vitamin, and a pint of cider may contain nearly 1 µg. Even vitamin D occurs, in water-soluble form, in some plants.

We would be happy to provide doctors and dietitians with our list of commonly available vegetarian and vegan sources of vitamin B₁₂.

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¹ Chapman, V J, *Seaweeds and their Uses*, 2nd edn. London, Methuen, 1970.

² FAO/US Department of Health, Education and Welfare, *Food Composition Tables for Use in East Asia*, 1972.

³ Blondeau, R, *Comptes Rendus Hebdomadaires des Séances de l'Académie des Sciences*, 1971, **272D**, 2781.

Tetracycline and toxoplasmosis

SIR,—Drs P L Grossman and J S Remington (25 June, p 1664) criticise our short report on toxoplasmosis (23 April, p 1064) because we did not give details of the oxytetracycline dosage used and because we ventured to suggest that one of the tetracyclines should be considered for the treatment of severe lymphadenopathic forms of toxoplasmosis.

In our article we were primarily concerned with the epidemiology and natural history of

the disease, but felt that the problems of treatment also deserved some attention. In the interests of brevity we omitted from our case descriptions whatever could be taken for granted. Thus the omission of all drug dosages clearly denoted that standard therapeutic doses were given. In the case of oxytetracycline the dosage was 500 mg four times a day. We prefer oxytetracycline to demethylchlorotetracycline (which was used in the experimental work we referred to) because the former is considerably less expensive and is less likely to cause gastric disturbance and photosensitisation. Nevertheless, possible differences in the activity of the various tetracyclines in human—as opposed to murine—toxoplasmosis should certainly be explored, as should the use of relatively large doses of these antibiotics.

We are not alone in our dissatisfaction with the standard treatment regimen, with or without corticosteroids.¹ We were therefore impressed by the rapid clinical improvement both with oxytetracycline used alone (but evidently for an inadequate length of time) and then when used for a longer period with prednisolone. This was in sharp contrast to the total lack of response in the two severely affected patients to a month's course of pyrimethamine and sulphadiazine, even though these drugs have proved so successful in murine toxoplasmosis.²

We were particularly interested in the probable source of infection in this small outbreak. The only communal meal eaten by the three affected men was also attended by four others who suffered no ill effects. This distribution was surprising but by no means unprecedented in infections due to ingested food. We have, however, subsequently elicited information on the varying degree of exposure to infection in the seven individuals. The unaffected four had already eaten well before the meat course and they ate only a small portion of inadequately grilled lamb on skewers. In contrast, the three men who developed primary toxoplasmosis eight days later had consumed large amounts of the meat and are assumed to have swallowed a relatively high infective dose of *Toxoplasma gondii*.

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¹ Beverley, J K A, *British Medical Journal*, 1973, **2**, 475.

² Eyles, D E, and Coleman, N, *Antibiotics and Chemotherapy*, 1955, **5**, 529.

Sclerosing peritonitis due to practolol

SIR,—Sclerosing peritonitis due to practolol therapy can present diagnostic difficulties and the excellent paper by Dr R P H Thompson and Mr B T Jackson (28 May, p 1393) is to be welcomed for recording the unfortunate fact that many cases are not diagnosed until laparotomy is performed. All six cases described by them had at least two laparotomies and one patient underwent six operations.

Dr Thompson and Mr Jackson do not say whether small-bowel barium studies were performed on their patients, but they do insist that they found radiology to be unhelpful. This has not been our experience at this hospital, where barium studies form part of the investigation of patients with subacute small-bowel obstruction.^{1,2} We have observed distinctive

radiological appearances in all the patients with symptoms due to practolol peritonitis whom we have examined. In two of our patients the disease was first suggested by the barium findings, and a past history of practolol therapy was elicited after the radiological investigation. There were no adverse effects due to barium examination.

In view of the poor results of unsuspecting laparotomy and the impaired cardiac status of many of these patients it is obviously important to make the diagnosis of sclerosing peritonitis before abdominal surgery. Small-bowel barium examination is indicated in patients with clinical evidence of practolol peritonitis to help confirm the diagnosis and to define its extent.

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¹ Lee, R E J, *et al*, *Clinical Radiology*, 1977, **28**, 119.

² Marshall, A J, *et al*, *Quarterly Journal of Medicine*, 1977, **46**, 135.

Solitary perforated diverticulum of ascending colon

SIR,—I would like to report an unusual case of perforated solitary diverticulum of the ascending colon.

A 29-year-old woman was admitted with a two weeks' history of epigastric pain, which later localised to the right iliac fossa. The clinical examination revealed an ill-defined, tender mass in the right lower abdomen with guarding. Rectal and pelvic examinations confirmed the presence of a mass in the right side of the abdomen, arising from the pelvis. She had had appendicectomy 10 years before this admission. The other relevant past history was that she had been having similar attacks of pain, though of less severe nature, for the past five years.

At laparotomy the pelvic viscera were normal. There was a hard, adherent mass in the ascending colon extending to the hepatic flexure upwards and to the pelvic downwards. An ulcer crater was felt in the centre of the mass. In view of the doubtful nature of the mass radical right hemicolectomy with end-to-end anastomosis was performed. Macroscopic and microscopic examinations established the diagnosis of perforated solitary diverticulum of the ascending colon with chronic pericolic abscess.

A review of the literature¹⁻³ revealed that perforated solitary diverticulum of the ascending colon is rare. The correct diagnosis is almost never made preoperatively. Even at laparotomy it is often difficult to recognise this abnormality; often malignancy is suspected, as in the above case. Although this is a rare clinical entity, surgeons should be aware of it so that major colonic resection is not needlessly undertaken.

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¹ Chughtai, S Q, and Ackerman, N B, *American Journal of Surgery*, 1974, **127**, 508.

² Wagner, D E, and Zollinger, R W, *Archives of Surgery*, 1961, **83**, 436.

³ William, K L, *British Journal of Surgery*, 1960, **47**, 351.

"Baby alarm" in hospital care of infants with pertussis

SIR,—With the controversy over pertussis immunisation causing a sharp decline in the numbers of infants immunised we may expect