Pregnancy after renal transplantation

SIR,—Mr M D Pickrell and others described a case in which pregnancy after renal transplantation and during treatment with cyclosporin resulted in severe intrauterine growth retardation (19 March, p 825).

We have observed six pregnancies in renal transplant patients receiving cyclosporin and cortisone. The age of the women ranged between 24 and 27 years. The interval between transplantation and pregnancy was nine to 16 months except in one case when it was six years. The patients received 200 to 460 mg (2.6 to 6.6 mg/kg) cyclosporin and 5 to 10 mg prednisolone daily. The trough median concentration of cyclosporin in the blood ranged from 218 (SD 116) to 336 (96) ng/ml.

In two patients a considerable reduction of kidney function was observed during pregnancy. Four patients were treated for hypertension before and during pregnancy. The pregnancies ended in two cases with a spontaneous delivery (at 38 and 39 weeks of gestation), in one case with a forceps delivery at 40 weeks, and in one case with a caesarean section at 39 weeks. The remaining two patients had caesarean sections in week 35 of the gestation.

Two of the six babies were growth retarded. One infant was under the third and one under the tenth centile of birth weight¹ (2250 and 2650 g at 39 weeks). The mother of one growth retarded infant showed a reduction of kidney function during and after the pregnancy, and both mothers of affected infants had pre-existing hypertension. The trough cyclosporin concentrations were in the normal range in both cases (238 (81) and 257 (60) ng/ml). Two patients delivered infants of normal weight, although their pregnancies were complicated by hypertension and a serious reduction in kidney function. One baby had hypospadias and clino-dactyly, but no other malformations were observed.

Further observations are necessary to evaluate whether treatment with cyclosporin during pregnancy increases the risk of intrauterine growth retardation.

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1 Hohenauer L. Beurteilung der Reife von Neugeborenen.
Z Geburtshilfe Perinatol 1976;**180**:239-45.

Iron and infection

SIR,—We write in response to the article by Professor C Hershko and others (5 March, p 660), in particular to that part of it that was critical of our report showing an increased incidence of Gram negative neonatal sepsis after the administration of intramuscular iron dextran.¹

Their first criticism was that incidences of neonatal infection before 1970 were not provided in our paper. Data were not available to provide that information, but we do have data on Polynesian live births and mortality from neonatal sepsis during this time. As the mortality from neonatal sepsis was 60% the data on mortality will parallel the incidence.

The table relates deaths from sepsis to iron injection in a similar way to our original paper but, in addition, shows no deaths for two years before the introduction of injections. Iron injections were started in 1965 as a pilot study (R Cantwell, New Zealand Paediatric Society meeting, Wellington,

Iron injection and death from sepsis in Polynesian neonates, 1963-74

Year	No of live births	Iron injection	No of deaths
1963-4	697	No	0
1965-9	1853	Yes (some)	6
1970-2	1582	Yes (most)	16
1972-4	1098	No	0

1967), so only a proportion of Polynesians received the treatment initially. The information on mortality and live births was obtained from the medical statistician, Department of Health.

Professor Hershko and colleagues quote a study by Leikin as contrasting with ours in showing no increase in susceptibility to infection with the use of intramuscular iron dextran.² This comparison is quite invalid: only 20 infants were given the iron injections in Leikin's study, requiring an incidence of neonatal sepsis of 50 per 1000 before one infant would have been affected. This must be compared with the group that we studied, in which over 1500 infants received iron injections, and, even though the rate of neonatal sepsis was extremely high, it was never more than 17 per 1000 live births.

The second study cited as contrasting with ours was that of Salmi *et al*³; we think that this comparison is even more inappropriate as Salmi *et al* dealt with 95 premature infants, two thirds of whom received varying doses of oral iron. Professor Hershko and colleagues speculate that these contrasting findings might result from differences in exposure to pathogens. This seems most unlikely in our study: all the Polynesian infants were delivered and cared for in the same facilities as those used by infants and mothers of European extraction, who constitute about 80% of our population. Furthermore, a low rate of neonatal sepsis comparable with that in the European population was found in the Polynesian babies before and after the iron was given. A low rate of sepsis has continued until the present day.

We continue to be convinced of the association between iron dextran injections and an increased incidence of neonatal sepsis, and we do not use parenteral iron in neonates.

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- 1 Barry DMJ, Reeve AW. Increased incidence of Gram-negative neonatal sepsis with intramuscular iron administration. *Pediatrics* 1977;**60**:908-12.
- 2 Leikin SL. The use of intramuscular iron in the prophylaxis of the iron deficiency anemia of prematurity. *Am J Dis Child* 1960;**99**:739-45.
- 3 Salmi T, Hanninen P, Peltonen T. Applicability of chelated iron in the care of prematures. *Acta Paediatr Scand* 1963;**140**:114-5.

Anorexia nervosa

SIR,—Drs N Nagaratnam and D F Ghougassian (21 May, p 1443) reported a fascinating case of chronic anorexia in a 70 year old man. They may, however, be incorrect to claim that he suffered from anorexia nervosa. The symptom of anorexia is common to many psychiatric and medical illnesses.

The evidence used to support the diagnosis of anorexia nervosa in this case includes the results of a muscle biopsy and the possibility of a decreased libido. These are non-specific findings in cases of severe cachexia and do not usually help or hinder the doctor in diagnosing anorexia nervosa. Much more specific are the psychological symptoms

which underlie the avoidance of food, such as a morbid fear of fatness and a disturbance of body image. In the reported case none of these symptoms were elicited.

Acute and chronic psychological sequelae are common among victims of torture and extreme stress.¹ Lunde found that mental symptoms were present in 75%,² suggesting that the authors' scepticism about the relation of the patient's psychiatric symptoms to his war experiences may be misplaced. The importance of untreated depression as a possible cause of severe cachexia (often needing tube feeding) is emphasised by Lewis's report of 61 cases of melancholia.³ Unfortunately there is no mention in the report of the patient's mood. If depression and organic causes had been completely excluded, and in the absence of more detailed information, a diagnosis of an unspecified disorder of eating would be most accurate.

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- 1 Eitinger L. Jewish concentration camp survivors in the post-war world. *Dan Med Bull* 1980;**27**:232-5.
- 2 Lunde I. Psykiske følger hos torturofcore. *Mandesskrift for praktisk laegegerning* 1982;**111**:476-89.
- 3 Lewis A. Melancholia: a clinical survey of depressive states. *Journal of Mental Science* 1934;**80**:277-378.

SIR,—I think that Drs N Nagaratnam and D F Ghougassian are mistaken when they attribute the cachexia in the patient they describe (21 May, p 1443) to anorexia nervosa. The features they list are non-specific and omit an assessment of his body image. It is not surprising that a man who has starved himself since 1945 might experience sexual difficulties.

I suspect that their patient suffered from the concentration camp syndrome.¹ Severe malnutrition was the rule among prisoners of the Japanese and was particularly severe among inmates of Changi and those working on the Burma railway. The patient would undoubtedly have lost many comrades through starvation. Guilt about survival is a common finding among patients with the concentration camp syndrome,^{2,3} and I suggest that the longstanding undernourishment described was a form of atonement. His resistance to talking about his war experiences is probably supportive of this interpretation. His and his wife's reluctance to discuss their sexual relationship would not be unusual in this age group.

While we are told about his family psychiatric history, we know nothing of his own symptomatology other than the fact that he had not binged or vomited. Purging was not even mentioned. More psychiatric information should be provided about this man before he is labelled as suffering from anorexia nervosa. The diagnostic distinction is not purely academic. Had the patient survived the psychiatric management of the two conditions would have been quite different.

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- 1 Ransom JA. Psychiatric syndromes in prisoner of war and concentration camp survivors. In: Friedman CTH, Faguet RA, eds. *Extraordinary disorders of human behaviour*. New York: Plenum Press, 1982.
- 2 Carmelly F. Guilt feelings in concentration camp survivors: comments of a "survivor." *Journal of Jewish Community Services* 1975;**52**:139.
- 3 Hoppe KD. The psychodynamics of concentration camp victims. *Psychiatry Forum* 1966;**1**:76.

SIR,—The case report of anorexia nervosa in a 70 year old man by Drs N Nagaratnam and D F Ghougassian (21 May, p 1443) probably