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## LEADING ARTICLES



## PAPERS AND ORIGINALS





## MEDICAL PRACTICE




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# CORRESPONDENCE



*Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.*

## Rubella antibody tests in pregnancy

SIR,—Facilities for testing pregnant women (and others) for rubella antibodies have been generally available in Britain for several years. It might be expected that the information derived from these screening tests would eliminate the need for the sometimes speculative interpretations which are inevitable when specimens are obtained *after* contact with a rubella case. We are concerned, therefore, how often specimens for rubella antibody tests are sent to this laboratory from pregnant women thought to have been recently in contact with rubella when their susceptibility or immunity to this infection has been determined previously, usually during an earlier pregnancy. There appear to be several reasons for this.

(1) Not all antenatal clinics report the results of rubella antibody tests to general practitioners, while some report only on patients with negative tests (that is, those believed to be susceptible and who should be vaccinated immediately after delivery).

(2) Some laboratory reports are phrased in a manner such that their significance escapes the practitioner—for example, "Rubella antibody tests—immune," others may state only the reciprocal of the dilution at which the serum has been tested and antibody detected without giving an interpretation. As this is often a low figure such as 16 or 20 the clinician may not attach much importance to it and not appreciate that it indicates past infection with rubella virus and therefore immunity from further infection.

We suggest that laboratories should report results of screening tests in terms of evidence of past infection and that when such evidence is reported clinicians should make it clear to their patients that they will not be at risk if exposed to rubella in any future pregnancy, thereby preventing much unnecessary anxiety and repetition of antibody tests.

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## Possibility of indigenous plasmodial transmission

SIR,—Some 20 years have gone by since the last autochthonous case of malaria was recorded in England, in Lancashire.

The current hot weather raises the possibility of recurrence of this phenomenon, since we do have reservoirs of plasmodia in returning tourists and immigrants from malarial countries, and two vectors, *Anopheles plumbeus* and *A labranchiae atroparvus*, are still around. The present weather should prove ideal for the development of plasmodia in these insects and for the rapid increase in their numbers.

In spring 1977 perhaps, if not earlier, we may taste the fruits of this tropical weather.

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## Chronic active hepatitis induced by nitrofurantoin

SIR,—In a report by Dr J Lindberg and others (11 October 1975, p 77) on trigger factors in chronic active hepatitis (CAH) this liver disease was considered to have been induced by nitrofurantoin in two of their patients. This drug was furthermore reported by Klemola *et al*[1] to have induced anicteric liver damage suggestive of CAH in as many as five patients, though these patients did not have the typical pattern of autoantibodies.

We have tried to evaluate a possible connection between nitrofurantoin and CAH by re-examining the records of the patients diagnosed as CAH (not secondary to viral hepatitis) at this hospital during the years 1969-74. Among 23 patients, eight recovered within a few months. All eight had had some kind of drug treatment at the onset of the liver disease. Three of them had taken laxatives (oxyphenisatin in two cases and an unknown preparation in one), one dihydrallazine sul-