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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Maternal phenylketonuria

SIR,—The paper by Dr G M Komrower and others (26 May, p 1383) based on their personal experience provides a valuable guide to the management of pregnancy in women with phenylketonuria; but, as the authors say, it is not yet possible to give confident advice and there is therefore need for a prospective study.

The steering committee of the MRC-DHSS phenylketonuria register, of which Dr Komrower is a member, has completed plans to set up a national register of women of reproductive age with phenylketonuria to serve as a basis for such a study. The approach will be an epidemiological one, the aim being to follow up a comprehensive national sample of women (through contact with their medical advisers) in order to document any pregnancies and assess outcome in relation to management. Full details of the register procedures are being sent to clinicians already known to have female patients aged 14 and over under their care, and the register staff will gladly communicate with anyone else involved in the medical care of such patients.

The potential value of such a study can be illustrated by considering the birthweight figures of the Manchester and other treated cases quoted by the authors from the literature. The mean birthweight of 2781 g is below the mean of 3287 g for the UK population in 1970[1] and the distribution of the birthweights shows a marked shift downwards, as has already been observed in untreated cases.[2] The infants in whom treatment was started during the first trimester had a higher mean birthweight (2960 g) than the infants in whom treatment was started later in pregnancy (2560 g). The finding of a higher incidence of congenital malformations in the earlier treated group (three out of six) than in the later treated group (one out of five) adds significance to the difference in birthweight between the two groups because of the recognised association between congenital malformations and low birthweight.

It is not surprising that dietary treatment started at some time after the first missed menstrual period may fail to prevent the gross malformations found in infants of mothers with phenylketonuria, because they have their origin very early in the pregnancy during the period of organogenesis. The first report of dietary treatment being started before conception has just been published by Nielsen *et al.*[3] The pregnancy resulted in the birth of a healthy infant whose birthweight of 3500 g is greater than that recorded in any of the infants born to mothers in whom treatment was started after conception, and greater than that of any of the infants born to the mothers who received no treatment reported by Frankenburg *et al.*[2] These data taken together suggest that the greatest benefit will be obtained by starting treatment prior to conception, but, failing that, the earlier in pregnancy the diet is started the greater the benefit to the fetus is likely to be. A larger sample of cases and consideration of other factors known to affect birthweight will provide further evidence in support of, or against, these speculations and should make it possible to give soundly based advice on the management of these pregnancies.

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[1] *British Births 1970*, ed R Chamberlain, p 50. London, Heinemann Medical, 1975.
[2] Frankenburg, W K, *et al*, *Journal of Paediatrics*, 1968, **73**, 560.
[3] Nielsen, K B, *et al*, *Lancet*, 1979, **1**, 1245.

Preventing postoperative thromboembolism

SIR,—I believe the conclusions of Professor E S Immelman and his colleagues of the Groote Schuur Hospital Thromboembolus Study Group (2 June, p 1447) are not supported by their data.

Perfusion lung scanning, is not specific for diagnosis of pulmonary embolism (PE). Forty-three patients developed new post-operative perfusion scan defects; in 28 of these, the score for PE was between 1/6 and 3/6. If one uses the criteria as defined by the authors (score 1/6 to 3/6 "PE possible but unlikely"), it is *unlikely* that 65% of scan abnormalities detected were caused by pulmonary emboli. It is amazing to read that these patients were still included in the