One case of Addisonian pernicious anaemia who became pregnant is described.

The rarity of haemolytic anaemia associated with pregnancy is emphasised, only 2 cases having been discovered in the course of 1 year.

References.


THE RESPONSE OF MEGALOBLASTIC ANÆMIA OF PREGNANCY TO VITAMIN B12.

By H. C. MOORE and E. W. LILLIE.

Eleven cases of megaloblastic anaemia of pregnancy were treated with a large dose of vitamin B12; the amount for most cases was between 900 µg. and 1,400 µg and was given in divided dosage over a variable period. Nine of the cases responded with a reticulocytosis, but which in most cases was delayed. Haematological improvement followed. The remaining two cases did not respond to vitamin B12, but later had a characteristic reticulocyte response to folic acid.

The present concept that all cases of megaloblastic anaemia of pregnancy are due to a deficiency of folic acid would appear to be incorrect. The underlying aetiology of most cases, if not all, may be a defective storage of vitamin B12.

Full details of these communications are to be published at a later date.

Our thanks are due to the Master of the Rotunda for affording every facility, to the Medical Research Council of Ireland for a grant to one of us (E.W.L.), and to Evans Medical Supplies, Ltd., for generous supplies of ferrous gluconate.

Discussion.

Dr. T. O. GRAHAM: As President of this Academy I would like to say that the Editor of the *Journal* of the Academy told me that he had received only one paper for publication in this term. Essentially, the papers brought to this Academy are the possession of the *Journal*. We have had magnificent addresses here, and now tonight we have this interesting communication from the team. I therefore appeal to those who come here to present their papers to Mr. Doolin for printing and distribution throughout the world. It will keep the Academy of Irish Medicine on the map. This work is worthy of wide publicity. The maternity work of this city should be kept before the eyes of the world.

Dr. THOMPSON, Master of the Rotunda: I have been keenly interested in this piece of research, but in order to carry out such vast examinations it was necessary to organise a clinic. Many of these things are liable to fall down owing to apathy on the part of the patient, but I feel that things should be made easy for the patient. After
a week or so it was evident that beds would be required. I got three beds from the gynaecological section. I hope when more beds are available that a medical ward will be at the hospital with a medical sister in charge. Great emphasis is now placed on the medical and ancillary aspect of the subject.

Dr. M. T. DRURY: This has been a most stimulating talk. We are generally aware of the frequency of anaemia in pregnant women. Recently, a detailed study was made in the Coombe, and we look forward to hearing the results of these investigations. They will admit that this is not a problem for doctors. It arises out of social circumstances. That aspect has been neglected, and it must be considered and investigated fully if the problem is to be placed before our administration. The pregnant woman has increasing demands for certain commodities to supply her baby. Our women are fertile and have many pregnancies, and become chronically ill from this relatively simple disease which should not occur. We, as doctors, are not responsible for this disease. It is not possible to appoint members to deal with nutritional factors. It is the women with iron deficiency whom we are concerned with. It is the iron deficiency patient who must be dealt with. No reference has been made to the prevention of this problem in the future. The patient comes in and is given iron, and is all right for the time being. The next time she comes in in exactly the same condition. We must indicate to patients that they have this anaemia which will occur in their next pregnancy unless they improve their diet and are advised as to the correct diet.

I was amazed they found 15 cases of megaloblastic anaemia of pregnancy. That is an extraordinarily high incidence. It is a more common disease than I realised. Is it due to the fact that eleven of the cases were post-natal? Perhaps that is why we miss so many cases. Many cases presented as queer toxæmas. The frequency of pyrexia suggests to me that if obstetricians remembered that the patient may have this anaemia, we might find it before it becomes a problem. As to the cause of megaloblastic anaemia of pregnancy, Dr. Moore emphasises diet. Some feel that diet has nothing to do with it. Many have insufficient diets, and vomit during pregnancy, yet this anaemia occurs in only one in three hundred cases. Therefore, I do not think diet is the cause.

I have here an article describing how B12 was given in big doses but without effect. Folic acid produced immediate response. You may say, "What about these cases tonight?" It seems to me these were puerperal cases. They clear up after delivery. Is it possible that some of these remissions produced by B12 are natural remissions and not due to Vitamin B12?

For iron deficiency anaemia we will have to switch over to ferrous gluconate. What intravenous iron was used in these patients? There is too frequent a tendency to give transfusions. Blood transfusion carries a definite risk. The time has come when one should consider whether it is necessary to give blood or not. In Holles Street Hospital intravenous iron has been given and found successful. By this method you avoid using blood.

Dr. A. P. BARRY: This has been an excellent and valuable paper. I am glad Dr. Gatenby discussed the danger of the "pink" patient. Such a patient often has iron deficiency anaemia.

Dr. DOYLE: Do hyperchromic cases include the hospital class? The diagnosis depends on sternal marrow biopsy.

Dr. MEAGHER: If we give iron into the blood stream the patient might respond more satisfactorily. This takes time, and does not suit the patient. Could we give intravenous iron in one single dose? You can estimate how much intravenous iron you need to give. The average dose we gave was 800 milligrams. We gave it into the arm and took about eight hours to administer. The patient might get severe vomiting, but apart from that there were no serious reactions. It may help to get over the iron deficiency anaemia rapidly.

Dr. A. BROWNE: Today obstetricians must be ready to be primarily physicians. A good maternity hospital must have good obstetricians who are good at medicine and good with megaloblastic anaemia. The establishment of an efficient maternity service demands the recognition by the authorities that that is so. We require team work. Going through the wards of a hospital one sees a patient not with puerperal sepsis but megaloblastic anaemia.

Dr. GECHEGAN: I am astonished at the incidence of megaloblastic anaemia. Of the fifteen patients, how many showed macrocytosis? Were these patients brought into hospital for the whole duration of treatment?