suspicious mind, discontent with shibboleths, and the ability to convey such attitudes to our pathological colleagues both help. Truth is successful prediction, and time and/or treatment will provide the answer.

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ANTIRHEUMATIC DRUGS IN PREGNANCY AND LACTATION

DURING pregnancy, arthritic patients usually prefer to manage without drugs, even if it means experiencing more pain than usual. But there are some patients, including those with active rheumatoid or juvenile chronic arthritis and other inflammatory joint diseases, for whom childbearing would either be impossible or intolerable without the help of antirheumatic drugs. Fortunately, these patients usually experience some reduction of disease activity during pregnancy(1) but this may occur late and can be preceded by a second trimester flare(2).

Generally, there is little published about the safety of drugs in pregnancy (3,4), particularly in relation to antirheumatic preparations, which makes the contributions of Needs and Brooks (pages 282 and 291) especially welcome. Relatively few women develop inflammatory arthritis until after the peak years of childbearing and so the opportunities for gaining experience of managing these patients during a pregnancy are limited. Such information as there is comes mainly from case-reports of suspected but unsubstantiated associations between a particular drug and an adverse effect on the fetus (5-7).

Prospective controlled studies, which might be able to provide the information needed to assess risks and establish causality, would be difficult to carry out. The small numbers of pregnant patients taking different drugs for a variety of rheumatic conditions would compound the difficulties of recruitment.

If a prospective study is impractical, it may be worthwhile to record the drug exposure of rheumatic patients during pregnancy, so pooling a wider experience to make it available to individual clinicians. The only danger of this approach is that it could lead to a false sense of security. It is impossible to prove a negative, therefore a recorded drug that had not been observed to affect the fetus adversely could, later on, be found to cause fetal damage.

A drug may be teratogenic either by a direct and specific action or, indirectly, by producing a deficiency(8). Some drug effects on the fetus are limited to a narrow 'window' of a few weeks of fetal development when a particular organ is differentiating(9), thus the greatest potential for drug damage is during early pregnancy. Even before conception, drugs interfering with DNA synthesis, such as cyclophosphamide, may damage germ cells(10). In later pregnancy the fetus is susceptible to metabolic and growth effects rather than gross structural disruption(11).

How soon after delivery of an apparently normal infant is it possible to say that no drug-related damage has occurred? The story of diethylstibestrol (DES) the 'time-bomb' drug
and the vaginal carcinoma in the daughters of women who took DES during pregnancy makes chilling reading(13).

Drug treatment of the lactating mother also raises problems but less difficult than in pregnancy. There is always the option of the mother to forego breast feeding if her need for drug treatment is considered to be paramount. Also, pharmacodynamic studies enable a reasonably accurate assessment of the proportion of the maternal dose of drug likely to be ingested by the infant(14).

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