

with C1 inhibitor concentrate. In some cases, however, the frequency and severity of clinical symptoms makes long-term prophylaxis inevitable. Among our patients, three boys and a girl had one to two acute attacks of intra-abdominal or laryngeal oedema formation every month. All four patients were started on danazol because of the ineffectiveness of or intolerance to antifibrinolytics. Danazol 100 mg administered every 2–3 days (alternating therapy) for 2–6 years was well tolerated. Complete resolution of clinical signs and symptoms was achieved and no drug-related adverse effects occurred. Initially, liver-enzyme activity was checked every 3 months, then every 6 months; abdominal ultrasonography was done every 6 months. Identification and elimination of precipitating factors such as mechanical trauma were crucial to the clinical protocol adopted by our centre.

We agree that under the best circumstances, substitution with C1 inhibitor concentrate would be the treatment of choice for children. We believe, however, that this approach is currently unfeasible because intravenous injections would have to be administered every 3 days (the half-life of the concentrate is 72 h), treatment costs would be high (at ?310 per ampoule), and, since C1 inhibitor concentrate is a blood product, there is a theoretical risk of transmitting blood-borne infections, even with vapour-heated preparations.³ Thus, long-term danazol therapy for children is frequently justified and occasionally has no alternative. In Hungary, patients with hereditary angio-oedema are provided with a comprehensive guidance leaflet on C1 inhibitor concentrate to store in their refrigerators.

The establishment of a European hereditary angio-oedema database would greatly facilitate the exchange of experience as well as the monitoring of the adverse reactions to therapy, as was proposed at the first European C1 inhibitor deficiency workshop held in Visegrád (Hungary), in May, 1999.

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Beeturia and iron absorption

Sir—Heinz Zoller and colleagues (June 26, p 2120)¹ elucidate the mechanism of excessive iron absorption in hereditary haemochromatosis. They also raise the question of whether other iron-related absorptive derangements might have a linked pathophysiology.

For example, the little studied condition of beeturia, defined as pink or red urine after the ingestion of beets, affects about 10–14% of the population.^{2,3} Beeturia in the normal population has been variously ascribed to genetic factors, food allergy, gastric acidity, gastric emptying, and colonic oxalic acid.^{3,4} However, beeturia is most common in individuals with enhanced iron absorption: 66–80% in patients with untreated iron-deficiency anaemia,^{2,5} and 45% in patients receiving treatment for pernicious anaemia (a condition in which augmented iron absorption is known to occur.² In seven such iron-hungry patients, beeturia resolved in all of them after 8 days of iron therapy.²

With the increased iron absorption of haemochromatosis, one wonders about the relation between beeturia and the homozygous and heterozygous haemochromatosis genotypes. Notably, the prevalence of beeturia is about the same as the prevalence of haemochromatosis heterozygotes.

An important association between beeturia and haemochromatosis would have major clinical implications. As a sign of haemochromatosis, beeturia would occur earlier in life than the other known signs of the disease, having been recorded in infants and children.⁵ As a screening test, consumption of beets would be convenient and safe, although anaphylaxis has occurred.² Another drawback, noted by Watson and colleagues² is that the 100 g dose of beets used in their study is “much more than anyone would eat from free choice”.

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Choice of treatment for menorrhagia

Sir—In reply to Gordon Stirrat's June 26 commentary (p 2175),¹ we sympathise with his pessimism about the current management of menorrhagia. However, various points need to be addressed before modern gynaecological practice can be judged to have failed menstruating women. Although the figures he cites suggest an enteric rather than an evidence-based practice of gynaecological care, efforts are currently being made in Scotland by national and international groups, such as the Scottish Intercollegiate Guidelines Network¹ and the Cochrane Menstrual Disorders and Subfertility Group,² that together with the Royal College of Obstetricians and Gynaecologists have pioneered the use of evidence-based practice in this field.

One of the strengths of the recommendations of these groups is that they had sufficient quality published data in the form of randomised controlled trials to provide mainly grade A recommendations for practice. However, one of the paradoxes must be that it was not until trials of modern surgical alternatives were started, in for example, the MISTLETOE study,³ that a proper critical reappraisal for our existing methods of medical and surgical treatment took place.

We concur with Stirrat's opinion that rates of intervention are intrinsically associated with psychosocial factors, and we await with interest the results of the IPMEN study. However, it is noteworthy that doctors' wives have the same rate of hysterectomy as matched controls. Also, only one in seven women will refuse surgery if they are shown to have a menstrual blood loss within the normal menstrual range.⁴ In the only randomised comparison of endometrial ablation with medical management as an initial treatment, Cooper⁵ showed patients' satisfaction with treatment