methane methylation of a 1-mL sample for four normal sera and six sera from patients with Refsum's syndrome. Results by the two methods were similar. For example, the regression of our method ($y$) on the classical method ($x$) for the peak ratios for phytic acid/total fatty acids from the six patients was $y = 1.037x + 0.0329$ ($r = 0.9935$).

When the serum is directly saponified with the KOH solution, as in the Williams and MacGee procedure (5), the peak ratios for phytic acid/total fatty acids were lower than by our method or by the comparison classical method. For samples containing phytic acid, therefore, one must saponify a lipid extract rather than the serum itself and, consequently, precede the Williams and MacGee method with a step for lipid extraction.

References

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A Question of Rubella Immunity

To the Editor:

A major advantage of the RIA for rubella antibody, as modified by Musto et al. (1), is that low concentrations of the circulating antibody can be detected. The significance of having a titre of antibody lower than 1:8 is somewhat controversial because a 1:8 titre, as determined by the hemagglutination inhibition method, is still considered the lowest titre sufficient to provide defense against rubella infection. However, detecting any of this antibody suggests past exposure to the virus because there is, as yet, no evidence for natural immunity against the rubella virus.

In this laboratory, a substantial proportion of patients whose serum was examined by the RIA method showed titres of <1:8; but with detectable antibody in about half of these patients; i.e. their titres were between 1:8 and 1:4. Of the 387 pregnant women we tested from July 1983 to September 1983, 22 were reported as having a titre of <1:8; of these, 13 had titres of 1:4 or 1:6, and nine had titres of <1:4. We considered a titre of <1:4 as "non-detected" because that is the titre of the lowest calibrator plotted.

One source (2) recommends that titres of <1:8 require re-immunization, whereas another (3) suggests that low titres may indicate immunity.

Because any titre <1:8 is, by convention, reported as "no immunity present," it becomes extremely important to have conclusive evidence as to whether immunity to rubella virus is truly a quantitative function. That is, is there a definite concentration of rubella antibody necessary to protect an individual exposed to the virus?

References

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Renal Handling of Pancreatic Lipase

To the Editor:

Lipolytic activity has not been detected in urine of healthy persons on attempts to measure lipase by its enzymatic activity (1). In renal disease, serum and urine lipolytic activity is increased, correlated inversely with creatinine clearance (2, 3). With a new enzyme immunoassay (4) for determination of pancreatic lipase (EC 3.1.1.3) none was detectable in normal uncentrateu urine (5) although one can find, after 30-40-fold concentration, a very low concentration in normal urine (6).

Large doses of lysine have a blocking effect on tubular protein absorption (7). We have measured the renal clearance and urinary excretion of pancreatic lipase, β₂-microglobulin, and albumin before and after intravenous injection of lysine into seven healthy men.

Their median age was 29 years (range: 25-42 years). To increase urine output, 250 mL of tap-water was ingested every 20 min. The urine was collected in 10 periods: eight periods of 20 min followed by two periods of 30 min. During 10 min in the middle of the third period, 0.4 g of lysine per kilogram of body weight was given intravenously. Blood was sampled in the middle of each period.

The concentration of pancreatic lipase in serum and urine was measured by an enzyme immunoassay (Enzymost-Lipase™, Behringwerke AG, Marburg, F.R.G.), β₂-microglobulin

Fig. 1. Pancreatic lipase (■), β₂-microglobulin (▲), and albumin (○) excretion in urine before and after intravenous lysine injection (→) into seven healthy men

Values are medians with interquartile range