A Case of Juvenile Pernicious Anemia: Study of the Effects of Folic Acid and Vitamin B₁₂

By DAVID H. CLEMENT, CHARLES A. NICHOL AND ARNOLD D. WELCH

PERNICIOUS anemia is a disease rarely encountered in persons under 30 years of age;¹ in fact, in the majority of instances the diagnosis of juvenile pernicious anemia has not been established unequivocally.² Until fairly recently such a diagnosis rested on the combination of a macrocytic anemia associated with a megaloblastic marrow, with or without gastric achlorhydria, in a child whose sustained remission was dependent on the continued parenteral administration of either liver extract or vitamin B₁₂. However a more nearly definitive diagnosis can now be made in such a patient through a demonstration of the absence of intrinsic factor activity in the gastric secretions and an inability to absorb a significant proportion of small amounts (0.25 to 10 µg.) of orally administered radioactive vitamin B₁₂, except when administered together with a source of intrinsic factor.³⁴⁻⁵

We have had an opportunity to study a four-year-old white boy with recurrent macrocytic anemia, glossitis, and megaloblastic marrow, in whom free hydrochloric acid was usually present in the gastric juice. Some light on the pathogenesis of this condition in the early years of life has been shed by studies (1) of the excretion of folinic acid-like materials in the urine (following the ingestion of folic acid); (2) of the absorption of orally administered vitamin B₁₂-cobalt⁶⁻⁷; (3) of the effect of the patient’s gastric juice on the absorption of radioactive vitamin B₁₂ in a patient with classic Addisonian pernicious anemia; and (4) of the results of a gastric biopsy.

In adults, the disease is almost never seen in the presence of free hydrochloric acid in the gastric secretions, but in children the presence of gastric hydrochloric acid in individuals with otherwise classic manifestations of pernicious anemia has been observed previously.² An hypothesis concerning the natural history of pernicious anemia has been offered that can account for this discrepancy. Some of the findings described in this paper have been referred to in earlier publications.³⁴⁻⁵

MATERIALS AND METHODS

Microbial Assays: Streptococcus faecalis (ATCC 8043), grown in the medium described by Flynn et al.⁵ with pteroylglutamic acid as a reference standard, was used for the determination of folic acid activity by means of a turbidimetric assay. Similarly, Pediococcus cerevisiae (ATCC 8081), earlier known as Leuconostoc citrovorum, grown in the assay medium described by Sauberlich⁶ with synthetic folinic acid (leucovorin) as a reference standard, was used for the determination of folinic acid activity. In this paper the results of analyses for folinic acid are expressed on the basis of the natural form, taking into

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account the presence of an inactive isomer in the synthetic material. Samples were autoclaved at 120° C. for 20 minutes in the presence of sodium ascorbate (2 mg./ml.) in order to insure conversion of certain heat-labile derivatives of tetrahydropteroylglutamic acid to the stable form, 5-formyl-tetrahydropteroylglutamic acid (folinic acid; CF). Thus the difference between the activity of heated and unheated samples provides an indirect measurement of the heat-labile reduced derivatives, resembling anhydrolevcorin, which occur in human urine.3,8,9

Paper Chromatography: Strips of Whatman No. 3 paper, 1 inch in width, were loaded carefully with 0.05-ml. portions of each sample and developed at 4° C. by a descending solvent (0.1 M. phosphate buffer, pH 6.0). The wet paper strips were placed directly on a solid assay medium that contained sodium ascorbate (2 mg./ml.) and was seeded with Pediococcus cerevisiae; long lucite trays provided with glass covers were used. Zones of growth observed after incubation overnight at 37° C. indicated the location of active compounds.

Case Report

C. E. K., a white boy aged 3 years and 9 months, was admitted to Grace-New Haven Hospital on March 17, 1955, because of pallor and lethargy. He was the result of his mother’s second normal pregnancy and at birth weighed 7 lb., 10 oz. The neonatal course was not remarkable. At four weeks of age the infant contracted thrush. When four months old he developed a localized, recurrent, erythematosus tender lesion of the tongue.

At the age of one year (June, 1952) he was hospitalized near his home for two weeks because of weakness and anorexia of one month’s duration. His skin was lemon-yellow in color, but no jaundice was present. The tip of the tongue was red. There was no enlargement of liver or spleen. A severe normocytic, normochromic anemia (hemoglobin, 35 per cent), megaloblastic marrow, and absence of free hydrochloric acid on gastric analysis were noted. Treatment consisted of transfusions, oral folic acid, parenteral liver extract, and vitamin B12. Recovery was dramatic. Free hydrochloric acid was then found in the gastric juice. The patient received 2 ml. of crude liver extract intramuscularly at weekly intervals for three weeks.

The child did well for about sixteen months on oral vitamin B12, folic acid, ascorbic acid, and iron. On December 15, 1953, he was again admitted to the same hospital because of anemia (hemoglobin, 44 per cent). During the hospitalization he developed a bloody diarrhea which cleared. Gastric analysis again showed no free hydrochloric acid. Following a transfusion he was discharged on daily oral medications of folic acid 15 mg. and ascorbic acid 300 mg.

In the year preceding admission to our hospital, the child suffered from frequent respiratory infections which were treated with antibiotics. He received daily oral doses of vitamin B12, folic acid, ascorbic acid, iron, and multivitamin preparations. It is noteworthy that the child’s diet had been a varied one, like that of his parents. He was a good eater with few dislikes. Five weeks prior to admission he developed chickenpox and thereafter did poorly. He soon contracted bronchiolitis. Petechiae appeared on the cheeks with hard coughing.

The family history revealed that both parents were living and well at the age of 32 and a 7-year-old brother was well. The patient’s maternal grandfather, although never anemic and living to 71, did have completely gray hair at 22. The mother had a French father and English mother. The father’s parents were Czechoslovakian. There was no history of anemia among relatives.

Findings on Admission: When admitted to our hospital on March 17, 1955, the patient appeared pale and chronically ill but well-nourished. Positive physical findings included atrophy of the papillae of the tongue without redness and a grade 1 systolic murmur over the entire precordium. There was no enlargement of lymph nodes, spleen, or liver. Neurological examination disclosed no abnormalities.

Laboratory findings at the time of admission included the following: Hgb., 7.2 Gm. per
100 ml. of blood; RBC, 2,150,000 and WBC, 4,000 per cu.mm.; hematocrit, 22. Differential leucocyte count: polymorphonuclears 24, basophils 2, lymphocytes 72, monocytes 3, and eosinophils 2 per cent. The platelet count was 212,000 per cu.mm. of blood; the mean corpuscular volume was 105 cu, the mean corpuscular hemoglobin was 35.5, while the mean corpuscular hemoglobin concentration was 34 per cent. The erythrocytes showed moderate microcytosis and slight macrocytosis, slight variation in shape, slight hypochromia, occasional target cells, slight polychromasia, rare ovalocytes, and stippled cells. Some of the erythrocytes appeared to be well-filled with hemoglobin, and reticulocytes were 1 per cent. Marrow aspiration on admission gave the values shown in fig. 1. Nose and throat culture, stool examination, urinalysis, and butanol-extractable iodine level were not remarkable.

**Results**

**Course:** The child was hospitalized for four weeks. Fever was present only during the first and part of the fourth weeks.

The therapeutic agents employed and the response of the blood and bone marrow values are depicted in figs. 1 and 2. It will be noted that, beginning on the sixth hospital day, the patient received, in three divided doses daily, 75 mg. of ascorbic acid for eight days and 15 mg. of pteroylglutamic (folic) acid for twenty days. Because the hemoglobin level fell from 7.2 Gm. to 4.8 Gm. per 100 ml. of blood on the ninth day without demonstrable blood loss, and the child had a temperature of 38.5° C. (rect.), he was given a transfusion of 210 ml. of sedimented red cells at that time. This elevated the hemoglobin level to 9 Gm. per 100 ml. of blood by the thirteenth day, but the reticulocyte value remained at only 0.3 per cent. Since the patient had received adequate amounts of ascorbic acid and folic acid daily for eight days (in addition to amounts of both vitamins that later were established as having been given regularly prior to admission to our hospital) without evidence of new blood formation, and because the clinical state of the child was clearly deteriorating rapidly, at this point he was given 30 g. of vitamin B1 intramuscularly. A reticulocytosis promptly ensued; after 36 hours, 3.9 per cent, and, after four days, a peak of 22.8 per cent was reached. The oral administration of folic acid, as indicated previously, was continued throughout.

On the basis of studies by Berk et al. and many subsequent workers, which demonstrated that vitamin B12 can be regarded as extrinsic factor whose absorption from the gastrointestinal tract is dependent upon the availability of intrinsic factor, studies of the capacity of the child to absorb vitamin B12 were carried out, at first according to the method devised by Schilling. Thus, about four months after the single parenteral dose of vitamin B12, the patient was given, by mouth, 0.5 μg. of vitamin B12-Co6 (0.06 μc.). Two hours following the above-described oral dosage, nonradioactive vitamin (1,000 μg.) was given...
Fig. 1.—Microscopic findings in bone marrow, and percentage of reticulocytes (RETICS) and hemoglobin levels (HGB) in peripheral blood, at time of admission and subsequent to therapy.
Fig. 2.—Total (WBC) and polymorphonuclear (PMN) leucocyte and platelet counts, in peripheral blood, as correlated with the therapeutic regimen.

parenterally; urine was collected for 24 hours. Of the radioactivity administered, less than 1 per cent appeared in the collected urine. One week later, the test was repeated, except that the oral dose of radioactive vitamin, 0.5 μg., was administered together with 25 mg. of a potent source of intrinsic factor, i.e., the
fraction B described by Prusoff and his associates, again 1,000 μg. of non-radioactive vitamin B12 were administered intramuscularly two hours subsequently. Urine was collected for 24 hours and was found to contain approximately 9 per cent of the radioactivity administered.

Approximately eighteen months later (January 14, 1957), during which time additional vitamin B12 had not been given, the boy again was given 0.5 μg. (0.06 μc.) of vitamin B12-Co66 by mouth, but additional nonradioactive vitamin was not administered, and measurements of the fecal excretion of radioactivity were made according to the procedure of Heinle et al. These studies indicated that, within a very small experimental error, all the administered vitamin was contained in the stools. One month later the above-described test was repeated, except that 20 mg. of the previously mentioned concentrate of intrinsic factor was administered together with the oral dose (0.5 μg.) of radioactive vitamin B12. Of the ingested radioactivity, only 28 per cent appeared in the stools, a finding indicating that as a result of the co-administration of intrinsic factor, approximately 70 per cent of the ingested vitamin had been removed from the gastrointestinal tract.

Just prior to the last administration of radioactive vitamin B12, 0.1 mg. of histamine was given intramuscularly and 28 ml. of gastric juice were withdrawn. This material, very rich in "mucus," had a pH of 2.1; its behavior on titration with a dilute solution of sodium hydroxide indicated that it contained free hydrochloric acid. Similar observations were made in April, 1957, and evidence indicating the presence of both free hydrochloric acid and pepsin in normal amounts and concentrations was obtained. A gastric biopsy, kindly taken at this time by Dr. Howard Spiro, disclosed only a mild diffuse superficial gastritis and gave no indications of an anatomical reason for the failure to secrete intrinsic factor.

**Studies on Urinary Folic Acid and Folinic Acid:** During the period that the patient was receiving pteroylglutamic acid (PGA) (5 mg. every 8 hr.), samples of urine were obtained for determination of folic and folinic acid activity. At the time, these tests were considered exploratory in nature and, in retrospect, it is unfortunate that continuous 24-hour collections were not made. Urine was collected during 8-hour periods (from 6:00 a.m. to 2:00 p.m.) on March 26 and April 1, 1955, while the first dose of parenteral vitamin B12 (30 μg.) was given on March 28. The samples were assayed, as described, for both folic acid and folinic acid activity. The results are presented in table 1. The marked differences in folinic acid activity in both the heated and the unheated portions of the samples collected before and after administration of vitamin B12 are considered significant, since there was no appreciable difference in the total folic acid activity (S. faecalis assay) during each period of collection.*

*The specificity of the requirement of *Pediococcus cerevisiae* 8081 (Leuconostoc citrovorum), for N5-formyl-tetrahydropteroylglutamic acid (folinic acid; CF) is only an apparent specificity related to the unique stability of the N5-formyl derivative and the assay technique. Of the various reduced derivatives of PGA, only that referred to as CF (and certain polyglutamate derivatives of it, e.g., the compounds containing two and three glutamic acid residues) withstands autoclaving temperatures in the usual microbial assay. The products of the metabolic reduction of PGA, however, include a substance (or sub-
words, an increase was observed in the proportion of the total folic acid activity that was excreted in the form of reduced derivatives of the vitamin (measurable as substances used by *Pediococcus cerevisiae*). Although it might be thought possible that an incomplete saturation of body tissues with reduced forms of folic acid existed at the time of the first collection of urine, this is quite unlikely, because PGA had already been administered by us for 8 days; in fact, the patient previously had been receiving regularly an oral vitamin supplement containing PGA (see history). In addition, the patient was undoubtedly "saturated" with ascorbic acid. Although the administration of supplemental ascorbic acid (25 mg. every 8 hr.) was discontinued on the day that vitamin B_{12} was first injected, the significance of this variation in treatment, with respect to the folinic acid activity observed in the urine, is considered to be negligible. The presence in the urine of larger amounts of ascorbic acid would not have affected the observed differences.

At a subsequent time, when the patient had been without specific therapy for over two years and megaloblasts had reappeared in the bone marrow, PGA was administered in oral doses of 5 mg. every 8 hours, and a similar comparison was made of the folic acid and folinic acid activity of heated and unheated samples of urine. These were collected for consecutive 24-hour periods (Sept. 13 through Sept. 30, 1957) before and after the parenteral administration of vitamin B_{12}. Unfortunately, under these conditions of partial relapse, the analyses disclosed no significant differences in activity between the two groups of samples.

The findings upon paper chromatography of the unheated samples of urine were of particular interest in relation to the initial administration of vitamin B_{12} in this hospital (March, 1955). The samples described in table 1 were examined by paper chromatography and the location of compounds with folinic acid activity is shown in fig. 3. Having observed many chromatograms of the folinic acid derivatives in the urine of normal subjects receiving PGA, it was unexpected to find, in the unheated sample obtained before administration of vitamin B_{12}, that the major portion of the activity remained at the origin (strip I, fig. 3). Similar treatment of the sample obtained after the administration of vitamin B_{12} resulted in a distribution of activity similar to that seen in urine samples of normal subjects receiving similar amount of PGA (compare strips II and III, fig. 3). The compound that moved to \( R_f \) 0.6 can be identified as the heat-stable form of folinic acid: 5-formyl-5,6,7,8-tetrahydro-pteroylglutamic acid.\(^3\) However, chromatography of the duplicate heated samples indicated that the zones of growth at and near the origin were due to heat-labile compounds. In each case, heating in the presence of ascorbate increased the activities) which, when diluted and autoclaved with the medium in the usual microbial assay, is not measurable as CF unless the autoclaving is carried out in the presence of ascorbate (usually 1 or 2 mg./ml.) or another appropriate reducing agent. If the samples are not heated with ascorbate, but are added aseptically to the previously autoclaved medium (without added ascorbate), full CF activity is not recovered, since the precursor of folinic acid (possibly anhydroleucovorin) is not measured.\(^3\)
Fig. 3.—Tracings of paper chromatograms of unheated urine samples* showing zones of growth of *Pediococcus cerevisiae* 8081 (*Leuconostoc citrovorum*) in plates of solid medium.

*Indicates a sample obtained from the child two days before the initial parenteral administration of 30 μg. of vitamin B₁₂ (as described in the text). II indicates a similar sample obtained four days after this treatment. Oral therapy with PGA (5 mg., every 8 hr.) was maintained throughout this period. III indicates a urine sample from a normal male donor receiving similar treatment with PGA; this observation is representative of many similar chromatograms.

The amount measurable as folinic acid (table 1); the size of the zone of growth at $R_f$ 0.6 was also increased. Chromatography of these samples and examination in this manner were repeated three times and the same observations were made consistently.

On two separate occasions within the past year, the boy has developed glossitis and a decrease in the level of hemoglobin to approximately 10 grams per cent 100 ml. of blood, in association with pinworm infestation (*Enterobius vermicularis*). Throughout this period he was being maintained on oral vitamin B₁₂ (15 μg.) together with a concentrate of intrinsic factor (15 mg.).* On

*Kindly furnished by Doctors L. Ellenbogen and W. L. Williams of the Lederle Laboratories Division of the American Cyanamid Company.
these occasions, with the latter medication maintained at its usual level, we treated only the pinworm infestation with piperazine. With the elimination of the parasites, the glossitis promptly cleared, as did the mild anemia. We have interpreted this observation as suggesting that the infestation upset in some way a marginal state of vitamin B₁₂ utilization or metabolism and created a deficiency of the vitamin. We are not aware of a similar association reported previously, although infestation with the fish tapeworm (*Diphyllobothrium latum*) has long been associated with the development of megaloblastic anemia.

**Discussion**

We have reported our findings in a young child with a juvenile pernicious anemia. His course and laboratory data present a number of noteworthy features, one or two of which contribute new knowledge to this syndrome. Although thrush in his mouth at the age of four weeks cannot confidently be regarded as evidence of mucosal atrophy, true glossitis was observed at the early age of four months, characterized by persistent redness and soreness which made feeding him difficult. By the age of one year his anemia was severe (*Hgb* = 5.4 Gm. per cent) and it was megaloblastic, as shown by marrow examination. That the child responded only to parenterally administered vitamin B₁₂ and relapsed in spite of orally ingested vitamin B₁₂, folic acid, ascorbic acid, and iron is a most significant combination of circumstances. It strongly points to an inability to absorb vitamin B₁₂, presumably due to lack of intrinsic factor secretion; in other words, Addisonian pernicious anemia. The macrocytic anemia of the peripheral blood (mean corpuscular volume = 105 cμ and mean corpuscular hemoglobin concentration = 34 per cent) and the megaloblastic marrow (40 per cent erythroid) also support the diagnosis.

But the diagnosis of pernicious anemia no longer can be said to have been proven by such data. Malabsorption syndromes and intestinal shunts may be associated with the foregoing findings. That our patient truly has pernicious anemia has been demonstrated by the fact that he failed to absorb orally administered radioactive vitamin B₁₂ alone, but did absorb the vitamin when it was given with intrinsic factor concentrate, and that his gastric juice, mixed with radioactive vitamin B₁₂ and fed to an adult with pernicious anemia in relapse, failed to enhance the latter’s absorption of the radioactive vitamin, as indicated by studies of the excretion of cobalt-60. The first two facts cited above were confirmed not only by measuring the quantity of the radioactive vitamin recovered in stools, but also by “flushing” it out in the urine with one milligram of parenterally administered conventional vitamin B₁₂ (Schilling test). Repeated relapses of the boy’s megaloblastic anemia in the absence of parenterally-administered vitamin B₁₂, or of the vitamin ingested with intrinsic factor concentrate, attest to his continuing need for such supplementation.

Of special interest is the presence of free hydrochloric acid and pepsin in the strongly acid (pH = 2.1) gastric juice and the essentially normal gastric mucosa, as demonstrated by biopsy. In adults with established pernicious anemia, achlorhydria and gastric atrophy are the rule. The failure to secrete acid and intrinsic factor were generally regarded as being secondary to atrophy.
of the gastric mucosa. That a child may have an anatomically normal stomach and free hydrochloric acid in the gastric juice, in the absence of intrinsic factor, suggests a reversal of the foregoing hypothesis. We believe that our patient's course supports the concept recently proposed by others\textsuperscript{15,16,17} that the primary inherited defect in pernicious anemia, presumably present from early life, is inability to secrete intrinsic factor. This defect ultimately may lead to gastric atrophy which, in turn, results in achyia gastrica. The atrophy eventually becomes irreversible. It should be possible to detect the absence of intrinsic factor in patients with pernicious anemia before gastric atrophy occurs. Furthermore, it seems reasonable to hope that in young patients such as ours, gastric atrophy and achlorhydria may be prevented by the appropriate administration of vitamin B\textsubscript{12} throughout life.

The familial occurrence of pernicious anemia has been well-documented. Three children with proven disease have had a family history of it.\textsuperscript{16} Our patient had no anemic relatives, although his maternal grandfather had completely gray hair at the age of 22, a sign often associated with the disease.

Neurologic signs, often observed in adults as combined system disease but rarely seen in children, have been reported in two children with pernicious anemia.\textsuperscript{16} At no time, however, did our patient show signs of central nervous system involvement, despite the fact that his appreciation of vibratory sensation was regularly examined in both ankles.

Of potential importance to the concepts of mechanism of action of vitamin B\textsubscript{12} and folic acid in pernicious anemia was the appearance in the urine of this patient, prior to the injection of vitamin B\textsubscript{12} but while folic acid was being continued, of a substance with chromatographic properties different from those of folinic acid, per se (although, after heating in the presence of ascorbate, it exhibited the microbial activity of the latter). The absence of this substance from the urine obtained subsequent to the parenteral administration of vitamin B\textsubscript{12} is of particular significance (fig. 3). Of additional importance is the marked increase in the urinary excretion, following the injection of vitamin B\textsubscript{12}, of substances with the microbial activity of folinic acid (table 1). It should be emphasized in this connection that the patient absorbed efficiently the orally administered folic acid. This is shown by the data of table 1, which demonstrate that the urinary excretion of folic acid exceeded 60 per cent of the 8-hour (5 mg.) dosages, both before and after the administration of vitamin B\textsubscript{12}. A group of normal adults receiving roughly comparable amounts of oral folic acid, on a weight basis (i.e., 50 mg. daily), excreted approximately 38 per cent of the daily dose in the urine.\textsuperscript{18}

It is conceivable that, under certain circumstances, a really profound deficiency of vitamin B\textsubscript{12} can lead to an alteration in the metabolism of folic acid and the accumulation of a derivative (traces of which appear in the urine) that is unable to catalyze a reaction critically concerned with normal erythropoiesis. A logical extension of such an hypothesis would suggest that vitamin B\textsubscript{12} (or a metabolically formed derivative of it) is involved in the conversion of a derivative of folic acid or tetrahydrofolic acid to a functional compound. Thus, recent studies of the role of vitamin B\textsubscript{12} in the synthesis of the thymine-containing precursor of deoxyribonucleic acid\textsuperscript{19} suggest that the effect is related to a tetra-
Table 1.—Effect of Vitamin B₁₂ on the Excretion of Folic Acid and Folinic Acid by a Child with Pernicious Anemia

<table>
<thead>
<tr>
<th>Urine samples*</th>
<th>Total folic acid (S. faecalis)</th>
<th>Assay of activity in urine Folinic acid (Pedi. cerevisiae)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before vitamin B₁₂</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unheated sample</td>
<td>—</td>
<td>4.1</td>
</tr>
<tr>
<td>Heated sample</td>
<td>3290</td>
<td>22.2</td>
</tr>
<tr>
<td>After vitamin B₁₂</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unheated sample</td>
<td>3120</td>
<td>53.5</td>
</tr>
<tr>
<td>Heated sample</td>
<td>3100</td>
<td>155</td>
</tr>
</tbody>
</table>

*The samples were obtained two days before and four days after the patient received a single injection of vitamin B₁₂ (30 μg. intramuscularly). The patient received pteroylglutamic acid (5 mg.) at 8-hour intervals throughout this period. Ascorbic acid was administered as described in the text. Portions of each sample were heated at 120° C. for 20 minutes after the addition of sodium ascorbate, 2 mg. ml.
†See discussion in accompanying text and footnote.

hydrofolic acid-dependent reaction concerned with the conversion of deoxyuridine 5’-phosphate to its methylated derivative, thymidylic acid. Furthermore, recent evidence obtained from the study of the formation or utilization of a derivative of tetrahydrofolic acid.²⁰,²¹

However, it remains to be demonstrated whether, in relatively simple systems, a sufficiently severe limitation on the supply of vitamin B₁₂ can cause an accumulation of a derivative of folic acid, as appears to have occurred in the present case. As has been suggested previously,²²,²³ there is steadily increasing evidence to suggest that the hematopoietic defect in pernicious anemia is a manifestation of a disturbance in the metabolism of folic acid that is secondary to the deficiency of vitamin B₁₂, which, in turn, is caused by an inadequate formation of intrinsic factor.

It is unfortunate that, upon withholding therapy with vitamin B₁₂ until the reappearance of anemia, a megaloblastic arrest of erythropoiesis in the bone marrow, and other manifestations of relapse, a repetition in the alteration of the pattern of excretion of folic acid-like compounds was not observed. In the absence of evidence to the contrary it may be suggested tentatively that the severity of the vitamin B₁₂-deficiency state which led to the first disturbances of folic acid metabolism studied by us was not, in the second instance, of sufficient magnitude to be reflected by comparable changes in the pattern of urinary excretion of metabolites of folic acid.

Whether or not the findings described have been interpreted correctly can be established only by additional investigation. Accordingly it is hoped that attempts will be made to discover other cases of very severe pernicious anemia in infants or young children, and that in them much more extensive studies will be made of the pattern of metabolic formation and urinary excretion of derivatives of folic acid before and after the parenteral administration of vitamin B₁₂.

SUMMARY

Observations on a 4-year-old boy with Addisonian pernicious anemia have been presented. Noteworthy clinical features included the onset of glossitis...
at the age of 4 months, followed by anemia severe enough to require hospitalization at the age of 1 year. Relapse occurred in the absence of specific therapy with vitamin B₁₂ and was completely unaffected by the administration of folic acid.

Studies with radioactive vitamin B₁₂ demonstrated that almost all of the compound administered by mouth was unabsorbed and was recovered in the stools. When the vitamin was given simultaneously with a concentrate of intrinsic factor, however, approximately 70 per cent was absorbed. Furthermore, the child's gastric juice, when mixed with radioactive vitamin B₁₂ and fed to an adult with pernicious anemia in relapse, failed to enhance the latter's absorption of the vitamin. The failure of our patient to absorb the vitamin alone, but his ability to do so when it was administered with intrinsic factor concentrate, was also confirmed by the "Schilling test," in which a proportion of the absorbed radioactive vitamin was "flushed" into the urine by parenteral injection of one milligram of conventional vitamin B₁₂.

Of special interest was the occurrence in the urine of an unidentified derivative of tetrahydrofolic acid, derived from orally administered pteroylglutamic acid. The presence of this compound in the urine was demonstrated chromatographically when the patient was critically ill with his disease prior to treatment with vitamin B₁₂. Subsequent to therapy with vitamin B₁₂, while the administration of folic acid was continued, the abnormal metabolite of folic acid could not be found in the urine. Similarly, the administration of folic acid did not lead to the appearance of this metabolite in the urine at a time when, after more than two years without specific therapy, a hematological relapse occurred that was much less severe than that previously observed. The implications of these observations, with respect to the metabolic interrelationships of folic acid and vitamin B₁₂, are discussed.

Of further interest were the findings of strongly acid gastric juice containing much mucus and free hydrochloric acid. A fairly normal gastric mucosa was demonstrated by biopsy. The meaning of these unusual findings is discussed and an hypothesis to account for them is offered. The probable sequence of events in these patients from childhood to the development of anemia, usually in later life, is set forth.

**Summario in Interlingua**

Es presentate observationes super un puero de 4 annos de etate. Notabile tractos clinic include be inception de glossitis al etate de 4 menses, sequite al etate de 1 anno per anemia satis sever pro requerir hospitalisation. Un recidiva occurreva in le absentia de specific therapia a vitamina B₁₂ e esseva complete mente inafficite per le administration de acido folic.

Studios con radioactive vitamina B₁₂ demonstrava que iste composito, administrate per via oral, remaneva inabsorbite in su quasi-totalitate e poteva esser retrovate in le feces. Tamen, quando le vitamina esseva administrate simultaneemente con un concentrato de factor intrinsec, approximativemente 70 pro cento de illo esseva absorbite. Etiam, quando le succo gastric del paciente esseva miscite con radioactive vitamina B₁₂ e administrate a un adulto con anemia perniciose in recidiva, illo non facilitava le absorption del vitamina
per le adulto. Le incapacitate de nostre patiente de absorber le vitamina sol, e su capacitate de absorber lo quando illo esseva administrate con concentrato de factor intrinsec esseva etiam confirmate per le test de Schilling, in le qual un portion del absorbite vitamina radioactive esseva “lavate” a in le urina per medio de un injection parenteral de 1 mg de ordinari vitamina B₁₂.

De interesse special esseva le presentia in le urina de un non-identificate derivato de acido tetrahydrofolic, le qual esseva derivate ab oralmente administrate acido pteroglutamic. Le presentia de iste composito in le urine habeva essite demonstrate chromatographicamente quando le patiente habeva essite criticamente malade ante le therapia a vitamina B₁₂. Post le inception del therapia a vitamina B₁₂ le administration de acido folic esseva continuate, sed le metabolito anormal de acido folic non esseva trovabile in le urina. Similemente le administration de acido folic non resultava in le reaparition de iste metabolito in le urine al tempore—post plus que duo annos sin therapia specific—quando occurreva un recidiva multo minus sever que illo previamente observate. Es discutite le signification de iste observationes con reguardo al interrelaciones metabolic de acido folic e vitamina B₁₂.

Etiam de interesse esseva le constatation de un fortemente acide succo gastric le qual contineva multe muco e libere acido hydrochloric. Un mucosa gastric satis normal esseva demonstrate per medio de biopsia. Le signification de iste constatationes inusual es discutite, e un hypothese as offerite pro explicar los. Es presentate le probable sequentia de eventos in le casos de patientes ab lor infantia usque al disveloppamento de anemia, generalmente a etates plus avanciate.

REFERENCES


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