In Utero and Early-Life Conditions and Adult Health
and Disease

TO THE EDITOR: In their article on the developmental origin of disease, Gluckman et al. (July 3 issue) state that “an altered long-term risk of disease is initially induced through adaptive responses that the fetus or infant makes to cues from the mother about her health or physical state.” This rather narrow definition and the overall focus of the review leave out adverse responses due to maternal exposures to environmental chemicals, occupational hazards, drugs, tobacco smoking, or infection. These factors are likely to make a very large contribution to adult diseases of developmental origin, and they have the advantage of being potentially preventable. Risk assessment of environmental hazards must therefore include the effects of developmental exposures to stimulate better protection of the most vulnerable life stages.

Philippe Grandjean, M.D., Ph.D.
Harvard School of Public Health
Boston, MA 02215
pgrand@hsph.harvard.edu

Jerrold J. Heindel, Ph.D.
National Institute of Environmental Health Sciences
Research Triangle Park, NC 27709


TO THE EDITOR: The article by Gluckman et al. highlights an ongoing fundamental change in medical thinking known as the life-course approach to the development of disease. The “developmental model” of chronic diseases postulates that early-life events affect individual differences in vulnerability to lifestyle and environment. This concept is supported by studies of in utero or early-life vulnerability to lifestyle and environment. This suggests that early-life events affect individual differences in developmental origin, and they have the advantage of being potentially preventable. Risk assessment of environmental hazards must therefore include the effects of developmental exposures to stimulate better protection of the most vulnerable life stages.

Laura Fratiglioni, M.D., Ph.D.
Bengt Winblad, M.D., Ph.D.
Karolinska Institutet
113 30 Stockholm, Sweden


of which need further investigation. Considering the immature stage of the exploration of these effects, we may well currently be looking at the tip of the iceberg, anticipating potential links with adult pulmonary and neurologic diseases like chronic obstructive pulmonary disease and dementia.

Jasper V. Been, M.D.
Boris W. Kramer, M.D., Ph.D.
Luc J.I. Zimmermann, M.D., Ph.D.
Maastricht University Hospital
6202AZ Maastricht, the Netherlands
jasper.been@mumc.nl


THE AUTHORS REPLY: We are pleased with the interest in our review, particularly, as noted, concerning the relevance of developmental exposures (environmental toxins, smoking, and alcohol consumption), intermediary phenotypes (chronic low-grade inflammation), and health outcomes (aging and cognitive decline). Although we focused on metabolic, cardiovascular, and bone disease, the areas most developed, we have little doubt that developmental plasticity and epigenetic change have much greater involvement in the etiology of human disease than has previously been considered. We would urge further research to clarify the involved epigenetic mechanisms, to develop risk-prediction tools that might be applied throughout the life course, and to delineate preventive and interventional strategies.

Peter D. Gluckman, M.D., D.Sc.
University of Auckland
Auckland 1023, New Zealand
pd.gluckman@auckland.ac.nz

Mark A. Hanson, D.Phil.
Cyrus Cooper, M.D.
University of Southampton
Southampton SO16 6YD, United Kingdom

A Case of Conjugal Azathioprine-Induced Contact Hypersensitivity

TO THE EDITOR: A man in his early 30s presented with an intermittent eczematous eruption over the shaft of his penis and scrotum (Fig. 1A). His wife was initially concerned about his fidelity, but a careful history-taking revealed that the rash coincided with his wife’s intermittent courses of azathioprine for Crohn’s disease. During four courses of such treatment over a 4-year period, her vaginal secretions were yellow, which raised the possibility of secretion of azathioprine or its metabolites that could have led to allergic contact dermatitis in the husband.

Further investigation was undertaken. Both the man and his wife had normal thiopurine methyltransferase levels. Epicutaneous patch testing of petrolatum alone or 1 to 10% of the drug in petrolatum was performed as previously described.1 Azathioprine (pure and tablet forms), its major breakdown product 6-mercaptopurine, and all available tablet excipients were tested on both partners. The husband, but not the wife, reacted to the tablet and pure forms of azathioprine only (Fig. 1B).

The presence of drug-specific lymphocytes in the husband’s peripheral-blood mononuclear cells was assessed by means of the lymphocyte transformation test,2 but no response was seen, probably reflecting the inherent antilymphocyte activity of azathioprine. However, as shown with the use of an enzyme-linked immunosorbent spot assay,3 both azathioprine and 6-mercaptopurine induced the release of interferon-γ from lymphocytes (50 and 70 positive cells per million, respectively, vs. 4 positive cells per million in the absence of drug) (Fig. 1C and 1D). No response was seen in controls (see the Supplementary Appendix, available with the full text of this letter at www.nejm.org). These data, in conjunction with the skin-test results, were interpreted to indicate that the husband had a hypersensitivity to 6-mercaptopurine or a metabolite of 6-mercaptopurine. The negative skin test for 6-mercaptopurine probably reflected its water solubility, causing it to penetrate into the epidermis much less than azathioprine.

Azathioprine is inactive until converted to 6-mercaptopurine and methyl-nitro-thioimidazole.