The interesting features of this case were: (1) that she lived to the age of 76; (2) that death was due to liver and not renal complications; and (3) that the degree of portal compression by the huge cysts was sufficient to cause portal hypertension and subsequent bleeding oesophageal varices, without cirrhosis of the remaining compressed liver tissue.

My thanks to Dr. C. Hinds-Howell for permission to publish this case.

—I am, etc.,

St. Charles's Hospital,
London W.10.*

N. G. KATZEN.

* Present address: Bethlem Royal Hospital, Beckenham.

The Lyon Hypothesis

SIR,—Your leading article of 16 November (p. 1215) makes very interesting reading. We would like to add the following points:

(1) There are a few reported cases in which an extra autosome was not associated with mental deficiency: trisomy 22 in a case of benign congenital hypotonia¹; trisomy F (19-20) in a case of atrial septal defect,² and trisomy 19 in an apparently normal individual.³

(2) The XO chromosome constitution may be associated⁴ with typical Turner's syndrome, male Turner's syndrome, fertile Turner's syndrome, or Turner's syndrome with virilization. T. Dent and J. H. Edwards⁵ investigated a case of Turner's syndrome who was found to have a twin brother. The blood, serum groups, and palm-print pattern suggested that they were monozygotic. The lymphocyte and fibroblast cultures showed predominantly XO chromosome constitution in both twins. The brother appeared to be a normal male.—We are, etc.,

W. R. M. MORTON.

N. P. BISHUN.

M. NABIL RASHAD.

Department of Anatomy,
Queen's University, Belfast.

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- ² Böök, J. A., Santesson, B., and Zetterqvist, P., *Acta paediat. (Uppsala)*, 1961, **50**, 217.
- ³ Fraccaro, M., Kaijser, K., and Lindsten, J., *Lancet*, 1960, **i**, 724.
- ⁴ Overzier, C., in *Intersexuality*, ed. C. Overzier, 1963, p. 174. London.
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Hypertension and Impaired Renal Function

SIR,—I am afraid Mr. H. G. Hanley (22 February, p. 487) misunderstood the reason why I wrote my letter (18 January, p. 169). The point I tried to make is that a large number of intravenous pyelograms are ordered routinely without a prior consideration of the renal status of the patient. I still maintain that when the blood urea is over 100 mg. per 100 ml. due to renal disease ordinary intravenous pyelography is usually a waste of time and money. I am aware that modern pyelography, in which 40 ml. of a tri-iodine compound is used, may if much-

delayed films are taken produce on rare occasions information not obtainable otherwise. I can also assure Mr. Hanley that in advocating circumspection in the use of intravenous pyelography where there is nitrogen retention I had in mind substituting for it the safer and very much less expensive clinical and laboratory assessment, and not the blood-thirsty and knife-happy procedures to which he thinks his physician colleagues are prone.

—I am, etc.,

Selly Oak Hospital,
Birmingham 20.

A. M. NUSSEY.

Tautological Lapse

SIR,—The recent admirable face-lift of the journal is not, I find to my dismay, matched by an improvement in its English. It is a source of continued amazement to me that in a journal edited by members of a learned profession one can still find almost every week such elementary misuse of words as exemplified by such a tautological blunder as "skin rash." (Rash—"eruption of the skin in spots or patches." *Concise Oxford Dictionary*, 4th ed., 1951.) This week I notice this is given the privilege of heavy type; not so very long ago it was even included in the title of a paper.—I am, etc.,

Hatch End,
Middlesex.

N. T. POLLITT.

Periodic Migrainous Neuralgia

SIR,—I was interested to read Drs. J. I. Bella and J. N. Walton's article in your journal of 25 January (p. 219) and Mr. A. S. Shalom's letter (7 March, p. 633), but find it difficult to accept that periodic migrainous neuralgia and Sluder's sphenopalatine neuralgia are one and the same syndrome.

There is some divergence of opinion as to the constitution of these syndromes, but Sir Charles Symonds's classical description of migrainous neuralgia does not mention nasal symptoms or relief from nasal treatment, but states that no local cause for the pain is to be discovered.¹

In recent years I have examined 11 cases with Symonds's typical periodic migrainous neuralgia and have been unable to discover any abnormality of the nose or pathology in the sinuses. Also treatment by such measures as ephedrine hydrochloride solution applied in the lateral head-low positions, wide cocaineization of the nose, and sinus wash-outs, has failed to bring relief.—I am, etc.,

County Hospital, M. SPENCER HARRISON.
Lincoln.

REFERENCE

- ¹ Symonds, C., *Brain*, 1956, **79**, 217.

Dangers of Steroids for Rheumatoid Arthritis

SIR,—In the excellent "Current Practice" of 29 February which deals with "To-day's drugs for rheumatoid disorders" (p. 545) the author writes about the type of patient most likely to benefit from injections of gold salts: "It is of course just for such a patient that corticosteroid therapy will be considered.

There is little beyond individual preference to indicate which choice to make." May I submit that this attitude is in no way in accordance with to-day's opinion of most of the experienced rheumatologists of my country?

Early use of corticosteroids at the onset of rheumatoid arthritis involves high risks, which are only briefly quoted in the article, "Corticosteroid hormones, once started, may have to be administered and carefully supervised for the rest of the patient's life." This sentence does not exemplify sufficiently the formidable danger of severe consequences, which we have met too often in the last years: the danger of *corticosteroid servitude*, a condition which destroys the will-power and the morale of the patient in his struggle against his disease and is responsible for a complex picture previously unknown in rheumatoid patients. It is worse than the disease itself. This must be taken into account by every physician before starting corticosteroid therapy. As Ravault and his colleagues have pointed out, it is a true moral problem. In such cases withdrawal is difficult and may involve new hazards.

For these reasons it seems wise to accept the following propositions:

(1) During the first months (or years) of rheumatoid arthritis never prescribe corticosteroids before gold salts, antimalarials, and salicylates have been prescribed and applied regularly, during a period of several months to a year, without success.

(2) Do not continue the use of corticosteroids in long-term treatment if a dosage of 15 mg. of prednisone (or equivalent) or higher is necessary to control arthritis. Attempts must be repeated to bring down this level; if they fail, corticosteroids should be withdrawn.—I am, etc.,

Aix-les-Bains,
France.

JACQUES FORESTIER.

Blood Groups and Disease

SIR,—Reports on investigations into relationships between ABO blood groups and diseases continue to appear from time to time in the correspondence section of your journal (11 January, p. 122). It has been noted that the diseases in which a positive correlation has been found are all related to the upper abdominal viscera.¹ No correlation has been found in diseases of the colon. There have been no reports on diseases of the small bowel.

A retrospective study was conducted on all patients who were admitted to the Grace-New Haven Community Hospital in New Haven, Connecticut, U.S.A., for appendicectomy for acute appendicitis (confirmed pathologically) during the period January 1955 to December 1959. Of these 976 persons 611 had the blood group tested and recorded: 30 of these were excluded as they were negro. The blood-group distribution was: 243 patients with blood group O, 232 A, 82 B, and 24 AB. This per cent.

Group	Blood Group (%)			
	O	A	B	AB
Experimental	41.8	39.8	14.3	4.1
Control	45.6	40.8	10.0	3.7

χ^2 (overall) = 2.23. $P > 0.05$.