significantly absorbed from the large areas of inflamed skin which may have to be treated.

In his brief account of haemangiomas Dr. Beare mentions the ulceration which may occur in the larger cavernous lesions, particularly in areas which are readily traumatized. I have been impressed by the curious degree of pain from such ulcerated areas, and, for example, when they are present in the napkin area a child will often start crying as soon as it knows the napkin is going to be changed.—I am, etc.,

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Clofibrate and Androsterone in Hypercholesterolaemic Xanthomatosis

SIR,—The excellent results obtained by Dr. Bernard Mason and Professor C. B. Perry (9 January, p. 102) confirm the general impression of the great benefit of Atromid (clofibrate and androsterone) in patients with hypercholesterolaemic xanthomatosis. The almost universal improvement contrasts with the failure to influence other types of xanthomata. Like Mason and Perry, I have had no success in treating two patients with xanthelasma and hypercholesterolaemia. Similarly, two patients with biliary cirrhosis and extensive xanthomata have failed to lose their disfiguring skin lesions. On the other hand the two patients reported in your columns last year (17 October, p. 990) remain free of xanthomata after a further year, and the dose of Atromid is being cautiously reduced.—I am, etc.,

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B. W. ROPER.

Percutaneous Transhepatic Cholangiography

SIR,—The article by Drs. S. G. Elkington and D. C. Bernstein (19 September, p. 733) and the subsequent letter from Mr. H. A. Kidd (3 October, p. 875) on this subject has unfortunately only just come to notice out here, and I hope that it is not too late to contribute.

While fully agreeing that this is a most valuable procedure, I would put in a plea for use of the "sleeved-needle" catheter technique, as described by Shaldon and his colleagues,¹ and also by Arner and his colleagues.² It would seem better to have a soft polyethylene catheter in the liver than a long needle liable to tear that very friable organ at every respiratory excursion. Most radiologists would be more familiar with a percutaneous catheter, which has the additional advantage that it can safely be left *in situ* to permit drainage of the biliary tree as a pre-operative measure. Housset and Vantsis³ observe that decompression of the biliary system improves the vascularity of the liver and this may well improve the patient's reaction to operation. It is, of course, important to secure the catheter firmly to the skin either with a suture¹ or with a combination of Nobecutane and adhesive tape.⁴

Failure to do so adequately permits the catheter to slip out of place and bile leaks out through the liver puncture, as happened in two of my cases.⁴

Interpretation of the films requires considerable care, and it is essential, by comparison with a previous barium meal, to locate the exact site of a lesion in the common bile-duct in relation to cystic duct, duodenum, ampulla of Vater, and pancreas.

Finally, it is prudent to perform this examination only as a pre-operative measure. Although, using a catheter technique it is relatively safe to assume that failure to find bile means that the biliary tree is not dilated and, in the absence of complications from the procedure, operation may therefore not be indicated, nevertheless most surgeons would prefer to regard a case of probable obstructive jaundice as one which requires exploration. The principal purpose of this investigation, I suggest, is to assist the surgeon by providing additional pre-operative information in such a case, and other indications are in my view of most doubtful value.—I am, etc.,

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Combining the Antidepressant Drugs

SIR,—In view of the recent correspondence in the *B.M.J.* regarding the dangers of combining monoamine-oxidase inhibitors with either imipramine (Tofranil) or amitriptyline (Tryptizol, Saroten, Laroxyl) in depressive illnesses, it would seem appropriate to mention that I have just completed and am preparing for publication a special survey of more than 80 patients on such a combination. All of these patients have been seen personally by me, some over a period of many months. All had been treated previously with either a monoamine-oxidase inhibitor alone or imipramine or amitriptyline alone, and, because of their failure to respond, combined treatment was instituted. In general the dosage prescribed with combined drugs was slightly lower for each antidepressant than that prescribed when the antidepressant was used alone, although in about 15% on combined drugs full therapeutic dosage was prescribed.

In this group of patients both the nature and the incidence of side-effects when taking one antidepressant alone were very similar to those experienced on a combination of two antidepressants. In more than 80% of patients treated side-effects were either entirely absent or so mild as to be of little consequence. This was true for both single-drug treatment and combined treatment. In about 10% of cases on combined treatment this had to be discontinued or modified by reduction of dose because of the incidence of unpleasant side-effects. The corresponding figure for single-drug treatment was about 7%.

In none of the patients followed up did any disastrous or irreversible toxic effects

occur. No side-effects on combined treatment had been previously seen in patients receiving single-drug treatment.—I am, etc.,

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SIR,—Combinations of antidepressant drugs have proved to be most valuable in the treatment of depressive states and obsessional neuroses which are resistant to other therapies.

At Charing Cross Hospital extensive use has been made of these drugs in combination without dangerous side-effects, and it would be most unfortunate if the caveats of the Witts Committee were to hinder their use in clinical practice. I would support Dr. W. W. Sargent's plea (23 January, p. 251) for a rational attitude towards their continued prescription in proper dosage by psychiatrists experienced in their use.—I am, etc.,

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JOHN RANDELL.

Male Breast Cancer in Klinefelter's Syndrome

SIR,—The findings of Dr. A. W. Jackson and his colleagues (23 January, p. 223) are of great interest. It would, however, have been helpful if they had included some account of the histological appearances in the non-cancerous portions of the breast parenchyma in their two cases where mastectomy was performed (Cases 1 and 3).

I have studied the histological appearances of the male breast in pubertal and senile hypertrophy; in liver disease (carcinomatosis, multilobular cirrhosis, haemochromatosis, Kinnier-Wilson disease, chronic venous congestion, and fatty change); in feminizing tumour of the adrenal cortex; after prolonged therapy with diethylstilboestrol; and in Klinefelter's syndrome. I hope to publish, in collaboration with Dr. Jean Fraser, an account of the hypertrophies of the male breast in Klinefelter's syndrome and other conditions. Acinar development and the formation of true lobules identical with those seen in the mature female breast has been seen on only one occasion after prolonged administration of diethylstilboestrol and in some, but not all, cases of *chromatin-positive* Klinefelter's syndrome.¹ The formation of acinar tissue after prolonged oestrogen therapy has been confirmed in eight further cases by other workers.²

These findings suggest that hormonal influences may play a part in the occasional development of lobular acini in the male breast in cases of Klinefelter's syndrome. This possibility could be confirmed by hormone assays in cases of *chromatin-positive* Klinefelter's syndrome which have undergone breast biopsy or mastectomy for cosmetic reasons.

If this is established it would be important also to discover whether cases of carcinoma of the male breast occurring after prolonged oestrogen therapy and in patients with Klinefelter's syndrome are ever accompanied by development of lobules of the female type. I have not seen evidence of such lobule formation in my material from cases of male breast cancer, but I have not had the oppor-