We question whether children born to diabetic families should ever consume cows' milk. Breast milk and goats' milk are readily available in Britain, and their use should be encouraged for infants, children, and adolescents at risk of developing diabetes mellitus.

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Genetic prediction of adult onset disease

EDITOR,—Genes for an increasing number of adult onset disorders are being defined, and in this era of budgetary restriction and planning by contract we wonder how long doctors can afford to ignore lessons learnt from predictive testing for Huntington's disease. After the localisation of the locus for Huntington's disease in 1983¹ caution was initially exhibited by transatlantic colleagues, who wanted patients and their families legally to exonerate them from the consequences of giving bad news and from the predictable errors inherent in the use of linked genetic markers. In the United States and Britain extensive counselling programmes were developed.² People could decide to be tested only after a period of reflection and after receiving accurate information about the limits of the test, the implications for other family members, and the problems of living with good and bad news.

The results of several hundred tests have now been given out in Britain,^{2,3} and the counselling programmes are accepted as the minimum for good practice in participating clinical genetics centres.⁴ This is in contrast to the situation in other centres in Europe and the United States, where appreciable problems have resulted when inadequate support was provided.

Counselling programmes may be expensive in clinical time, but follow up of the people who have had predictive testing for Huntington's disease in Britain has shown that over half are free of risk and its associated morbidity, while those who receive high risk results cope well with no appreciable changes to their lifestyle.⁵ These programmes save the NHS money as well as providing a good service for patients. People at high risk can be followed up so that their problems are dealt with promptly and they may benefit from current research into the disease. Patients find this reassuring, and some visit their general practitioner less frequently than before testing (personal communications from general practitioners).

To give predictive information about other incurable disorders of adult onset to asymptomatic people without such support may well be considered to be negligent. Genetics centres are receiving requests for predictive testing for motor neurone disease, Alzheimer's disease, and some cancers. We believe that clinicians must become aware urgently of the impact of the information

that can be produced for these people and that these people should receive the benefit of the experience of the programmes concerned with Huntington's disease.

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Clusters of anophthalmia

EDITOR,—Eduardo E Castilla states that the reported prevalence of anophthalmia and microphthalmia at birth in England and Wales (0.22/10 000) is less than a quarter of the figure for the other populations for which the International Clearinghouse for Birth Defects Monitoring Systems receives data.¹ He also states that anophthalmia is the diagnosis in more than half the cases in England and Wales but in one quarter of those reported elsewhere.¹

The data for England and Wales come from the nationwide system centred on the Office of Population Censuses and Surveys, which covers only malformations notified soon after birth. In the experience of local English registries, which ascertain malformations from multiple sources, the prevalence of anophthalmia and microphthalmia at birth is much higher (1.3/10 000 in both Birmingham and Liverpool) and at least two thirds of affected subjects have only microphthalmia.^{2,3} These findings strongly suggest that the differences reported by Castilla are due (as he hinted that they might be) to incomplete ascertainment, especially of less severe cases, by the nationwide system for England and Wales. This and earlier evidence of the limitations of the nationwide system⁴ shows the need for caution when data from this source are used to explore possible clusters of malformations.

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Tuberculous pericarditis

EDITOR,—The patient reported on by C P Clifford and G J Davies, who had tuberculous pericarditis that rapidly progressed to constriction, was Sri Lankan.¹ Tuberculosis is the commonest cause of pericardial effusions in Sri Lanka. We recently prevented constrictive pericarditis in a boy in our unit by using steroids.

A 13 year old boy was admitted with fever and cough of two weeks' duration. He was febrile with a pulse of 96 beats/min and a jugular venous pressure of 5 cm water. He had a remarkable pericardial rub in the left sternal edge. A chest x ray film showed severe cardiomegaly, and echocardiography confirmed a large pericardial effusion. A pericardial aspirate contained many red cells and lymphocytes but was repeatedly negative for acid fast bacilli. A Mantoux test yielded a negative result. He was given a course of antituberculosis treatment, and the fever settled completely in five days. Steroid treatment (prednisolone 10 mg three times a day) was started one week after the start of antituberculosis treatment. An echocardiogram at one month showed a mild pericardial effusion with good contractility of ventricles and a normal ejection fraction.

A controlled clinical trial has shown that adding steroids increases the rate of recovery from tuberculous pericarditis compared with that with standard antituberculosis treatment alone.² It also reduced the risk of death due to pericarditis and the need for pericardectomy. Furthermore, the highly potent antituberculosis regimen of streptomycin, rifampicin, isoniazid, and pyrazinamide daily for 14 weeks followed by rifampicin and isoniazid for six months is believed to be associated with a lower death rate than the less potent regimen of rifampicin, isoniazid, ethambutol, and pyrazinamide for two months followed by rifampicin and isoniazid for four months.^{3,4}

It is our practice to start steroids for all patients with tuberculous pericarditis only after the fever has responded to antituberculosis drugs. Thus antituberculosis drugs can be a diagnostic aid in pericardial effusions when the result of a Mantoux test is negative and acid fast bacilli cannot be isolated from pericardial fluid or sputum.

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Imaging methods used in acute aortic dissection

EDITOR,—Our experience as radiologists in a large cardiothoracic centre does not lead us to support the imaging policy put forward by C M Francis and colleagues.¹ Because aortic dissection requires rapid and accurate diagnosis since early surgery may be lifesaving² we disagree with the suggestion that transoesophageal echocardiography is the best imaging method. The decision to intervene surgically and the type of operation depend on whether any part of the ascending aorta or vessels of the head and neck are affected. Francis and colleagues themselves state that transoesophageal echocardiography has a restricted view at this site, and it may result in an inaccurate diagnosis. This is supported by results of a study by Nienaber *et al.*, which found a specificity of only 68% for transoesophageal echocardiography largely because of false positive findings in the ascending aorta.³ In addition, none of the useful information on aortic branch vessels, which are easily seen on angiography, can be obtained with transoesophageal echocardiography. We have also found

that transoesophageal imaging has not been immediately available to provide surgeons with a viable alternative to biplane angiography in acute thoracic surgical emergencies. We therefore concur with D W Hodgkinson and colleagues.⁴

The much less common condition of stable chronic dissection may satisfactorily be imaged by any of the radiological techniques available, including computed tomography, magnetic resonance imaging, transoesophageal echocardiography, and angiography.

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Sharing journals and reference books

EDITOR,—Trish Groves has written about schemes that get health information to developing countries.¹ I have been sending journals to the Ceylon College of Physicians since 1986, when I took over from Dr Dewi Davies, who had done this for many years. The journals are collected after notices are placed in the journals of the Royal College of Physicians and the Royal College of General Practitioners. On average I send about 10 000 journals a year. Last year I visited Sri Lanka and saw these journals in use. They are often the only source of information for the local clinicians as the price of books is so high: one moderately sized text costs the equivalent of a month's salary for a consultant.

I would be happy to accept any journals not more than two years old and to forward them to colleagues in the Third World. It is helpful if boxes are labelled on the outside with a list of contents as this saves us from having to repack them and means that they can be processed more easily. I would also welcome copies of the *British National Formulary* as this is a first class reference book for therapeutics and enables drug prices to be kept down. Please send the journals and books to me at the address below.

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Radiological assessment of the knee in children

EDITOR,—In a retrospective study of 203 new referrals to a paediatric rheumatology clinic 42 came from orthopaedic surgeons.¹ Most of these patients were admitted from the accident and emergency department or referred to the fracture clinic with a presumptive acute injury.

Juvenile chronic arthritis, although uncommon (occurring in 1 in 1000 schoolchildren), has an excellent prognosis, with 85% of children having

no acute disease 15 years after its onset.² Recognition of this disease is therefore important so that subsequent deformity and disability can be prevented. The commonest type, pauciarticular disease, often presents with a single inflamed joint, such as the knee, simulating trauma. These children are at risk of asymptomatic iridocyclitis, an important complication.

The radiological changes of juvenile chronic arthritis are subtle and erosions rare. The commonest change is altered maturation of ossification, commonly seen in the wrist and knee. Comparison of both sides of the body is important. Overgrowth of the medial condyle in the knee can be identified in this way. Radiographs of both knees on the same plate may show linear overgrowth, indicating long term disease and excluding recent fractures. The knee will be magnified in patients with a fixed flexion deformity as the joint is held further away from the plate.

We suggest that P Sanville and colleagues' article on radiological assessment of the knee³ should have mentioned that in children a comparison of the opposing side facilitates the distinction between acute and chronic disease.

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Medical ethics and human reproduction

Scientists predict unbalanced future with sex selection

EDITOR,—The recent opening of a gender clinic in north London and the publication of a report of the Human Fertilisation and Embryology Authority¹ have focused attention on the morality of selecting the sex of children. The resulting debate has taken place in the absence of valid scientific data on the genetic and demographic consequences of this practice. Preliminary studies have found that parental preferences at such clinics around the world can be strongly biased towards sons.^{2,4} We report the results of a theoretical study that establishes that substantial genetic distortions of the primary sex ratio (the sex ratio at conception) may result if parents consistently prefer sons to daughters.⁵

If parents are given the opportunity to choose the sex of their child and if children of one sex are preferred this will result in a distorted sex ratio among children and adults. We have found that a prolonged and widespread imbalance in the adult sex ratio can generate natural selection for any genes that contribute to distortion of the primary sex ratio. This genetic distortion could be male biased or female biased, depending on the circumstances. When parents who favour sons do not "pay" for sex selection by having fewer children natural selection will act to generate a female biased primary sex ratio. If, on the other hand, parents who are biased towards sons have appreciably fewer children than average then natural selection will act to generate a male biased primary sex ratio. We suggest that the former alternative is more likely in most postindustrial societies, such as Britain. If the distortions in the adult sex ratio are severe then atypically strong natural selection is generated, and these genetic distortions can occur

within tens rather than thousands of generations. In the presence of such socially induced selection pressures the evolutionarily stable sex ratio will not be 1:1.

In considering the effects of sex selection it is important to remember that the interaction of genetic and cultural processes can fuel increasingly pronounced genetic distortions. These would have to be compensated by more sex selective and discriminatory practices to preserve a "desired" sex ratio.

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Ova from fetuses "against the laws of nature"

EDITOR,—I suppose that the use of fetal tissue for research on fertility, and even the use of ova from fetuses to treat infertile women, is a logical step from the legalisation of abortion in the 1960s.¹ It seems so logical not to waste useful human tissue. Those of us who oppose abortion see it as the inevitable "domino effect" we predicted. Once fundamental respect for the origins of human life was breached then use of embryos in research and of fetal tissue for treating disease and as a source of new life was inevitable.

Unfortunately, just as unchecked power for too long corrupts politicians, so performing abortions for decades or working for decades alongside colleagues who perform them gradually dulls the ethical checks we have on our work. The BMA's ethics committee seems to have prejudged the issue and rushed to support the idea of fetal tissue providing ova. As in the debate over abortion, it has quickly acquiesced in the prevailing climate of opinion.

In this transplantation oriented age I can see some logic in accepting ova that have been voluntarily donated by live donors, but removing ova from fetuses or cadavers to produce human beings seems against the laws of nature. If some of the hundreds of thousands of normal babies aborted in Britain each year were available for adoption would all this be necessary?

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Human rights in Iraq and Iran

EDITOR,—The evasion and dissembling by British government ministers at the inquiry into illegal arms sales to Iraq (the Scott inquiry) come as no surprise. It has long been clear, not least to purchasers like Saddam Hussein, that Western governments sell arms on the basis of their geopolitical and business priorities and that records regarding human rights generally do not count. These imperatives are robust enough to tolerate