with morphine, intravenous "cedilanid" (lanatoside C), and aminophylline the patient fortunately recovered.

This brief case history illustrates the futility of arranging careful supervision for such patients if at the time that emergency hospital facilities are required they are not available.

Our object in writing this letter is to draw attention to the difficulty in arranging emergency admission to hospital in this area. This is common knowledge to all doctors practising in Merseyside, and it is impossible to see how the proposed reduction in the number of available beds in the Liverpool area under the new hospital plan can be justified. In view of the difficulty already experienced in trying to find hospital beds for seriously ill patients we wish to express our extreme anxiety and alarm at any contemplated reduction in the existing bed complement. We sincerely hope that the authorities concerned will reconsider this injudicious and dangerous plan.—We are, etc.,

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A. M. PYE. S. SOLOMON.
Liverpool 4.

Indications for Tonsillectomy

SIR,—I wonder whether there are not many medical practitioners like myself who feel that the pendulum has swung just a little too far away from the erstwhile tonsillectomy craze? Recently I saw a boy with acute follicular tonsillitis. He had had so many previous attacks that he was repeatedly out of school, but although referred to a consultant his mother was told that no operation was required.

How long must he go on being ill? Is he to live through years of ill-health like other children I know, becoming year by year more toxic, and lucky if they do not finally end up with acute rheumatism or subacute bacterial endocarditis? One has to see the miraculous change in an exhausted endlessly ill child, no longer able to join in normal school activities when the tonsils are at last removed. It seems as if, in a matter of weeks, their vitality becomes such that no amount of play or work can tire them any more.

It is all very well to assure a mother "he will grow out of it," but meanwhile there is not only the physical damage done to the whole system year after year but the appalling psychological stigma of being the odd child out—the "delicate" one—and the added strain of having to catch up on weeks of school work missed through ill health. It is true that all operations carry a certain risk, but when life has become so intolerable perhaps it is worth the risk.

Is it impertinent to suggest that the medical history of these cases is a more reliable guide to the necessity for tonsillectomy than the appearance of nose and throat at the time of consultation?—I am, etc.,

VIOLET SPILLER.
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Waiting for Hospital

SIR,—Drs. Lachlan Carmichael, Fraser Ross, and J. S. K. Stevenson have written an interesting article on delays in obtaining hospital consultations (March 16, p. 736), but I think that the matter requires to be put in its true perspective. The authors seem to think themselves a little hard done by in that it takes them just under 20 days to receive a consultant's report, and they are indeed a bit unfortunate compared with us in Sheppey, where we can usually obtain a consultant appointment within a week and have a report a few days later. However, having worked in many parts of the country I have found that it usually takes a month before a patient can see a consultant, and in some places it is as much as two months for consultations in general and four months for an orthopaedic consultation. I hope the situation is improving, but I fail to see how it can do anything but deteriorate while the population rises and hospital facilities show no signs of expanding *pari passu*.

Another aspect of waiting is the waiting-list for admissions to hospital. I know one provincial hospital where the E.N.T. waiting-list was 18-months long in spite of two E.N.T. surgeons; and no one got on that list just because his tonsils were meeting in the middle—it was necessary to have chronically infected tonsils or recurrent attacks of frank tonsillitis. I know one city where the waiting-list for cold surgery was 18 months: it was a bit hard for a woman who had had recurrent bouts of pain from cholelithiasis to be told that she had still several months to wait as she had only been on the waiting-list for a year. I have been told of another city where the waiting-list for cold gynaecological surgery was four years.

Perhaps someone could provide an up-to-date report on waiting-lists for admissions in various towns.—I am, etc.,

R. T. D. FITZGERALD.
Sheerness, Kent.

Male or Female?

SIR,—The case of a uterus presenting in an inguinal hernia of an apparently male subject reported by Mr. K. K. Bhatnagar (November 10, 1962, p. 1236) has many interesting features and it raises many questions. Fourteen per cent. of the buccal mucosal cell nuclei showed the presence of sex chromatin body. The conclusion drawn from this that the individual had male character is surely unwarranted. It is well established that over 30% (usually 40–60%) of suitable nuclei from buccal mucosal cells in the female show the sex chromatin body,[1] but a number less than 30% does not permit of the conclusion that the individual is a genetic male. Nuclei with sex chromatin are not found in oral smears from chromosomal males.[1 2] Hence the individual reported by Dr. Bhatnagar is a chromatin-positive one; this suggests that the individual is a genetic female (XX).

The gonads of this individual did not possess any epididymis or vas deferens, and their relationship to the uterus was that of two ovaries to a uterus. This, together with the finding of sex chromatin body in 14% of buccal mucosal cell nuclei, favours the conclusion of the presence of a uterus and Fallopian tubes in a genetic female manifesting as a phenotypic male.

Other important features of the case are the presence of a prostate and the presence of seminiferous tubules in one of the gonads. These features suggest the possibility that the individual might be a female pseudohermaphrodite, i.e., a genetic female with external or internal genitalia masculinized. Instances of female pseudohermaphroditism not due to adrenal hyperplasia and with normal 17-ketosteroid levels, although rare, have been reported by Potter,[3] Armstrong,[4] and Broster.[5] Another possibility, a more probable one in this case, is that of true lateral hermaphroditism. Unfortunately this entirely depends on the histological

examination of the other gonad, which was not carried out. If the other gonad turned out to be an ovary or an ovo-testis, the individual would be a true hermaphrodite. Bromwich[6] has reported a case of true lateral hermaphroditism with female nuclear morphology, the patient being psychologically a normal male, married, and capable of intercourse. Similarly, Armstrong[4 7] has reported a case of true lateral hermaphroditism with female nuclear morphology.

Out of the 15 reported cases of true lateral hermaphroditism, 14 had more or less completely formed male and female internal genital organs on opposite sides, accompanying their appropriate gonads. The external genitalia and bodily configuration ranged from almost female but with a phallus-like genital tubercle, to almost normal male but usually with hypospadias. Most of the cases had been regarded socially as male. In most of these cases the testis lay in the scrotum.[8] Considering these observations in true lateral hermaphroditism it is likely that the undescended gonad in this case was an ovary or an ovo-testis. It would be interesting to know which of the gonads (the descended or the undescended one) showed the presence of seminiferous tubules. The author has not mentioned from which gonad the biopsy was performed.

Hence the apparently surprising features in this case, viz., the presence of a prostate, the potency of the individual, the evidence of seminiferous tubules in one of the gonads, and the presence of an ejaculate cannot be considered prima facie as points conclusive of the sex of the individual. The histological examination of the other gonad, a sex chromosome analysis of the individual, and examination of different tissues, including the gonads for mosaicism, would be of much help in this case.—I am, etc.,

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Berylliosis

SIR,—I was very interested to read the article by Drs. G. F. Norris and Mary C. Peard (February 9, p. 378) and wish to comment on the histological aspect. I have shown that the granuloma and Schaumann bodies of beryllium disease and sarcoidosis are indistinguishable[1 2] and not merely "similar" as stated in their summary.

I must express surprise as to their histological description and comment made on the patch-test biopsies. In my study of the granuloma in the lung in 52 cases necrosis was not found. If necrosis is present, then the granuloma is indistinguishable, not from sarcoidosis, but from tuberculosis. Central hyalinization is not uncommon (52%) but can be distinguished from necrosis by the demonstration in the early lesion of intact and thickened reticulin, and in older lesions by collagen. If true necrosis is present in Case 2, it is a very unusual finding and perhaps suggests an acute hypersensitivity reaction in a patient with previous chronic disease. This man may have had previous exposure but remained symptomless (Hardy[3] instances latent intervals of up to 10 years), with acute symptoms then developing after a further heavier exposure and resensitization. He might therefore be better classified as a chronic case rather than the not generally used term "subacute."

It should further be pointed out that, in sections I have examined from the lungs of acute cases, granulomata are absent, the lesion being that of chemical pneumonitis.—I am, etc.,

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Death after Oxyphenbutazone and Steroids

SIR,—It is truly interesting to read in Professor W. Gaisford's medical memorandum (December 8, p. 1517) what happened to the boy whose attack of "metabolic wet brain" he had previously described.[1] On that previous occasion the boy became very ill when prednisone (5 mg. daily) was stopped; but he recovered with larger doses. Professor Gaisford drew the correct lesson—that steroids should not be abruptly withdrawn. On the second occasion he tells us the boy was having 1 mg. of paramethasone and that this dose was halved when oxyphenbutazone was prescribed.

In the Fourteenth Rheumatism Review[2] the editors remind us that patients who have been long on steroids may be sensitive to even slight lowering of the dose. And this patient's chief symptoms (jaundice, purpura, fever, convulsions, colitis) are known effects of steroid derangement.

Horowitz and Fujimoto[3] treated with steroids a patient with mild purpura; he died from deranged liver function with jaundice. Cooke *et al.*[4] treated dermatitis with prednisone. When treatment was suspended the patient got acute arthritis of the hip followed by fatal haemorrhagic disease.—I am, etc.,

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Cyclophosphamide and Mustine

SIR,—Dr. K. P. Goldman (February 2, p. 312), when describing the use of high-dose mustine therapy for bronchial carcinoma, refers to the use of cyclophosphamide in the treatment of this condition.[1] We hasten to correct the impression created by him that cyclophosphamide is "relatively ineffective" compared with mustine.

Our criteria for assessing results were strict. We only claimed a response when definite objective improvement occurred. This compares with category A in Dr. Goldman's series. In our series reported in 1961, eight out of 27 patients with carcinoma of the bronchus showed objective improvement. Since then we have had more patients who responded to treatment.