Analysis of 79 Episodes of Respiratory-tract Infection in Adults in which Rhinoviruses were isolated. Subjects classified according to History of Asthma or Bronchitis with Wheeze

Previous History of Subject	Total No. of Episodes	Upper Respiratory Tract Symptoms	Lower Respiratory Tract Infection	
			No Wheeze	Wheeze
No wheeze	56	40 (71·5%)	9 (16%)	7 (12·5%)
Asthma or bronchitis with wheeze	23	2 (8·7%)	1 (4·3%)	20 (87%)
	79	42	10	27

Laboratory, Colindale. Preliminary analysis has not found any serotypes which are especially associated with lower respiratory infection or wheeze. Recurrent episodes of rhinoviral infection have been observed in many adults and children, but in only five subjects was the serotype the same as that isolated during the previous infection.

It has been impossible to determine whether the episodes of viral infection associated with wheeze were primary or reinfections. In either case susceptibility could be due to a defect of immune mechanisms but it would still be necessary to explain the occurrence of wheeze. In the case of reinfection this might conceivably be due to some form of hypersensitivity reaction. However, it seems that subjects who wheeze in association with viral infection are constitutionally different from the normal population because they have inherited or acquired bronchial hyperreactivity.

It is a pleasure to acknowledge the outstanding contribution of the Virus Department at the Brompton Hospital, formerly under the direction of Dr. J. M. Inglis and latterly of Mrs. Susan Yealland.—I am, etc.,

IAN GREGG

Department of Clinical Epidemiology in General Practice,
Cardio-Thoracic Institute,
Brompton Hospital,
London S.W.3

Uganda Asians

SIR,—We have all known for some six weeks now that Asians in Uganda are to be robbed of their homes and possessions and expelled from the country that has been theirs for several generations. Among them will be at least fifty doctors and I have waited in vain for a lead from the British Medical Association to suggest what help the profession here can give them.

Medicine in East Africa has always had close ties with Britain, and general practice in urban Uganda in particular is conducted along lines very similar to our own. There are some thirty-five members and associates of the Uganda Faculty of our Royal College of General Practitioners and their secretary tells me that most expect to come, in the first instance anyway, to Britain.

Two of your correspondents have in the past three weeks written to warn us of the hazards of imported tropical disease but some mention of the plight of our colleagues is conspicuous by its absence. As far as I can ascertain, neither the Department of Health and Social Security nor the B.M.A. has seriously considered any practical steps to help them and very few offers of either hospitality or employment have been made.

Recent developments in the Uganda capital may well have placed these doctors incommunicado for the moment. I beg the courtesy of your columns therefore to ask that help should be offered via the Association.—I am, etc.,

M. J. AYLETT

Corsham, Wilts

**The Secretary states that the facilities of the Association's Personal Services Bureau at B.M.A. House are available. Inquiries would be welcome from Asian doctors from Uganda seeking employment in Britain. The bureau would also be glad to hear from G.P. principals in Britain who are able to offer them employment.—ED., *B.M.J.*

SIR,—The letter (16 September, p. 698) from Professor A. W. Woodruff is timely. It might be useful to mention one point with regard to bone and joint tuberculosis in non-Europeans which can confuse a diagnostician in Britain. Pyrexia, even a quite high swinging temperature, and an E.S.R. reaching 50 and over can easily suggest staphylococcal bone disease, though the lesion is, in fact, tuberculous.—I am, etc.,

F. H. STEVENSON

Royal National Orthopaedic Hospital,
London W.1

SIR,—The opportune letter of Professor A. W. Woodruff (16 September, p. 698) concerning malaria among Uganda Asians is both timely and helpful.

Over the past 18 years nearly 3,000 blood films for malaria of people returning from tropical countries have been examined by the staff of this laboratory under the direction of Professor P. C. C. Garnham. On every occasion a questionnaire was sent to the sender of the films, and whenever a heavy infection with *P. falciparum* was found the hospital involved was contacted by telephone and our findings reported. The information provided by these questionnaires[1] has enabled an analysis to be made and may be summarized as follows. (1) Over 90% of all imported cases from tropical Africa were *P.falciparum*. (2) A significant percentage were primary cases and occurred among people who had spent less than a month in Africa.[2] (3) Of the many fatal cases all were *P.falciparum* infections, all were primary cases all of them died within a month of arriving home, none had taken prophylactic drugs (paludrine or daraprim) for the recommended one month after leaving the malarious area, and none had received treatment for at least seven days after the onset of fever.

It would therefore seem that children arriving from Uganda who may have acquired their infections a few days before leaving will be especially prone to severe attacks unless treated without delay, and this calls for early diagnosis. May I mention that, in addition to the units stated by Professor Woodruff where blood films may be sent for examination, specimens, preferably unfixed and unstained, may be sent to Professor Garnham, Malaria Reference Laboratory of the Department of Health and Social Security and Malaria Reference Laboratory of W.H.O., Horton Hospital, Epsom, Surrey.—I am, etc.,

P. G. SHUTE

Horton Hospital, Epsom

1 Shute, P. G., and Maryon, M., *British Medical Journal*, 1969, 2, 781.
2 Maegraith, B., *Lancet*, 1963, 1, 401.

SIR,—In answer to Mr. C. R. Salkeld's letter (9 September, p. 644) on arrangements for the medical examination of the Asian immigrants shortly to arrive in this country, I am pleased to inform you that arrangements are being made. In addition to the complete initial screening which the Asians will have on landing, given by permanent staff at the airports, the director of the medical department of War on Want, Dr. David S. Rosenberg, has been asked to arrange for volunteers to stand by in case assistance is needed. Volunteer doctors and nurses able to serve at Luton, Heathrow, Gatwick, or Stansted airports should apply in writing to the Medical Director, 3 Madeley Road, Ealing, London W.5, as soon as possible giving details of availability, etc.—I am, etc.,

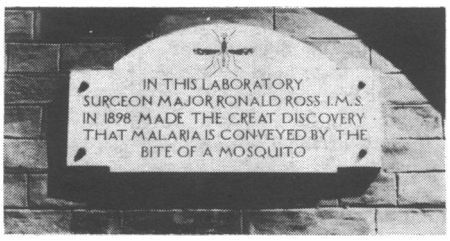
ANN FORD
Medical Promotions Secretary,
War on Want.

**See also *Supplement*, p. 179.—ED., *B.M.J.*

Transmission of Malaria

SIR,—I enjoyed Professor L. J. Bruce-Chwatt's account (19 August, p. 464) of Sir Ronald Ross's discovery 75 years ago of the transmission of malaria by the anopheles mosquito. The commemorative tablet at Secunderabad actually states that his discovery there was the finding of the malaria parasites in a dissected anopheles mosquito.

I enclose a photograph of another commemorate tablet, which is on the wall of his



laboratory in the grounds of the Calcutta Medical School. It is dated the following year, 1898, when his decisive observations about the life cycle of the parasite were made.—I am, etc.,

J. D. SPILLANE

University Hospital of Wales,
Cardiff

Palmar Dermatoglyphs in Wilson's Disease

SIR,—Hodges and Simon[1] reported an increased incidence of fingertip whorls in patients with Wilson's disease (hepatolenticular degeneration), particularly on the right thumb but also on the left thumb and the index and middle fingers of both hands. They correctly urged caution in interpretation of the results until these could be confirmed, and suggested that fingerprints "may be helpful as a genetic tool." How-

TABLE I—*Fingerprint Patterns on all 10 Fingers*

Subjects	Whorls (%)	Twinned Loops (%)	Ulnar Loops (%)	Arches (%)	Radial Loops (%)
Controls (1,000)	22	5	63	6	5
Wilson's disease (22) ..	21	8	59	8	4
Wilson's carriers (13) ..	24	3	59	7	7

TABLE II—*Right Thumb Patterns*

Subjects	Whorls (%)	Twinned Loops (%)	Ulnar Loops (%)	Radial Loops + Arches (%)
Controls (1,000)	25	14	60	1
Wilson's disease (22) ..	25	15	60	0
Wilson's carriers (13) ..	46	0	54	0

ever, their findings have never been confirmed, and they have become so widely quoted both in papers and books that they have come to be unquestioningly accepted. Thus, in Professor Sheila Sherlock's book[2] it is stated in the chapter on hepatolenticular degeneration that the genetic factor is emphasized by the finding of increased "whorl" fingerprint patterns in sufferers.

Wilson's disease is an inborn error of hepatic copper metabolism and it is inherited as an autosomal recessive. We have studied the palmar dermatoglyphs of 22 consecutive patients with the disease seen at the Royal Free Hospital as well as 13 parents and offspring of these patients who are obligative heterozygotes. Our controls consisted of 500 males and 500 females who were healthy, unrelated, and came from the south and west of England. The results for fingerprint patterns are shown in Table I.

It is clear from these results that the possession of the gene for Wilson's disease in a single or double dose has no consistent effect on fingerprint patterns. To ensure that an increase in whorls was not localized to the right thumb the figures for this digit are given in Table II.

Other dermatoglyphic measurements—namely, total finger ridge count, a-b ridge count, and atd angle were also normal in our patients with Wilson's disease and their heterozygous relatives.

We conclude that dermatoglyphs will not help with the diagnosis of Wilson's disease nor will they help to detect heterozygotes, and therefore they cannot be used to aid genetic counselling. We are unable to confirm any of the positive findings of Hodges and Simon.[1]

We are indebted to Professor S. Sherlock for permission to study her patients. T.J.D. is in receipt of a grant from the South-Western Regional Hospital Board and the United Bristol Hospitals.

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1 Hodges, R. E., and Simon, J. R., *Journal of Laboratory and Clinical Medicine*, 1962, **60**. 629.
2 Sherlock, S., *Diseases of the Liver and Biliary System*. Oxford, Blackwell, 1968.

The Artist's Eye

SIR,—With regard to the prevalence of red-green colour-blindness (Dr. Ann J. Gower, 2 September, p. 586), the recent findings of the follow-up at 11 years of children in the national child development study[1] showed that 6·1% of boys and 1·1% of girls were reported by examining school medical officers using Ishihara plates to have impaired red-green colour vision. Thus in this national sample about 1 in every 16 males was affected.—I am, etc.,

CATHERINE PECKHAM
National Children's Bureau,
London

1 Davie, R., Butler, W. R., and Goldstein, H., *Birth to Seven*. London, Longmans, 1972.

SIR,—Your leader writer was of course quite right (19 August, p. 434): many investigators in many places have found an incidence of colour vision defect of between 7 and 8% in males and of 0·4 to 0·5% in females. So Dr. Ann J. Gower (2 September, p. 586), rather than finding your statement "incredible" should surely be asking herself why she seldom discovers any such defect. She does not say at what age the children are tested. The Ishihara plates, though probably the best practical test for routine examination of school children, are by no means a perfect instrument, and older children with lesser degrees of colour vision defect may escape detection—probably without detriment.

A detailed study of the impact of colour vision defect upon education, carried out in Hampshire,[1] revealed incidentally that there was very considerable observer variation in the use of the Ishihara test. In view of the extensive use made of colour in teaching, particularly in the infant schools, it is important that significant degrees of colour vision defect should be detected at an early age so that these children are not at an educational disadvantage. A colour vision test applicable to 5-year-olds is now in use in Hampshire schools.—I am, etc.,

LIONEL BACON
Winchester

1 Bacon, L. J., *Medical Officer*, 1971, **125**, 199.

SIR,—I was interested to read the letter from Dr. Ann J. Gower concerning colour-blindness in school children (2 September, p. 586). It is a pity that she does not quote any figures.

A few years ago I formed a similar impression of an unusually low prevalence of this condition in the schools where I performed routine medical examinations. When I came to check this I found that out of 308 boys in two schools there were 22 cases of red-green colour-blindness as shown by the Ishihara plates. This is a prevalence of just over 7%, or 1 in 14, not very different from the figure of 1 in 12 to which Dr. Gower takes such exception.

I did incidentally find a higher prevalence in grammar school boys (8 out of 85 or 1 in 10·6) than in boys at a secondary modern school where there were 14 cases out of 223 boys examined, a prevalence of 1 in 15·9. I do not know the significance of this, but it might explain the small number of cases found by Dr. Gower. I believe that a higher prevalence of refractive errors has also been found in boys of grammar school standard.—I am, etc.,

R. H. G. CHARLES
London W.5

Abortion Deaths

SIR,—I serve as one of the regional assessors on maternal deaths, and I must dissociate myself from Sir George Godber's preface to the *Report on Confidential Enquiries into Maternal Deaths in England and Wales 1967-69* (Reports on Health and Social Subjects No. 1).

Sir George writes: "In 1969 there was a substantial reduction in the number of deaths due to abortion." In chapter 5 on Abortion (page 47) the following figures of deaths from abortion reveal clearly a drop in deaths from illegal abortions but a rise in deaths from legal abortions. The total remains approximately the same.

	Deaths from Abortion		
	Illegal Abortions	*Legal Abortions*	*Total*
1967	28	1	29
1968	29	5	34
1969	17	12	29

As the total number of abortions, legal and illegal, rises towards 200,000 per annum in England and Wales it seems likely that the *total* number of deaths from this operation (quite apart from subsequent serious complications) will keep pace.—I am, etc.,

HUGH CAMERON MCLAREN
Birmingham Maternity Hospital,
Birmingham 15

Aetiology of Varicosity

SIR,—Mr. Denis P. Burkitt's data (3 June, p. 556) on the geographical distribution of venous disorders are very striking, and it is interesting to see the outcome of all the forms we fill in for him. However, I find the postulated mechanisms much less convincing. He implies throughout that rural Africans are happily free from constipation. This is certainly not their own opinion, though their definition of constipation differs from ours and would be something like less than two bowel actions a day. They frequently complain of it, and a loaded colon is commonly palpable in the African abdomen (at least, it is around here). Even though their stool transits twice as fast as that of people in the U.K., if its volume is, as Mr. Burkitt states, more than four times as great, the amount in the colon at any one time could be at least as great as that of people in the U.K. They might not have faecal arrest but the hypothetical pressure on pelvic veins would be no less. This would invalidate Cleave's explanation.[1]

Similarly, the alternative explanation that Africans do not strain at stool is an unproved assumption. They are avid users of