despite vaccination and a good "take," can develop modified smallpox.

With regard to the question of severe chickenpox versus smallpox, I think it is sensible and wise to err on the wrong side and regard all severe cases of chickenpox as potential cases of smallpox until proved otherwise. In such situations, in my experience, mapping of the lesions on a chart and comparing it with Langer's lines[2] as shown in the accompanying figure has been found very useful, as the distribution of lesions in chickenpox follows the Langer's lines very closely, whereas those of smallpox do not.

Lastly, with regard to laboratory diagnosis I think agar-gel diffusion based on antigen and antibody reaction, a test devised by Dumbell and Nizamuddin,[3] has proved outstandingly successful, giving reliable, rapid results in about six hours.—I am, etc.,

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1 Ramsay, A. M., and Emond, R. T. D., *Infectious Diseases*. London, Heinemann Medical Books, 1967.
2 Dixon, C. W., *Smallpox*. London, Churchill, 1962.
3 Dumbell, K. R., and Nizamuddin, M., *Lancet*, 1959, 1, 916.

Treatment of Systemic Lupus Erythematosus with Renal Insufficiency

SIR,—I was interested to read the papers by Dr. M. L. Snaith and others (28 April, p. 197) and Dr. P. H. Feng and others (26 May, p. 450) on the use of chlorambucil and cyclophosphamide respectively in the therapy of systemic lupus erythematosus (S.L.E.). I would like to record a case of S.L.E. with renal insufficiency which responded to a combination of cyclophosphamide and corticosteroids.

An Indian girl aged 13 years presented in January 1972 with weakness, chest pain, arthralgia, and ulcers in the mouth. She was emaciated and pyrexial. Lymphadenopathy was present in the right axillary region and the left posterior triangle of the neck. The haemoglobin level was 7·5 g/100 ml, leucocyte count 5,000/mm³, and platelet count 50,000 c/mm³. L.E. cells were present in the blood. The urine was normal and blood urea 40 mg/100 ml. Chest *x*-ray showed a honeycomb picture at the bases compatible with S.L.E. She was treated with prednisone 60 mg daily, and though she was on it on an intermittent basis in that follow-up was not regular she deteriorated clinically. The patient was readmitted in March 1973 complaining of weakness, fever, backache, and chest pain. She was markedly emaciated, pale, and ill-looking and weighed only 55 lb (25 kg). Investigations showed that her renal condition had deteriorated: the urine contained albumin 1+ and 5 leucocytes per high-power field, the blood urea was 105 mg/100 ml, and the glomerular filtration rate 18 ml/min. Other investigations showed: serum complement 43 mg/100 ml, haemoglobin 6·5 g/100 ml, leucocyte count 6,000/mm³, platelet count 30,000/mm³, Coombs test positive, and mild haemolytic anaemia present. Renal biopsy showed focal tuft adhesions and cellularity of the glomeruli with marked focal thickening of the basement membrane ("wire loop" lesion). An ammonium chloride test confirmed that the patient could not acidify her urine in that the pH of the urine remained at 5.8 in spite of systemic acidosis.

The patient was treated with prednisone 30 mg daily and cyclophosphamide 50 mg on alternate days. She gradually improved, her weight gain was 100 lb (45 kg), and there was no temperature. The glomerular filtration rate rose to 31 ml/min, the blood urea dropped to 40 mg/100 ml, and the serum complement rose to 66 mg/100 ml. Chlorambucil 4 mg daily was then substituted for the cyclophosphamide, but this produced a relapse in her condition in that she became febrile. On reintroducing cyclophosphamide the patient became afebrile. Efforts to stop cyclophosphamide failed as she became febrile and began to lose weight. She was finally discharged on prednisone 30 mg daily and cyclophosphamide 50 mg on alternate days. The only side effect from cyclophosphamide was mild alopecia.

This case illustrates the following features: (1) Patients with S.L.E. may improve in a combination of prednisone and cyclophosamide even in renal insufficiency. (2) The combination of prednisone and cyclophosphamide in this case was shown to be more effective than chlorambucil and steroid therapy. (3) Some patients with S.L.E. may become dependent on cyclophosamide and stopping it may produce a relapse.

In a study of 14 patients suffering from S.L.E. who had evidence of renal involvement shown on renal biopsy it was found that the combination of steroids and cyclophosphamide was more effective and produced fewer side effects than steroids alone. Details of this work are being prepared for publication.

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Infantile Overnutrition

SIR,—Your leading articles (30 June, p. 727) and the article by Dr. R. K. Oates in the same edition (p. 762) have once more drawn attention to the dangers of obesity in infants. The danger stressed in this condition is the probability of obese infants remaining obese children and becoming obese adults. In 1965[1] and again, with a colleague, in 1971[2] I drew attention to another danger of obesity in infants—namely, the increased morbidity rate in the first year of life. We suggested that this obesity might be due to increased retention of minerals in tissue fluids subsequent to the greater protein content of cow's milk, and this now seems to be confirmed by Dr. Oates's work.

Since we have become aware of this problem, my partners and I have tackled it energetically from the early months of infancy, and our health visitors, who look after our 150 new babies each year, are now well alerted to spot those babies who are gaining weight excessively in the early weeks and give the appropriate advice to the mothers on the question of feeding. It is probably true to say that since about 1968 infant obesity has been virtually eliminated from this practice. There is no doubt in our minds that if general practitioners, doctors working in well-baby clinics, and health visitors were adequately alerted to this problem and dealt with it energetically by early advice and close supervision the problem could be almost completely overcome in a very short period of time. I would like to pay tribute to the work which our health visitors have done in combating this problem; our success has been due entirely to their vigilance and competence.—I am, etc.,

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1 Hooper, P. D., *Practitioner*, 1965, **194**. 391.
2 Hooper, P. D., Alexander, E. L., *Practitioner*, 1971, **207**. 221.

Infant-feeding Practices

SIR,—Dr. R. K. Oates (30 June, p. 762) and your leading article (p. 727) outline the many hazards of the artificial feeding of infants. It is time that the medical and nursing professions gave the lead in encouraging the natural feeding—that is, breast-feeding—of infants and educating mothers to choose it.

Dr. Oates says: "Clearly the problem is one of education of mothers beginning in the maternity unit and continuing through the advice of health visitors and family doctors"—yes, but education in breast-feeding, with artificial feeding only a second choice. It should be stressed that breast-feeding is the best start for infants.—I am, etc.,

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Psychosomatic Disease

SIR,—In the introduction to his Charles West Lecture Dr. John Apley (30 June, p. 756) discusses briefly the history of the notion of psychosomatic illness, stating: "I cannot find that he (Charles West) used the word psychosomatic, though it was known in his time. Like Willis and Sydenham before him, he did, however, describe patients with what today would be called psychosomatic disorders."

In the original Arabic textbook of medicine *al-Qanoon*, which was written early in the eleventh century, Avicenna (979-1037) gave a good detailed clinical description of what nowadays would be regarded as a psychosomatic manifestation of a reactive depression. He described the emotional and physical changes in the frustrated lover. He was aware of the relation between emotional excitation and the appearance of extrasystoles in the pulse. Moreover he was able to make use of this relation to detect the identity of the love object through the appearance of extrasystoles as the names of various towns, streets, families, persons, etc., were mentioned to the patient.—I am, etc.,

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Women Doctors' Pensions

SIR,—It is clear from recent correspondence that there remains a good deal of misunderstanding in regard to the pensions of women doctors. The absurd example of the gigolo husband referred to by Dr. Mary Duguid (14 July, p. 111) was intended to be so ridiculous as to bring home to women doctors the fact that such a situation would never arise, and I hope most people understood this.

If I might perhaps once again endeavour to clarify the position in regard to the lack of a widower's pension for women doctors:

(1) This is not the control of the Department of Health, nor of the Superannuation Committee. It is a firm ruling by the Inland Revenue and it applies to several million women workers in this country. This situation can be changed only by the Inland Revenue rules; a concerted effort by many of the women's organizations is