abstracted and will be published in the form of a supplement to the report, together with footnotes explaining to the readers the fallacies and paradoxes of the arguments of the C-D-E protagonists. The body of the report has also been revised, but no valid argument has been received why the recommendation regarding nomenclature should be changed. Therefore it is anticipated that the revised report will be approved for publication at the committee meeting to be held at the end of February, so that the final report should appear in April or May. Study of the correspondence received has merely served to fortify the committee in its conclusion that the C-D-E notations must be discarded.

The dilemma of workers who still use the C-D-E notations could have been avoided through familiarity with the history of the blood groups, since the same problems arose in connexion with the A-B-O groups. As can be seen in my book on *Blood Groups and Transfusion*,[2] in addition to the theory of multiple alleles the possibility of heredity by independent pairs of genes or by linked genes was considered. In the absence of crossing over, the hypothesis of completely linked genes was also considered, although 30 years ago the impressive term pseudoallelism had not yet been introduced. Now the theories concerning Rh-Hr heredity have gone through the same process of evolution —namely, multiple alleles, linkage with crossing over, and then completely linked genes. Since a set of completely linked genes is really a unit, this represents a complete circle with a return back to the theory of multiple alleles. Also, the controversy regarding nomenclature is reminiscent of the Moss-Jansky terminologies for the A-B-O groups, except that the latter preferred numbers instead of letters for their notations. The use of the so-called shorthand notations again represents a complete circle, since these notations are nothing but a slightly altered version of the original Rh-Hr nomenclature.

In conclusion, one cannot help but note the parallelism between the following two quotations: "'What genotypes correspond to the phenotype large C plus, large D minus, large E plus, small c minus, and small e plus ?' asked the professor. (This professor must have just run out of little d antiserum.) 'I don't know,' said the student; 'I lost track. Could you give me the phenotype name in shorthand symbols ?' 'You fail. You don't know your rhesus blood types,' said the professor."—*Somewhere in England.* "'What is one and one and one and one and one and one and one and one and one and one ?' 'I don't know,' said Alice, 'I lost count.' 'She can't do addition,' said the Red Queen."—*Lewis Carroll.*—I am, etc.,

New York. A. S. WIENER.

REFERENCES

1 *J. Amer. med. Ass.*, 1956, **161**, 233.
2 Wiener, A. S., *Blood Groups and Transfusion*, 1943, 3rd ed. C. C. Thomas, Springfield, Ill.

Reactions to Acetarsol Vaginal Pessaries

SIR,—Considering the vast number of patients who have been treated with acetarsol vaginal pessaries during the last twenty years, reported systemic reactions have been few, and Dr. A. White's memorandum (*Journal*, December 29, 1956, p. 1528) prompts this further report of a case.

A healthy primipara, aged 27, developed a trichomonas vaginitis at the 12th week of her second pregnancy. One acetarsol 4 gr. (220 mg.) vaginal pessary was inserted nightly for twelve nights with improvement at first, followed by an increase in the discharge, swelling of the labia, and erythema and folliculitis in the skin of the medial surface of the upper thighs. Misdiagnosis at this stage resulted in the application of ten acetarsol 4 gr. (220 mg.) pessaries in the vaginal fornices.

The patient spent a restless night and was ill the next day, with malaise, photophobia, and generalized pruritus; her temperature was 103° F. (39.4° C.), pulse rate 120 beats to the minute, and there was a generalized maculo-papular rash, confluent in places, with bullae on the skin of the upper medial aspects of the thighs, and vesicles on the swollen, cyanosed lips and buccal skin. The vagina was emptied and cleaned, pulmonary tuberculosis was excluded, and the fasting blood sugar found to be 116 mg. per 100 ml. One 5 mg. prednisolone tablet was given 4-hourly for five days, 6-hourly for three days, 12-hourly for three days, and she made an uneventful recovery. There was no history of previous treatment with arsenical compounds and no history of allergy either in the patient or her family.—I am, etc.,

Great Baddow, Essex. ANTHONY PEARSON.

Lesions of the Feet in Diabetes

SIR,—May I refer those who are interested in the aetiology of lesions of the feet in diabetes to the recent work of Dr. A. L. Woolf ? In a paper read to the Pathological Society of Great Britain in January, 1956, Dr. Woolf has described changes in the intramuscular nerve endings in diabetic neuropathy, and his technique based on a biopsy study should enable a definite decision to be made on the presence of diabetic neuropathy. Dr. Wilfrid Oakley and his colleagues (*Journal*, October 27, 1956, p. 953) might be able to settle the point in question by making use of Dr. Woolf's method.—I am, etc.,

Southampton. R. A. GOODBODY.

Glycyrrhetinic Acid

SIR,—Dr. E. Colin-Jones mentions our work[1] in his letter (*Journal*, January 19, p. 161) in support of his contention that glycyrrhetinic acid has therapeutic value in skin diseases. The National Research Development Corporation, acting on behalf of our employers—the Medical Research Council—took out a patent on a preparation of ours which contained a highly active substance which depressed sensitivity to tuberculin in B.C.G.-infected guinea-pigs. This substance was not glycyrrhetinic acid, which we found to have no measurable desensitizing effect.—I am, etc.,

J. W. CORNFORTH.
London, N.W.7. D. A. LONG.

REFERENCE

1 British Patent 713, August 18, 1954, 651.

SIR,—I have hesitated for some months from adding to the dreary correspondence on the efficacy of glycyrrhetinic acid. Some say it cures eczema, some say it does not. Drug firms send sheets of "literature" and stacks of samples. To me it has always had a pseudo-scientific ring about it. To be sure, it is fairly cheap in comparison with hydrocortisone, but, as ointments containing it do not, in my experience, do the least good, it really seems a waste of money. I am sure Dr. E. Colin-Jones (*Journal*, January 19, p. 161) is absolutely right about glycyrrhetinic acid being frightfully complex chemically, but that doesn't make it any more useful clinically—and how does one tell an "active" isomer from an inactive one, anyway ? I presume because of the "biosone G.A." side chain.

It is a great misfortune that dermatologists to-day have to rely more and more on ready-made proprietary preparations when taking advantage of the tremendous advances in therapeutics which have occurred during the last few years. Under such conditions it behoves us to be particularly cautious in extolling the virtues, or even mentioning the trade name, of any particular product, let alone repeating its commercial claims, while many of one's experienced colleagues are patently unconvinced.—I am, etc.,

Plymouth. R. D. SWEET.

Translumbar Aortography

SIR,—Dr. David Sutton (*Journal*, January 26, p. 225) has expressed his opinion that Mr. H. Gaylis and Dr. J. W. Laws (*Journal*, November 17, 1956, p. 1141) advocate the use of a quantity of contrast medium (30–40 ml. of 70% diodone) for translumbar aortography which he would now regard as excessive. Dr. Sutton states that he never uses more than 25 ml. of 70% sodium acetrizoate or 70% diodone. He then states: "Mr. Gaylis and Dr. Laws suggest that other previously reported complications of aortography have been