treatment with azathioprine (Imuran), but after a month, because of gastric intolerance, we were compelled to stop its administration. At the beginning of September 1965 6-thioguanine (Thioguan) was given together with prednisone four days a week. After a very low initial dosage of 6-thioguanine (1 mg./kg. per day) the prednisone was stopped and the dosage raised to 2 mg./kg., which is tolerated perfectly. The general pulmonary (Fig. 2) and haematologic conditions have markedly improved, and siderophages are no longer found in the sputum.

Two conclusions may be drawn from this case. The contemporary presence of pulmonary and retinal haemorrhages, already reported in two cases by Charochopos *et al.*,[2] indicates a general and not exclusively a pulmonary illness. Furthermore, antipurine therapy with intermittent cortisone therapy allows this girl, previously in an extremely serious condition, to lead a normal life for her age.

In our opinion, immunodepressive treatment with antipurines, eventually associated with cortisone and desferrioxamine, should be tried in all cases of idiopathic pulmonary haemosiderosis which show rapid and serious deterioration, although a more prolonged trial on many more cases will be necessary in order to draw definite conclusions.—We are, etc.,

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Cytostatic Agents in Systemic Lupus

SIR,—Dr. J. M. Sowa asks (2 April, p. 858), "Why should cyclophosphamide be any different, since like the mustards it is an alkylating agent?" The answer must surely be that it has a higher "therapeutic ratio" than have the conventional alkylating agents such as nitrogen mustard itself. This is expressed on the toxicity side by a more rapid recovery from leucopenia when the dose is reduced or the drug is stopped, a relatively greater depression of lymphocytes and plasma cells than of granulocytes, a negligible effect on red cells, and a relative sparing of platelets. Dr. Sowa's experience with the drug ("Another common side-effect of cyclophosphamide . . . is thrombocytopenia") is most unusual if he means depression of platelets below 100,000/c.mm., the figure to be expected if the total white-cell count is depressed to 1,000/c.mm.[1,2] Controlled leucopenia can be looked upon as a helpful guide to adequate immunosuppressive dosage rather than as an undesirable side-effect.

Dr. Cheng Siang Seah (5 February, p. 333) advocates cyclophosphamide, particularly for the patient in whom "high dosage and prolonged steroid therapy can cause most undesirable side-effects"—in fact five out of his nine patients followed up for more than three months received corticosteroids as well as cyclophosphamide in treatment. At the present stage of development of immunosuppressive therapy in autoimmune disease the best policy may be to employ cyclophosphamide only in two categories of patients: (1) those who become intolerant of corticosteroid therapy (gastric ulceration, osteoporosis, etc.), and (2) those whose disease is inadequately controlled by moderate tolerated doses of corticosteroids. It was children of this kind with nephrotic syndrome that Coldbeck[3] treated successfully with cyclophosphamide. The use of an immunosuppressant alkylating agent or antimetabolite does not close the door to future corticosteroid therapy.—I am, etc.,

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Glucose-6-phosphate Dehydrogenase Deficiency in Marfan's Syndrome

SIR,—The association of glucose-6-phosphate dehydrogenase deficiency with lens abnormalities and congenital malformations reported by Dr. J. D. Harley and others (12 February, p. 421) may well be coincidental, yet in the light of their comments the following case is reported. It is thought to be the first recorded example of glucose-6-phosphate dehydrogenase deficiency occurring in Marfan's syndrome.

The patient, a Jewess aged 41 years, was first admitted to the London Hospital (Dr. N. L. Rusby) two years previously with bacterial endocarditis following tooth extraction. The diagnosis of Marfan's syndrome was made, all the stigmata of this condition being present except that no lens abnormalities were found. She made an uneventful recovery and remained well until her present admission, which was necessitated by the onset of severe cardiac failure following an upper respiratory infection. Treatment by her family doctor had been with tetracycline, and she had taken not more than three tabs. codeine co. for symptomatic relief. Signs in the chest suggested that she had developed a severe respiratory infection, and broad-spectrum antibiotic therapy with ampicillin and cloxacillin was commenced. Digoxin, frusemide, and initially intravenous hydrocortisone were also given. Two days after admission she was first noticed to be icteric, and together with a rapid rise in serum bilirubin the typical picture of an acute haemolytic episode developed. Investigations into possible causes of this were all negative except that her erythrocytes were found to be deficient in glucose-6-phosphate dehydrogenase, the level of deficiency rising as she made a spontaneous recovery from this crisis. As this condition is rare in females but is known to be frequently associated with defective colour vision, the patient was tested and found to be red-green colour blind. Investigations for possible chromosomal abnormalities were negative. The patient's mother, who comes from English parentage, was found to have normal red-cell enzyme levels, normal colour vision, and none of the stigmata of Marfan's syndrome. Her elder sister, however, has arachnodactyly and a high-arched palate, together with a low level of erythrocyte glucose-6-phosphate dehydrogenase activity. Her colour vision is normal. The father, who was of Polish descent, had died elsewhere at the age of 57 years from "heart failure."

Unfortunately no further details are available, and there are no other close surviving relatives.—I am, etc.,

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Measles Vaccination

SIR,—Successive leading articles in the *B.M.J.* urge us not to inoculate against measles. We are now told (2 April, p. 815) that the healthy child should be excluded because the vaccine may not prevent the disease.

Meanwhile about 800,000 cases with about 80 deaths occur in this country annually. The position in other countries is much worse—about 50 die in every 1,000 cases in Africa, and it is estimated that there were 84,500 deaths from measles in India in 1959.

Apart from this really serious aspect, measles is a miserable and disabling disease from which complications, some with life-long effects, are not uncommon. The most troublesome are bronchitis, otitis media, and encephalitis. Changes in the electroencephalogram regularly occur during an attack of measles, and these may persist after recovery, reflecting the underlying pathology of the mental retardation and behaviour disorders which are occasionally evident.

We can only suspect from these facts that many more children, without obvious clinical signs, suffer minor central nervous system complications which cause prolonged disability at a formative age.

In our practice we have already given over 100 doses of the single shot attenuated vaccine, and we intend to inoculate all children who have no contraindication. We do not think any parent who knows all the facts will exclude the healthy child.—I am, etc.,

Cupar, Fife. DAVID W. W. HENDRY.

"Pink Medicine Disease"

SIR,—Mr. P. V. Reading's article on the diagnosis of pharyngitis (9 April, p. 905) is of great interest, particularly to general practitioners. Do we have to have, however, yet another disease syndrome to be labelled "Pink Medicine Disease"? In febrile infections treatment with penicillin and, indeed, on occasions tetracycline, according to one's instinct and experience with the current cross-infection, will cut short a state of affairs which drags on for weeks. I see very few adverse reactions in young children, and the benefits of an immediate return to health are obvious. The enormous diminution in the amount of mastoid operations is an extreme example of the value of such prompt treatment.

As it has been established that oral penicillin gives adequate blood levels, surely all steps should be taken to avoid unnecessary injections in children.—I am, etc.,

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Ambulances and the Injured

SIR,—I refer to your leading article on ambulances and the injured (19 March, p. 691).

In deciding the extent that ambulance drivers should be trained in emergency procedures, I would suggest that committee members inquiring into this should put themselves in the place of the injured party.

If I became a roadside casualty I would ask that the ambulance driver should: (1) Ensure respiration is possible, to the