

Blood Groups and Disease

SIR,—The pioneer investigation of the incidence of the blood groups in diseases—that of Buchanan and Higley¹ in 1921, at the Mayo Clinic—had a significant excess of blood group O in its series of peptic ulcer cases.² The ratio of duodenal to gastric ulcer cases was 102:42—diagnosis of gastric ulcer was then less advanced—and now Dr. C. A. Clarke *et al.* (*Journal*, September 10, p. 643) have found a significant excess of group O in their duodenal but not in their gastric ulcer series. The latter study illustrates one method of investigating the subject, while Buchanan and Higley's data can be used for a rough-and-ready illustration, as is seen in Table I, of an alternative method recently described.³ Table I shows the descending order of percentages of blood group A in the (very broadly) comparable disease groups of the Mayo Clinic study and the Finnish studies of Streng and Ryti,⁴ Sievers,⁵ and Mustakallio⁶ combined. Table II shows the same in the Finnish workers' studies of diseases due to infection, and suggests⁷ that investigation should be resumed while such diseases are still quite common.

TABLE I.—Percentage of Blood Group A in Hospital Patients

Data of Buchanan and Higley			Data of Finnish Authors		
Number of A Patients	Disease Group	Percentage of A Patients	Disease Group	Percentage of A Patients	Number of A Patients
301	Anemias	43.5	Anemias	49.5	145
119	Carcinoma	40.8	Malignancy	46.7	140
7	Heart	35.0	Heart	44.5	446
21	Kidney	33.9	Kidney	42.2	209
38	Blood	33.3	Blood	40.6	56
12	Thyroid	32.4	Thyroid	40.3	108

TABLE II.—Percentage of Blood Group A in Hospital Patients

Number of A Patients	Disease or Group of Diseases	Percentage of A Patients		
		Streng and Ryti	Sievers	Mustakallio
1,125	Tuberculosis	44.5	44.8	45.7
222	Rheumatic fever	—	42.8	43.5
451	Respiratory infections	39.9	41.3	42.4
907	Infectious diseases	31.0	41.1	40.9

By the use of Streng's⁸ adaptation of an analogous graphic method Streng and Ryti⁴ found a shortage (in every age group) of tuberculous group O patients (see, in addition, Rubashkin and Leiserman⁹), and by the same method Mustakallio⁶ found a deficit of A in thyroid diseases and an excess of A in anaemias. These results were thought by the authors to be due, at least in part, to geographic variation in distribution alike of patients and of blood groups—the method partially exemplified in the tables would presumably get round this—and there has lately been given by Woolf¹⁰ a more abstruse statistical reason why intra-national variation should be allowed for in the assessment of results. There may, however, be a genetic reason also, since if a disease were more common, for instance, in AA than AO individuals it would be relatively commoner in regions of high A incidence—other things, that is, being equal—as in these a higher proportion of A's would be AA. Furthermore, if a disease were more common in A₁ than in A₂ individuals the descending order of liability to that disease in A and AB individuals might, other things again being equal, be something like A₁A₁—A₁A₂—A₁O—A₁B—A₂A₂—A₂O—A₂B.

Age group and sex, too, may be important, as appears from the Maxwells' series of hypertensives (*Journal*, July 16, p. 179) mostly referred for venesection in their 60's. There is here a significant shortage of AB males (Aird *et al.*, *Journal*, July 30, p. 321), but in the donor series of Hart¹¹ and Fraser Roberts¹² there is also a shortage, albeit a non-significant one, of AB males over 50, and especially of those in their 60's. (The descending order of sex ratios of the other donors over the age of 50—namely O—A—B—is reversed in the Maxwell's series of hypertensives.) Such a shortage, if confirmed, would be consistent with the fact that in the study by Aird *et al.*² of four diseases the males with the lowest mean age were the AB's in all but one, and with their suggestion that hypertension may kill AB males at an earlier age than other people—a suggestion implying the reasonable assumption that hypertensives (and so an excess of hypertensive AB males) are not so likely to be referred for venesection in middle age as

in their 60's. On the other hand, AB males may tend to be free of hypertension till an age when venesection might be harmful.

Such problems suggest that the method exemplified in the tables should be refined to deal with patients of different sexes and age groups as well as of different blood groups, and that on the other hand detailed comparison should be made of the medical history of people of each combination of age group, sex and blood group. Sources of data for this—a study of the incidence of diseases in the blood groups, as opposed to that of the blood groups in diseases—would be schoolchildren, National Service men, blood donors, blood-test subjects, general hospital out-patients, patients in paediatric, maternity, and geriatric hospitals, and necropsy subjects in every age group. Positive findings in child as well as adult populations would suggest that the ABO blood groups of none but the newborn could with safety be regarded as the norm, and as an index alike of regional variation and of secular change, if any. And in that case the ABO blood groups of newborn infants might well be added to the country's vital statistics.—I am, etc.,

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"The Private Pestilence"

SIR,—Any account (*Journal*, October 29, p. 1083), however cursory, of the early literature of puerperal fever which omits my ancestor Charles White's *Treatise on the Management of Pregnant and Lying-in Women* (London, 1773) must be considered woefully inadequate.

This work, which was published in Boston also in 1773, and was later translated into French and German, contains the following paragraph: "If separate apartments cannot be allowed to every patient at least as soon as the fever has seized one she ought immediately to be moved into another room not only for her immediate safety, but that of the other patients . . . whenever a patient has recovered from this fever and is removed to another room the bedding and curtains should be washed, the floor and woodwork cleansed with vinegar, and it would still add to the salubrity of the apartment if it were stoved with brimstone."

To what else does this advice amount than to a recognition of the contagious nature of puerperal fever? White claimed that he never lost a case of puerperal fever in a mother who was delivered without the aid of instruments. He preached personal cleanliness of the obstetrician and attendants, clean instruments and linen, and fresh air. He wrote 22 years before Alexander Gordon and 88 years before Semmelweis.—I am, etc.,

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Munchausen Syndrome

SIR,—I was interested to have further news of the patient described by Drs. R. A. Gawn and E. A. Kauffmann (*Journal*, October 29, p. 1068). I have often wondered if he was still doing the rounds of the hospitals, and have kept an eye open for him in those I have worked in.

There is in his case records in the Western Infirmary, Glasgow, a dossier of letters which I received from hospitals where he was known. His mobility was remarkable—within two days of his discharge in Glasgow he was admitted to a London hospital, and on another occasion he entered a hospital in the Midlands, having been discharged the same day from one in Kent. At that time he nearly always used the same name; I wonder if he still uses it. Dr. Asher,¹