have the opportunity of attending a theoretical and practical course on this subject as part of their undergraduate course. This co-operation has been extremely fruitful, but the development of such projects is costly, and if they are to succeed funds need to be provided as a matter of urgency. Both the N.H.S. and the drug companies could benefit from such ventures, and it seems appropriate that both should offer to help at a time when funds for universities are so severely restricted.—We are, etc.,

R. J. ANCILL.
D. A. NORTON.

Bath University of Technology,
Bath, Somerset.

REFERENCES

- ¹ Report of the Committee on Clinical Pharmacology, 1969. London, Royal College of Physicians.
- ² Beckett, A. H., *British Medical Journal*, 1967, 2, 632.

Haemoglobin C in a Spanish Family

SIR,—In a routine blood examination a specimen was found whose erythrocytes showed many target cells, some poikilocytosis, and decreased fragility (Fig. 1).

FIG. 1.—Microscopic aspect of the erythrocytes of the propositus.

The propositus was a white male child 5 years old, whose only complaint was chronic tonsillitis. Electrophoresis of this child's haemoglobin and that of his parents was carried out. The result obtained in both the propositus and his father is seen in Fig. 2. Their haemoglobins contained two fractions, approximately 50% each, the first of which was normal Hb A, but the second fraction migrated slower than Hb S, in the characteristic position of Hbs C and E (sample of Hb A-S kindly supplied by Dr. J. M. Melo, Lisbon). Owing to its greater mobility in Tris buffer, we suppose that it is an Hb C¹ in heterozygous state with Hb A. The mother's haemoglobin was of the normal type A.

The original locus of this haemoglobin is Northern Ghana, and when it has been found

outside the country of origin it has always been in connexion with the introduction of slaves or soldiers from West Africa.² Our cases are from Malpartida de la Serena, province of Badajoz, in the west of Spain,

FIG. 2.—Comparative electrophoretic patterns of the abnormal haemoglobins, together with the mother's Hb and a sample of Hb A-S in barbital buffer pH 8.6.

and there is no local history of African forebears. The surname of this family is an Arabic word which means something like "bush," perhaps suggesting a remote ancestor of African origin coming to Spain during the Moorish invasions. However, it is also possible that this haemoglobin could have arrived from the small numbers of Negroes resident some time ago in the adjacent province of Huelva³ or from contacts through the nearby frontier of Portugal, where other African haemoglobins have been described.⁴ Haemoglobins S and D have also been found in Spain by Escartin, Chantar, Candell, and Anaya,⁵ and by Candell.⁶ The possibility of a mutational origin of this abnormal haemoglobin in Spain is unlikely.

The purpose of the present communication is to report the first two cases of haemoglobin C found in Spain.—We are, etc.,

ANGELA CASADO.
A. PELLICER.
L. VICENTE.

Instituto de Genética y
Antropología,
Centro de Investigaciones Biológicas,
Madrid 6, Spain.

REFERENCES

- ¹ Itano, H. A., and Neel, J. V., *Proceedings of the National Academy of Sciences*, 1950, 36, 613.
- ² Lehmann, H., in *Abnormal Haemoglobins*, ed. by J. H. P. Jonxis and J. F. Defresnay, 1959. Oxford, Blackwell.
- ³ Larrea, A., *Archivos Instituto Estudios Africanos*, 1952, 20, 39.
- ⁴ Melo, J. M., *Sangre*, 1966, 11, 383.
- ⁵ Escartin, P., Chantar, C., Candell, R., and Anaya, A., *Communication at Reunión Sociedad Española de Medicina Interna*, 1967. Madrid.
- ⁶ Candell, R., 1967, personal communication.

"Chronic" Haemodialysis

SIR.—Surely the time has at last come to take a stand against the hideous solecism perpetuated yet further in the title of the article by Dr. Y. K. Seedat (10 May, p. 344). For the past few years I have waited in vain for a champion against the perverted use of a word hitherto applied to a disease, and not to its treatment, but was recently even more horrified to see its application to anticoagulant treatment, and fear lest its permissive use may spread yet further to describe yet more treatments of diseases requiring long-term management.

In passing, I may perhaps be permitted to castigate the "trendy" use of the word "presently" to mean "at present" instead of "soon," which has appeared not only in

lay, but (alas) medical publications. I trust all editors will now take the necessary measures (*verb. sap.*).—I am, etc.,

J. DE SWIET.

East Glamorgan General Hospital,
Pontypridd, Glam.

Disodium Cromoglycate in Treatment of Asthma

SIR,—The reference made by Dr. H. Herxheimer and Miss Helga Bewersdorff (26 April, p. 220) to the paper by Dr. G. F. Devey and myself,¹ appears to me to be misleading. Of the 44 children in the clinical trial only 23 used aerosol bronchodilators; this reflected a choice of antispasmodic treatment on the part of their family doctors. The remainder used other forms of antispasmodic treatment, but this did not imply a greater or lesser severity of their asthma. To quote the paper accurately, "The number of doses inhaled was reduced from an average of 30 a patient during the placebo period to 13 during the active period." The reduction in the inhaler usage was statistically highly significant. Reduction in prednisolone dosage from 15 mg. to 10 mg. or from 5 mg. to 2.5 mg. daily is of real clinical importance in childhood asthma. The period of the clinical trial, one month for each treatment, was too short to show the full effect of disodium cromoglycate on steroid dosage.

The same group of patients was followed for a further year and all were given disodium cromoglycate. Of the 18 patients on steroid treatment eight were able to discontinue the treatment. The average daily dosage of steroid treatment was equivalent to 4.4 mg. in the placebo period of the trial, 3.3 mg. in the active period, 1.8 mg. at six months after the trial, and 1.3 mg. at 12 months.

Similar experience was obtained with a further 45 children on an open basis over a period of a year. There were 27 on steroids initially, but by the end of the year on disodium cromoglycate 15 had been able to discontinue this treatment.—I am, etc.,

J. MORRISON SMITH.

Birmingham Chest Clinic,
Birmingham 3.

REFERENCE

- ¹ Smith, J. M., and Devey, G. F., *British Medical Journal*, 1968, 2, 340.

Topical Corticosteroids

SIR,—Your article in the series "Today's Drugs" on topical corticosteroids (3 May, p. 297) offers an extremely helpful review of what is otherwise a confusing picture of continual proliferation of products, and forms a considerable contrast with the brevity with which the subject is dismissed in the current issue of *Prescribers' Journal*.¹

For the doctor in general practice where up to 10% of all consultations are for dermatological reasons,² the choice of topical corticosteroid is often bewildering and must frequently relapse into one dictated by habit, familiarity, or favourable experience in the past. Certain principles are necessary in this subject, and I would like to support your correspondent's assertion that "it is wiser to use the weakest preparation which will bring