peutic ingestion and accidental ingestion themselves? In the article reference is made to 16 subjects with poisoning for whom the drugs had been prescribed for enuresis in themselves, the only ones who were ingesting the substances for therapeutic purposes. It would be interesting to know the comparative incidence of cardiovascular, neurological, and atropinic features of poisoning in this group and the other group of 44 subjects where the ingestion was wholly accidental. If in fact it is found that the more severe cases of poisoning occurred in the therapeutic group, the real significance of the article would be evident.—I am, etc.,

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Turner's, Ullrich's, and Noonan's Syndromes

SIR,—May I be allowed to add a few comments to your leading article on Turner's and Noonan's syndromes (16 March, p. 470)?

I have been particularly interested in Turner's syndrome^{1,3} and there is little doubt that the terminology, both eponymous and descriptive, of these conditions has been confusing, owing to some extent to the way they were described. Thus Henry Turner,⁴ working as he did with women of post-pubertal age, overlooked the paediatric descriptions of Ullrich's^{5,6} from Munich; and Noonan and Ehmke,⁷ starting with children with pulmonary valve stenosis, behaved similarly. Flavell⁸ used the term "Turner's syndrome in the male" to describe males with webbing of the neck and hypogonadism.

My colleagues and I have repeatedly tried to clarify the terminology^{9,14} and relate it to clinical features and to causes. Though matters of clinical classification and the use of eponyms depend often on fashion and taste, I feel that the use of Turner's and Ullrich's¹⁵ eponyms is adequate, as well as being historically correct, and that in general there is no need for Noonan's eponym. In using the terms clinical criteria should be strictly adhered to so that the names may truly represent and be used as a shorthand notation for clinical descriptions. If this is done, for example, extensive deletions of the short arm of an E-group chromosome, presumably no. 18, are among the rarer causes of Ullrich's syndrome^{16,17} and clearly some autosomal anomalies may be responsible for it.

May I make two other points? First, as you note in your article, not all 45,X (XO) subjects, indeed probably not more than half,¹⁴ have the aggregate of features outlined by Turner; and those with sex chromosome anomalies other than 45,X have even less often, in about 10% of cases, the cluster of abnormalities described by him. Your article implies that it is correct to use the eponym in all cases, whether they fully fit Turner's description or not. We prefer to refer to patients with these incomplete forms, without webbing of the neck, as having "ovarian dysgenesis" and suggest that it may be useful to continue making a distinction since it is possible that the two clinical forms with 45,X chromosomes do not represent just the extremes of

a spectrum of clinical variation. Secondly, in familial example of the Ullrich syndrome in addition to patients with the classical external phenotype, including webbing of the neck, one may find subjects who show only some less obvious external stigmata, with or without cardiac lesions, or even only the cardiac lesions so often detected in this disorder.¹¹

Finally, may I say that Ullrich had suggested the use of the eponym Bonnevie,¹⁸ coupled with his name, because he had felt that her animal model was appropriate to the condition he had described in man.—I am, etc.,

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- 1 Polani, P. E., Hunter, W. F., and Lennox, B., *Lancet*, 1954, 2, 120.
- 2 Polani, P. E., and Magnus, I. A., *Lancet*, 1955, 1, 1202.
- 3 Polani, P. E., Lessof, M. H., and Bishop, P. M. F., *Lancet*, 1956, 2, 118.
- 4 Turner, H. H., *Endocrinology*, 1938, 23, 566.
- 5 Ullrich, O., *Zeitschrift für Kinderheilkunde*, 1930, 49, 271.
- 6 Ullrich, O., *Monatsschrift für Kinderheilkunde*, 1937, 68, 94.
- 7 Noonan, J. A., and Ehmke, D. A., *Journal of Pediatrics*, 1963, 63, 468.
- 8 Flavell, G., *British Journal of Surgery*, 1944, 31, 150.
- 9 Bishop, P. M. F., Lessof, M. H., and Polani, P. E., in *Sex Differentiation and Development*, p. 162, ed. C. R. Austin. London, Cambridge University Press, 1960.
- 10 Polani, P. E., *British Medical Bulletin*, 1961, 17, 200.
- 11 Polani, P. E., *Guy's Hospital Reports*, 1968, 117, 323.
- 12 Polani, P. E., Angell, R., and Polani, N., *Lancet*, 1967, 2, 421.
- 13 Polani, P. E., *Birth Defects: Original Series*, 1969, 5, pt. 5, p. 24.
- 14 Polani, P. E., *Excerpta Medica International Congress Series*, 1970, 204, 233.
- 15 Caffish, A., *Das Prerygum*, M.D. Thesis, University of Zürich, 1952.
- 16 Polani, P. E., *British Medical Bulletin*, 1969, 25, 81.
- 17 Lurie, I. W., and Lazjuk, G. I., *Humangenetik*, 1972, 15, 203.
- 18 Ullrich, O., *American Journal of Human Genetics*, 1949, 1, 179.

B.M.A. and H.C.S.A.

SIR,—Past chairmen, their task completed, should rarely intervene in the problems of their successors, especially when no longer personally involved in the N.H.S. and indeed working in another country. Nevertheless, the matters discussed in your leading article "Think Again" (9 February, p. 211) have bedevilled the work and, more important, impaired the efficiency of the Central Committee for Hospital Medical Services ever since its creation (under another title) in 1948 and are evidently still continuing to do so, so that some comment from long experience may not be amiss. I was in fact one of the original members of the Regional Hospitals' Consultants and Specialists Association (now the H.C.S.A.) and remained a member for some time after becoming a member of the C.C.H.M.S. Early experience of difficulties of negotiation with the then Ministry of Health soon convinced me of the importance of the whole hospital branch of the profession being represented in negotiation by one body which could speak with one voice.

It is very regrettable therefore in my view that the H.C.S.A. should appear to wish for a separate and divided approach to the Department of Health. The former Secretary of State appeared to have no wish to accept separate negotiating bodies for

hospital staff, but there is no surety that the new Minister will not seize upon the opportunity to increase her power to impose solutions by the opportunity to divide and rule now being offered her.

As one who started his medical career as an R.H.C.S.A. member and for all his professional life has been a regional consultant may I plead with the H.C.S.A. to think again; and with those consultants who are tempted to give their support to this body, however strongly their members may feel they have a special cause for separate rights to negotiation, to pause before asking this "pressure group" to take over the negotiating responsibilities from the B.M.A. with its long experience and skill in this field. Zeal is no substitute for experience in negotiation with an absolute employer, with immense expertise and vast resources of statistical data to support the Government view. Should the H.C.S.A. succeed in their objective the loss of authority suffered by the "official" B.M.A. negotiating team could be catastrophic for the whole profession.

Lastly, I would, as a past C.C.H.M.S. chairman who held this office for 10 years and as a member of various joint negotiating teams and of the B.M.A. Council for very many years, totally deny that the B.M.A. is a "G.P.-dominated" body. If the C.C.H.M.S. has appeared to be weaker in negotiations it has not been for lack of support from the B.M.A. Council, or even the General Medical Services Committee, but because of divisions and differences within the hospital staff ranks which do not exist in the general practitioner field. It is also because of lack of support for the Hospital Medical Staffs Defence Trust—which if of comparable size to the general practitioner fund could so much more effectively support the necessary statistical research needed to strengthen the hospital staff case. Indeed so impoverished was the hospital staff fund at one period that the G.M.S.C. made a special donation to assist the C.C.H.M.S. in the preparation of a specific case, an extremely generous gesture of which the H.C.S.A. may be unaware.—I am, etc.,

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Consultants' Salaries

SIR,—I am so sorry if my Personal View (9 March, p. 451) upset Mr. A. E. Carter (23 March, p. 579) and Dr. C. I. Roberts (30 March, p. 643).

More than half the human race is starving, millions live in unspeakable squalor, they sleep on the streets not only of Calcutta but of London, and in this country 9 million people (not one a consultant, I imagine) have no bathroom or indoor sanitation. Mr. Carter may conclude that we live in egalitarian times and is entitled to his opinion, but I beg to be allowed feelings of guilt, greed, and confusion. Dr. Roberts and I appear to be in basic agreement; we all have a right to a warm, dry house.

I am aware of the cogent arguments for substantial increases in our pay so ably put forward by Dr. J. Winter (9 March, p. 458) and others. But the gap widens between the rich and poor of this world and unless it is reduced we face a catastrophic situation. In