CORRESPONDENCE

Correspondents are asked to be brief

Prevention of Accidents W. Gissane, F.R.C.S. 765	An XYY Individual of Average Height A. Dora Black, D.P.M. 768	Destruction of Case Records E. C. O. Jewesbury, F.R.C.P. 769
Therapy-linked Leukaemia F. P. Li, M.D., and D. G. Nathan, M.D.; A. N. Walker, M.B. 765	Filling the Gaps in Venereology R. S. Morton, F.R.C.P. 768	Preclinical Salaries K. R. Hill, F.R.C.PATH. 770
Disposing of the Undisposable C. L. Hewer, M.R.C.P., F.F.A. R.C.S. 766	The Lungs in Ankylosing Spondylitis D. Davies, F.R.C.P. 768	Hospital Staff Appointments J. de Swiet, F.R.C.P. 770
Addiction or Dependence? H. A. Wendel, M.D. 766	The Virgin Queen P. Rhodes, F.R.C.O.G.; M. J. Pleydell, M.D. 768	Sauce, Spices, and the Kidney K. J. Murphy, F.R.A.C.P. 770
The New F.F.R. H. C. Anton, F.F.R. 766	Flatulence N. B. Eastwood, M.B. 769	"Clinical" and "Administrative" Pharmacists J. Fogg, F.P.S. 770
Evidence to the Coroner J. Shackleton Bailey, M.R.C.S. 766	Prophylaxis of Wound Infection T. A. M. Stoker, F.R.C.S., and H. Ellis, F.R.C.S. 769	Cremation Regulations H. C. Maingay, M.D. 770
Fibrin/Fibrinogen Degradation Products in Glomerulonephritis H. Yatzidis, M.D. 767	Survival in Severe Congenital Heart Disease Olive Scott, M.D. 769	Periodic Haemorrhages in Haemophilia A J. Benbassat, M.D. 771
Lung Transplantation P. Hugh-Jones, F.R.C.P., and M. Clarke, B.Sc. 767	Abortion or Contraception? D. S. Holland, M.B. 769	Name Badges for Technical and Ancillary Staff A. Platten, F.R.C.S. 771
Arteriosclerosis, Duodenal Ulcer, Blood Group, and Secretor Status R. Hall, F.R.C.S., and others. 767	Pregnancy Testing A. D. Thursz, F.R.C.S. 769	Air Embolism during Haemodialysis Mary G. McGeown, F.R.C.P. 771
Dermatoglyphics and Chromosomes in Cat-eye Syndrome B. Dallapiccola, M.D. 767		Why is Serum Hepatitis Virus absent from Faeces? M. Piazza, M.D., and others. 772

Prevention of Accidents

SIR,—One of the many reasons why accidents should be separated from other emergencies—at least in major units—is to give the responsible heads of these departments time to think, to teach, and to stimulate research.

Not the least important aspect of research concerns prevention, and particularly research that could lead to a lessening of the present severity of road injuries, now described as the first surgical epidemic.

Physicians started their attack on the infectious diseases by defining the susceptible host, the predisposing environment, the inciting agents, and their interrelationships at a time when the infections were killing twice as many people as all accidents. Though their research was not wholly responsible for the final control of the infections, it was the core of the matter and stimulated others on such important subjects as rationalized

nutrition, clean water and food, and effective sanitation. Now that the infections are under control, accidents, and particularly road accidents, have become the main killers and disablers of young people. Yet the same epidemiological approach can, and in the United States is, being applied to road accidents and with worthwhile results.

Perhaps medical research is now unduly concerned with prolonging life by studies of diseases that mainly affect those in advanced years and is left with few, if any, scientists to study the causes of the main killers of the young. Certainly the Health Service does not provide financial support for such endeavour.—I am, etc.,

WILLIAM GISSANE

Road Injuries Research Group,
Birmingham Accident Hospital,
Birmingham

Therapy-linked Leukaemia

SIR,—Dr. I. W. Delamore and Dr. C. G. Geary (26 June, p. 743) raise the possibility that oxymetholone has a leukaemogenic influence on patients with aplastic anaemia. The report prompted a review of the treatment records on our patients who developed acute leukaemia following aplastic anaemia.

Over the last 15 years, nearly 100 children have been treated for aplastic anaemia at the Children's Hospital Medical Center of Boston. The diagnosis of aplastic anaemia in each patient was based on the criteria of Shahidi and Diamond,¹ and none of the children showed evidence of acute leukaemia initially. Patients with the peripheral blood or bone marrow features of preleukaemic refractory anaemia were excluded from the series.² Four children with constitutional aplastic anaemia and three with acquired aplastic anaemia later developed acute myelocytic or myelomonocytic leukaemia

(Table). The intervals between the diagnosis of aplastic anaemia and acute leukaemia ranged from 6 months to 16 years, with a median of 3 years. All the children had been treated with corticosteroids, and five had received androgen preparations other than oxymetholone.

The present data and studies cited by Drs. Delamore and Geary indicate that acquired

and constitutional aplastic anaemia, like other myeloproliferative disorders, may terminate in acute leukaemia without the influence of oxymetholone.^{3,4} Not all series on aplastic anaemia have noted the occurrence of leukaemia in part because of short duration of follow-up and high mortality in aplastic anaemia. Also, patients who later developed acute leukaemia may have been excluded from other series to avoid doubt regarding the accuracy of the initial diagnosis.^{5,6}

The possibility persists that all corticosteroid or androgen therapy for aplastic anaemia enhances the leukaemia diathesis independent of its influence on survival. However, the likelihood of such an effect appears remote since patients receiving these drugs for other disorders are not reported to be at increased risk of developing leukaemia.—We are, etc.,

FREDERICK P. LI

DAVID G. NATHAN

Children's Hospital Medical Center,
Children's Cancer Research Foundation and
National Cancer Institute Field Station,
Boston, Massachusetts, U.S.A.

¹ Shahidi, N. T., and Diamond, L. K., *New England Journal of Medicine*, 1961, **264**, 953.

² Linman, J. W., *Journal of Chronic Diseases*, 1970, **22**, 713.

³ Glasser, R. M., and Walker, R. I., *Annals of Internal Medicine*, 1969, **71**, 285.

⁴ Karanas, A., and Silver, R. T., *Blood*, 1968, **32**, 445.

⁵ Melhorn, D. K., Gross, S., and Newman, A. J., *Journal of Pediatrics*, 1970, **77**, 647.

⁶ Shahidi, N. T., *Journal of Pediatrics*, 1971, **78**, 549.

Patient	Aplastic Anaemia			Age at Diagnosis of Acute Leukaemia (yrs)
	Type*	Age at Diagnosis (yrs)	Drug Therapy	
1.. ..	A	2	corticosteroids	3 6/12
2.. ..	A	1 6/12	testosterone, corticosteroids	4 7/12
3.. ..	A	2 9/12	fluoxymesterone, corticosteroids	3 9/12
4.. ..	C	5/12	testosterone, corticosteroids	1 4/12
5.. ..	C	6 1/12	corticosteroids	13 8/12
6.. ..	C	8 11/12	testosterone, corticosteroids	13 3/12
7.. ..	C	birth	testosterone, stanozolol, corticosteroids	16 7/12

*A = acquired; C = constitutional.