a case under a doctor's care suddenly choose to "go it alone" at some point?

Probably the forthcoming report of the Brodrick committee will favour less rather than more formality in relation to coroner's inquiries. All the same, a doctor might well feel a little uneasy about giving his usual ready co-operation with a coroner in a case where a health visitor has been involved if he thinks she might be going to demonstrate publicly that she regards such co-operation as a breach of professional confidence. Such a demonstration would not seem to favour happy relations between the health visitor and doctor. The obstruction and discourtesy to the coroner who finds himself presiding over such a situation is also an unfortunate matter, and it seems to me it would be a good idea for the representatives of all concerned to get together and consider the question.

I would hope that the Health Visitors' Association could be persuaded to withdraw from its present position, as the association in my view is letting down its members badly and prejudicing good relations between them and the doctors.—I am, etc.,

J. SHACKLETON BAILEY

Eye,
Suffolk

¹ *Health Visitors and the Courts*. London, Health Visitors' Association, May 1971.

Fibrin/Fibrinogen Degradation Products in Glomerulonephritis

SIR,—Dr. A. R. Clarkson and others (21 August, p. 447) have produced evidence that the urine concentration of fibrin/fibrinogen degradation products (F.D.P.) provide a reliable and sensitive index of activity, progression, and natural history in proliferative glomerulonephritis. They suggest that the F.D.P. are derived from lysis of intra-glomerular fibrin deposits and limited proteolysis of fibrinogen filtered through an abnormally permeable basement membrane.

Some years ago¹ we had demonstrated the presence of fibrinogen in the urine of certain patients suffering from the nephrotic syndrome due to glomerulonephritis. This fibrinogenuria was estimated in the range of 0.057–0.230 g/24 hrs with a clearance two to ten times smaller than the total proteins clearance. In this work, as well as in a previous paper,² we had studied the different factors including proteolysis, which may, in certain circumstances, have a suspensive effect on the fibrinogenuria, resulting from the passage of plasma fibrinogen through the damaged glomerulus.—I am, etc.,

HIPPOCRATES YATZIDIS

General Clinic of Athens,
Athens, Greece

¹ Yatzidis, H., *Nature*, 1964, **201**, 187.

² Yatzidis, H., and Richet, G., *Revue Française d'Etudes Cliniques et Biologiques*, 1957, **2**, 717.

Lung Transplantation

SIR,—Reference was made in a paper entitled "Lung Transplantation in a Patient with Fibrosing Alveolitis" (14 August, p. 391) to the use of antilymphocytic globulin labelled with radioactive iodine-125. It was suggested (p. 395) that this material was "eliminated in two days," which could imply that the binding of the label to the globulin

was very poor. In fact globulin-bound radioactivity was followed in the blood plasma for nine days, at which time the radioactivity per ml was 10% of its initial value. A graph of the change in plasma radioactivity with time was approximately mono-exponential, after the initial equilibration period, with a biological half-life of 70 hours.—We are, etc.,

PHILIP HUGH-JONES

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Arteriosclerosis, Duodenal Ulcer, Blood Group, and Secretor Status

SIR,—The association of peptic ulcer and abdominal aortic aneurysm has been emphasized^{1,2} and a similar link suggested between arteriosclerosis and peptic ulcer by Barabas *et al.* (26 June, p. 768). Two series of patients suffering from occlusive peripheral arteriosclerosis have contained an excess of blood group A subjects,^{3,4} yet it is well known that duodenal ulcer is associated with blood group O.⁵

	N	O	A	B	AB
Male arteriosclerotics	554	216 (39.0%)	268 (48.4%)	52 (9.4%)	18 (3.2%)
"Proved" D.U.	81	31	37	10	3
"Possible" D.U.	28	12	13	3	—
Total D.U.	109	43 (39.4%)	50 (45.9%)	13 (11.9%)	3 (2.7%)
Blood donors (Leeds region)	98,054	45,399 (46.3%)	41,006 (41.8%)	8,510 (8.7%)	3,149 (3.2%)
Male peptic ulcer (York)	1,526	846 (54.8%)	557 (36.5%)	87 (5.7%)	36 (2.4%)

This dilemma may be clarified by our findings in 554 men with occlusive peripheral arteriosclerosis recently subjected to retrospective analysis in relation to blood group incidence. Because the surgeon contributing the majority of cases (Shucksmith, personal communication) had long recognized a clinical association between peptic ulcer and claudication, most patients had been asked about dyspepsia. A patient was classified as having a "proved" duodenal ulcer if it had been demonstrated by a prior barium meal examination, or by inspection of the duodenum during an intra-abdominal vascular operation, or by post-mortem study, or if he had had an operation for duodenal ulcer. Information was also collected with regard to patients who gave a suitable history of dyspepsia or of haematemesis or melaena but in whom definite evidence was lacking that the peptic ulceration was duodenal in site. Known gastric ulcers were excluded.

In all, 14.6% of 554 men were proved to have or to have had duodenal ulcer, and a further 5.1% fell into the "possible" category. The blood group distribution of the duodenal ulcer subgroup followed closely that of the larger arteriosclerotic group, but was markedly different from the blood donor contrast data and from a typical series of male peptic ulcer patients in York.

Our figure of 19.7% total duodenal ulcer cases is in close accord with the finding by Allan and Dawson⁶ of 19% duodenal ulcer in 353 male Aberdeen myocardial infarction survivors though they noted an excess of duodenal ulcer in the group O patients.

Because of the known deficiency of secretors in duodenal ulcer⁷ saliva from 66 currently attending survivors from the original 554 patients was tested for the ABH substances.⁴

Assuming a frequency of 77% secretors,^{7,8} this is a significant deficit of arteriosclerotic secretors ($\chi^2=19.1$, $n=1$, $P<0.001$). It may be that the non-secretor is not only liable

	O	A	B	AB	Totals
Sectors	12	20	2	2	36 (54.6%)
Non-sectors	13	15	2	—	30 (45.4%)

to duodenal ulcer but also to arteriosclerosis, and this could explain the paradoxical associations of blood groups O and A respectively in the face of the clinical association of the two diseases.

We wish to thank Dr. J. D. Crossland for the blood donor data, Dr. C. N. Pulvertaft for the York peptic ulcer blood group data, and Mr. K. Cumberbatch for technical assistance in testing saliva samples for ABH substances.

—We are, etc.,

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G. A. BUNCH
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General Infirmary,
Leeds

¹ Jones, A. W., Kirk, R. S., and Bloor, K., *Gut*, 1970, **11**, 679.

² *British Medical Journal*, 1971, **1**, 129.

³ Kingsbury, K. J., *Lancet*, 1971, **1**, 199.

⁴ Hall, R., Bunch, G. A., and Humphrey, C. S., *Arteriosclerosis Research*, in press.

⁵ Aird, I., Bentall, H. H., Mehigan, J. A., and Roberts, J. A. F., *British Medical Journal*, 1954, **2**, 315.

⁶ Allan, T. M., and Dawson, A. A., *British Heart Journal*, 1968, **30**, 377.

⁷ Clarke, C. A., *et al.*, *British Medical Journal*, 1956, **2**, 725.

⁸ Camps, F. E., Dodd, B. E., and Lincoln, P. J., *British Medical Journal*, 1969, **4**, 457.

Dermatoglyphics and Chromosomes in Cat-eye Syndrome

SIR,—In reply to Drs. C. W. Darby and D. T. Hughes (3 July, p. 47) I should like to report the results of the dermatoglyphic analysis I carried out¹ in a patient who was extensively studied by Curcio.² The patient was a newborn baby displaying several of the typical cat-eye syndrome features: anal atresia, rectovestibular and pre-auricular fistulae, presence of short metacarpal bones, and 13 ribs. In this patient, as in other published cases,^{3,4} there was an extra chromosome, about half the size of those in group G. As in the case reported by Drs. Darby and Hughes, the patient's father had a normal karyotype, but the mother was found to have the same marker chromosome. The dermatoglyphic pattern of the patient¹ was characterized by the presence of 10 ulnar loops on digits; distal t (axial) triradius; and a whorl pattern in the proximal hypothenar area on the right palm, and a radial loop in the hypothenar area on the left palm.

As suggested by Drs. Darby and Hughes it is possible that the peculiar chromosome anomaly of cat-eye syndrome affects the growth pattern of dermal ridges. However,

I think that no conclusive evidence of the correlation between dermatoglyphic and chromosome abnormalities in this syndrome can be drawn until further informations on similar cases are collected.—I am, etc.,

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Medical Clinic,
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Ferrara, Italy

- 1 Dallapiccola, B., *I Demotoglifi della Mano*, p. 177. Milan, Zambon, 1968.
- 2 Curcio, S., *Archivio di Ostetricia e Ginecologia*, 1967, 72, 533.
- 3 Schachenmann, G., et al., *Lancet*, 1965, 2, 290.
- 4 Schmid, W., *Journal de Génétique Humaine*, 1967, 16, 89.
- 5 Weber, F. M., Dooley, R. R., and Sparkes, R. S., *Journal of Pediatrics*, 1970, 76, 594.
- 6 Gerald, P. S., Davis, C., Say, B. M., and Wilkins, J. L., *Pediatric Research*, 1968, 2, 297.

An XYY Individual of Average Height

SIR,—With reference to the article by Dr. J. Kahn and others (28 August, p. 521), no mention has been made of the possibility of further growth occurring in this boy. According to Tanner's growth and development tables for boys 9-18 years,¹ he is at present between the 25th and 50th percentile for height and between the 50th and 75th percentile for weight. Extrapolating, one could expect at his present rate of growth that he will grow at least another 3 cm in height and 5 kg in weight by 18 years, and that his growth will not necessarily be finished at that age.—I am, etc.,

DORA BLACK

Child Guidance Centre,
London Borough of Barnet,
London N.3

- 1 Tanner, J. M., in *Modern Trends in Paediatrics*, ed., A. Holzel and J. P. M. Tizard, p. 325. London, Butterworth, 1958.

Filling the Gaps in Venereology

SIR,—Drs. F. M. Lanigan-O'Keeffe and W. Fowler (17 July, p. 184) and Dr. A. S. Wigfield (21 August, p. 480) give some idea of the urgent need for recruits to venereology. It can be added that two consultant posts advertised in the last year remain unfilled. Three more are currently advertised and at least two retirements are due in the first half of next year. This, together with the accelerating growth of demands on the V.D. service, is likely to precipitate a serious situation.

As regards trainee venereologists the aim over the past 20 years has been directed at taking the Edinburgh M.R.C.P. with venereology as the special subject. This has had some success. With the passage of time, however, and the degree of control of syphilis in this country, there has been a changing emphasis in the work of special clinics. Nowadays it concerns much more the infections largely confined to the genito-urinary systems of men and women. There has been some recognition of this in other quarters. In the new training programme for the M.R.C.O.G. an elective year in venereology may now be approved. This is helpful. More could be done.

Experience in this department over the last seven years suggests that holders of the M.R.C.O.G. have a sound foundation for the rapid learning of modern venereology. Three senior registrars with this qualification have moved on to consultant posts and one is

currently in training. All have found satisfaction in their new specialty.

In the present state of affairs a male or female holder of the M.R.C.O.G. may expect, with application, to make consultant status in venereology after three years. In the case of females the specialty offers the regularity of working hours which allows of a well ordered domestic life during training and thereafter.

It is to be hoped that both junior and senior doctors in the hospital service will give early and serious consideration to these views.—I am, etc.,

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Sheffield, Yorks

The Lungs and Ankylosing Spondylitis

SIR,—In your leading article (28 August, p. 492) it is stated that there are 16 published reports of non-tuberculous upper lobe fibrosis occurring in ankylosing spondylitis. The number already reported is, in fact, over 50 and the condition is evidently not very rare. I mentioned four cases in 1970¹ and now have a report on a further seven nearly ready for publication. There is good evidence that this is an extra-articular manifestation of ankylosing spondylitis.—I am, etc.,

D. DAVIES

Ransom Hospital,
Rainworth, Notts

- 1 Davies, D., *Tubercle*, 1970, 51, 246.

The Virgin Queen

SIR,—Dr. P. M. Bloom (28 August, p. 535) asks whether Queen Elizabeth I was examined to see if she could bear children, and he wondered if an impediment to sexual function had been discovered. I think that the evidence, so far as it goes, does not suggest that any impediment was found. Neale in his classic *Queen Elizabeth*¹ wrote "When the French king was a suitor for Elizabeth's hand in 1566, his ambassador asked her physician about the talk of sterility. He pooh-poohed the story. 'If the King marries her,' said he, 'I guarantee ten children; and no one in the world knows her constitution better than I do.' Burghley and others had at least a tenth of the physician's confidence. They wanted an heir to the throne, and did not doubt that marriage would provide one." Again in 1578, when Alençon was a suitor, Neale quotes an ambassador "an unreliable retailer of gossip, although in this instance he may be right—says that she held a consultation of doctors to decide whether she could hope for children, and they saw no difficulty." This was when she was 45.

Sir Arthur MacNalty² retells the story of Ben Jonson, possibly in his cups, suggesting that Elizabeth had a membrana (? imperforate hymen), but he is not a reliable witness. The Abbé de Brantôme, one of those in the train of Mary, Queen of Scots, also wrote that he believed that Elizabeth had a very narrow passage, but in this he was probably only repeating a rumour.³

There were two "official" medical opinions given about the Queen's ability to bear children, when she was 32 and 45. Both expressed no doubt that she would be fertile

if she married. Only ill-informed rumour seems to have doubted her sexual adequacy.—I am, etc.,

PHILIP RHODES

St. Thomas's Hospital,
London S.E.1

- 1 Neale, J. E., *Queen Elizabeth*. London, Cape, 1967.
- 2 MacNalty, A., *History of Medicine*, 1971, 3, 9.
- 3 Jenkins, E., *Elizabeth the Great*. London, Gollancz, 1958.

SIR,—I would certainly make no claim to be an Elizabethan scholar, but the following facts are relevant to Dr. P. M. Bloom's inquiry (28 August, p. 535).

In early childhood Elizabeth came to associate sexual intercourse and pregnancy with the most unhappy results. Her father cut off her mother's head; one step-mother died in childbirth; another was beheaded for adultery and buried on Tower Green with her mother. Little wonder she confided to Robert Dudley, when they were both only eight years old, that she would never marry. Subsequently she saw her half-sister go through all the unhappiness and despair associated with pseudocyesis.

Soon after her accession to the throne at the age of 25, the Spanish ambassador made careful inquiries about her and came to the conclusion, as he told King Philip, that she would have no children. Ben Jonson's after-dinner remarks can probably be discounted as so much loose talk.¹

Seven years later (1566) there is the account by Melville that when Elizabeth heard that Mary, Queen of Scots, had been delivered of a son, she exclaimed: the Queen of Scots is lighter of a fair son but I am but a barren stock. Both the authenticity and meaning of this remark have however been considered open to doubt. It was in this year that conflicting medical opinions were recorded, and it is evident that doctors and obstetricians disagreed with each other as much then as they do now. In Elizabethan times they were probably subjected to more religious and political pressures. Be that as it may, Dr. Huick, who had been physician to Katherine Parr and had known Elizabeth since she was 15, advised her not to marry, according to Camden "for I know not what womanish infirmity." Yet in the same year the French ambassador, on behalf of the French King and his mother Catherine de Medici, was pursuing similar inquiries to those previously undertaken by his Spanish counterpart. When he requested information about the current talk of the Queen's sterility he was told in round terms by one of the Queen's physicians: "Take no notice of what she says; if the king marries, I will answer for her having ten children, and no one knows her temperament better than I do."²

Here was confidence indeed. But perhaps it was not misplaced. For 13 years later when a marriage was proposed between Elizabeth, now aged 45, and the French Catholic prince M. Alençon, the Queen's physicians were again asked about her aptness for childbearing. Their answer is given in Lord Burghley's memorandum which states: "It cannot be denied but if her Majesty, when she was younger in years [had married] it had been better for her and the nation also; but considering the proportion of her body, having no impediment of smallness in stature, of