

grains in Ireland than in England and Wales.⁴

Additional support is afforded by our recent report.⁵ We found that relapsed schizophrenics who on admission ate a cereal-free, milk-free diet for a relatively brief period were discharged from hospital twice as fast as those who had been on a high-cereal diet. The disappearance of this beneficial effect when wheat gluten was secretly added to the cereal-free diet indicates that it was not due to non-specific psychological factors.

Though findings such as these need full confirmation before acceptance or application, I believe they, plus previous evidence, amply justify further studies. In addition to genetic-epidemiological studies such as the one suggested by Dr. Walsh and more extensive dietary experiments, I suggest that unmedicated, relapsed schizophrenics consuming a high-gluten diet for weeks or months should be investigated for coeliac-like histological and metabolic abnormalities. In particular, peroral multiple biopsies of the small intestine should prove fruitful, since prior to the use of phenothiazines—a time when cereal grain consumption was much greater than now—patchy pathological changes in the small intestine, more or less similar to those more recently described in coeliac and dermatitis herpetiformis patients, were found at necropsy in a high proportion of schizophrenics.⁶⁻⁸—I am, etc.,

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Haemolytic-Uraemic Syndrome with Pericarditis and Pleurisy

SIR,—The report by Drs. J. A. Utting and D. R. Shreeve (9 June, p. 591) of pleural and pericardial haemorrhage occurring late in the course of the haemolytic-uraemic syndrome raises three important points.

First, streptokinase was given for twice as long as the manufacturers' recommended five-day period. Prolongation beyond this time may give rise to complications arising from the development of antibodies.

Second, the data provided do not allow a firm conclusion to be reached concerning the cause of the haemorrhagic pericardial and pleural effusions which occurred one month after admission. The absence of a rise in blood urea argues against recurrence of the original disease process. A very marked rise in serum fibrin degradation products was recorded but, in the absence of other evidence of increased intravascular coagulation (recurrence of thrombocytopenia, fall in coagulation factor levels, increase in circulating fragmented red cells) this might have been caused by lysis of fibrin within the haemorrhagic effusions. It would therefore

be of value to know the platelet count at the time of the haemorrhage and also the degree of prolongation of the thrombin clotting time resulting from heparin therapy.

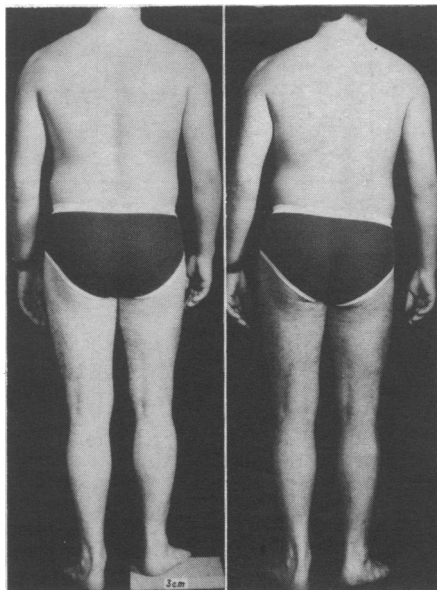
Third, the clinical improvement which occurred in parallel with the introduction of aspirin and dipyridamole is not necessarily evidence of a cause-and-effect relationship.—We are, etc.,

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Congenital Hemihypertrophy

SIR,—The memorandum by Dr. M. Henry and others on congenital hemihypertrophy with aortic, skeletal, and ocular abnormalities (13 January, p. 87) is of interest. The authors mention possible lines of pathogenesis, and in a subsequent letter Dr. A. W. Johnston (17 March, p. 678) has reported that out of nine cases of congenital asymmetry only one had abnormal chromosomes. The accompanying photograph illustrates a further case of greater development of one side of the body than the other. The longer left side was noted from infancy, and the ultimate leg length difference of 3 cm produced a scoliosis, corrected by an appropriate raise. There was no special congenital disorder present and no chromosome studies are available.



The more dramatic features of patients with hemiatrophy or hemihypertrophy should not be allowed to overshadow the patients who have asymmetry extending to the lower limbs only. Greater clinical awareness is required, since asymmetry of this kind is not apparently as gross as that associated with hemihypertrophy. Once suspected, accurate measurement is required. The tape-measure or iliac crest palpation may give misleading results, as was shown when they were compared recently with a simple x-ray method¹ involving no more radiation than that for an x-ray of the pelvis, suitable protection being used as necessary. The x-ray taken erect gives accurate in-

formation about the actual discrepancy in the height of the femoral heads. It is interesting to note that any scoliosis observed clinically always appears greater on the x-ray. Lesser degrees of scoliosis may not be detected clinically, and this and other clinical features are obscured by obesity.

Though the least discrepancy worth correcting is still not clearly established, there are good clinical grounds for believing that it is at least $\frac{1}{2}$ in (12.5 mm), and in a report on one very large series based on radiological measurements it was suggested that 7 mm is the upper limit of the normal range.²—I am, etc.,

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Antibiotic Sensitivity of Klebsiella

SIR,—In our report on the contamination of E.C.G. electrode pads (19 May, p. 400) we stated that the *Klebsiella aerogenes* isolated appeared sensitive to ampicillin on disc sensitivity testing, and despite the finding that the minimum inhibitory concentration was well into the resistant range we do not share Dr. T. D. M. Martin's concern (9 June, p. 614) regarding our antibiotic sensitivity methods. Disc testing of this organism has produced the same results in two separate laboratories on several occasions.

We used the word "appeared" advisedly as the problems of interpreting disc sensitivity results of β -lactamase-producing organisms are well known. Almost all strains of *K. aerogenes* produce β -lactamase to a greater or lesser extent. Even with well-controlled disc sensitivity methods false results are easily obtained for such organisms, apparently as a result of small differences in inoculum. Hence in this paper, as elsewhere, when β -lactamase-producing *K. aerogenes* appears sensitive to ampicillin on disc testing, we would use the minimum inhibitory concentration as an essential and more accurate indication of susceptibility.—We are, etc.,

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Epidemiology of Simple Hypospadias

SIR,—Our colleagues Dr. C. J. Roberts and Mrs. Setsuko Lloyd reported (31 March, p. 768) that there was a marked seasonal variation in the incidence of hypospadias among 93,000 newborn infants in South Wales during the period 1964-6. This seasonal fluctuation was even more marked if the date of last menstrual period was used as the index of incidence. A similar finding had also been reported from the United States for 1963-5 by Wehrung and Hay.¹

In England and Wales the local public health authorities keep a register of all congenital malformations which are reported at birth, from which the Registrar General has kindly provided a tabulation of hypospadias or epispadias for each month during the past five years, notified from the whole country. This is given in the table.