risks of unnecessary catheterization in such patients—possibly precipitating retention, possibly causing haematuria, possibly introducing infection, etc.—the effect of the instrumentation might well be more than that of the drugs being tested. By this I mean that it might cause a temporary improvement in obstruction caused by a fibrous prostate.

The correct method of assessing the amount of residual urine is known to all urologists to be the intravenous postmicturition cystogram. This is the test which should have been advocated to determine the effect of the medical treatment of prostatic obstruction. I am afraid that I am also critical of the title of your leading article. It says itself that enlarged prostates do not necessarily need any treatment—obstruction is the critical factor.—I am, etc.,

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Synovial Fibrinolysis and Haemophilic Haemarthrosis

SIR,—In recent years synovectomy has been introduced as a treatment for haemophilic haemarthrosis.¹⁻⁴ Since the role of synovial fibrinolysis in haemophilic haemarthroses does not seem to have been previously considered we decided to investigate fibrinolytic activity in synovial specimens. These were obtained from the knee joints of five haemophilic patients, aged 12, 14, 19, 20, and 22 years respectively, who had had synovectomy. Synovial membranes obtained postmortem from a newborn infant and from a patient aged 18 with no abnormalities of clotting factors were used as controls. Cryostatic (-20°C) sections $10\ \mu\text{m}$ thick were processed by the fibrinolysis autography technique of Todd as modified by Pandolfi and Astrup,⁵ using a plasminogen-rich fibrinogen film coated on the microslides. Plasminogen-free fibrin, obtained according to the method of Bishop *et al.*,⁶ was used to detect unspecific fibrinolytic activity. Serial sections in each case were incubated at 37°C in a moist chamber for periods varying from 5 up to 40 minutes. Some sections were formalin-fixed and incubated for the same times.

The shortest period of incubation which produced some areas of fibrinolysis in normal synovial tissues was approximately 10 minutes. Our results in normal subjects agree with those of Bach, Andersen, and Gormsen⁷—that is, the lytic activity was mainly localized around the capillaries and venules of the connective tissue underneath the synovial lining (Fig. 1). Lytic activity on the surface of the synovial lining seemed in most cases to be due to the extension of fibrinolysis from inside the vessels under the synovial lining. The shortest time of incubation before fibrinolysis appeared in the synovial tissue from haemophilic arthropathies varied according to different pathological patterns—for instance, the angiomatous type which may evolve into the pigmentary or fibrous type.⁴ The fibrinolysis appeared in the angiomatous type or arthropathy after 5 minutes incubation. A pronounced increase in perivascular fibrinolytic activity was evident, reflecting the angiomatous granulation tissue present in these joints (Fig. 2).

FIG. 1—Normal synovial membrane from 18-year-old patient. Perivascular areas of fibrinolysis are evident. Incubation time 30 minutes ($\times 27$).

FIG. 2—Synovial membrane from case of haemophilic arthropathy of angiomatous-pigmentary type with confluent areas of fibrinolysis in the granulation tissue. Incubation time 30 minutes ($\times 31$).

Fibrinolysis appeared after 10 minutes of incubation of synovia from the fibrous or pigmentary type of arthropathy. Areas of lysis were localized mainly along the synovial lining and were not very prominent. In the plasminogen-free fibrin-coated slides from both normal and haemophilic patients lysis did not appear for up to 30 minutes of incubation. After 40 minutes some small areas of fibrinolysis appeared. That may have resulted from small amounts of plasminogen being present in the sections and being activated by plasminogen activators.⁸ Fibrinolysis was never seen in formalin-fixed sections.

The evidence of a pronounced increase of vascular fibrinolytic activity in the granulation angiomatous tissue of the haemophilic synovial membranes could explain the difficulties of intrarticular clotting. Likewise the excellent therapeutic effects of the anti-fibrinolytic compounds such as epsilon-aminocaproic acid in the surgical treatment of haemophilic arthropathies¹ could conceivably be attributed to the depression of active fibrinolysis in the articular angiomatous tissue.

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—We are, etc.,

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Poland's Syndrome

SIR,—Two male patients (one white and the other mulatto) with Poland's syndrome have been found in a sample of nearly 60,000 births ascertained through a home-to-home survey in Central Brazil, about half being among whites and half among non-whites (mulattoes and negroes). This leads to an approximate incidence of 1:30,000. Based on information from the literature,^{1,2} an indirect approach led to estimates from somewhat lower than 1:10,000 to 1:100,000.

The white patient had the right side affected; the mulatto the left side. Both showed typical four-finger lines and the axial triradii displaced to a distal position in the affected hands. Walker relation was equal to 48% in the first patient and to 46% in the second; in a normal male Brazilian sample it was about 20%.³ A pattern suggesting an incipient digital tri-radii formation was seen in the position *bc* of the first patient. The second also showed a vestige in the thenar area and only one digital triradius (*ab*) forming a large cubital loop. The digital triradius *c* was absent in his normal hand.

The existence of only one digital tri-radii with a cubital loop in one patient is consistent with syndactyly data.⁴ The pattern found in the interdigital area of the other patient may be interpreted as an extreme variation of the same characteristic.

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Transfer of Geriatric Patients

SIR,—A great problem in clinical geriatric care is to decide what proportion of elderly patients should be accepted for transfer from general medical and surgical wards. Some geriatric departments base their policy on statistical principles, others allocate a quota of their long-stay beds to individual consultants, and others take patients in rotation and notify the physicians and surgeons when

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