detected material with similar chromato-
graphic solubility characteristics in the faeces of
normal subjects and patients with a
variety of porphyric syndromes.

The authors seem to us untrustfully reluctant
to offer any significant positive diagnoses or explanations for the
many clinical syndromes described.

Cerebral symptoms of confusion, stupor, con-
vulsion, and death in some of the subjects
have clearly been due to uraemia, dehydration, alka-
losis after prolonged vomiting, or many other toxic or infective states. The ileus and generalised
weakness of some of the patients may well have been the result of hypokalaemia—a
well-known complication of protracted vomiting, characterised by violent purgation. Repeated blood-
letting may also have contributed to the profound
weakness experienced by many of the subjects.

Drs. Macalpine and Hunter discard the diagnosis of gout made by the physicians of the time in
several of the descendants of James VI, pre-
fering to regard acute porphyria as the explana-
tion of a limb pain that the patients experienced.

Surely Sydenham's masterly 17th-century
approach appears soundly reasoned.

The clinical features of the patient's illness
with repeated attacks of left loin pain radiating
to the bladder and the glans penis, transient
passage of "dark blood and urine with a thick
red sediment" (on one occasion after horse-
riding while strolling), and the necropsy find-
ings of "concretions in the right kidney" make the
diagnosis of renal calculi much more likely
than porphyria. The absence of stones in the
left kidney at post-mortem examination is not
surprising. It is small stones that cause ureretic colic, and these are likely to have been passed.
In the words of Charlotte Augusta Princess of Wales the clinical picture of collapse, hours after
an apparently uncomplicated delivery, with acute
chest pain, laboured respiration, and conscious-
sness, suggests amniotic fluid embolism, and in
our experience is totally unlike acute porphyria.

It is not our intention to detract in any
way from the praise due to Drs. Macalpine
and Hunter, and Professor Rutherford, for
developing an interesting and provocative
test. We were, however, left with the im-
pression that their researches and interpret-
atations are based on an understandable
desire to sustain the thesis rather than to
examine it. If there are reasonable grounds
for suspecting that an inborn metabolic error such
as variegate porphyria (or, as seems to
us equally possible, familial hyperuricaemia)
afflicts the Royal Houses of Hanover, Stuart,
and Prussia we feel it incumbent upon those
who have raised the suspicion to examine as
many as possible of the living descendants of
these Houses and to make known the results.

By so doing they will best serve the interests
of the persons concerned and the interest of historical truth. Until this study has been
undertaken and the results examined, we
should reserve judgement on their conclu-
sions. We are, etc.,

B. L. MITCHELL
EUGENE B. DOWDLER

Correspondence

British Medical Journal

Complication of Tuberculous Meningitis

SIR,—We note with interest the case report
by Dr. V. K. Summers and others on "A Hypothyroid Child with Tuberculous Meningitis" (10 February, p. 359), as
we have seen two similar cases.

Case 1.—A 25-year-old female first seen at
this hospital in April 1965. There was a history of tuberculous meningitis at the age of 10 years which
responded to chemotherapy but with residual right hemiparesis. There was evidence of diabetes insipidus
by hypothalamic, hypocorticosdrenalism, and hypogonadism. Skull x-ray showed calcification in the region
of the sella.

Case 2.—A 14-year-old male seen with Dr.
N. V. O'Donnoghue in Our Lady's Hospital for
Sick Children, with a two-year history of infan-
tilism, obesity, and diabetes insipidus. There
was a history of tuberculous meningitis at the
age of 8 years which responded to chemotherapy.
 Investigations confirmed the diagnosis of diabetes insipidus and secondary hypogonadism. There
was some evidence of secondary hypothyroidism and hypopituitaryism. Skull x-ray showed calcification in the region of
the sella.

At the age of 16 years the patient died
during a "syncopal" attack, and the diag-
nosis of pituitary insufficiency secondary
to cured tuberculous meningitis was confirmed at post-
mortem.—We are, etc.,

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More Cases of Scabies

SIR,—Treatment centres established by the
local authorities are indeed helpful in the
management of scabies, as mentioned by

Dr. A. S. Shrank and Suzanne L. Alexander
(17 February, p. 445) and Dr. J. K. Morgan
(9 March, p. 641). Working in Central
London one has the benefit of such centres;
sometimes, however, they function but im-
perfectly.

I saw recently a man with scabies and referred
him to the local cleansing centre. The next week
he returned, still complaining of severe itching.
I expected to find only evidence of post-licen-
se eruptions, but he proved to have hands still
showing burrows from which the live scabies could
be extracted. It transpired that the painting of
benzyl benzoate had spared his hands.

When this fact had been confirmed (and the
help of the medical officer of health in
preventing its recurrence enlisted) and the
importance of including the hands explained to
the attendant in question the patient returned
to the centre and treatment was
entirely successful.—I am, etc.,

London W.1

C. M. RIDLEY

Acrocrosis

SIR,—After reading the letter by Drs. Stephenia A. Davies and F. J. Woodroffe (30 December, p. 804) I wish to report a similar
case in a very young male fitter working on the
railways.

Although his symptoms began about five
years ago, the condition has remained benign
and has not progressed in spite of the dis-
charge, a carotid arteriograph has been
negative. We concluded that a carotid arteri-
ography is indicated in cases of this nature.

The patient has now received treatment for
about five years and his condition is much
better, but at times he is still plagued by
hypokalaemia—a condition which is expected
to be seen in this hospital in the near future.

Drs. C. M. Ridley and J. E. Jones

Status of the Representative Body

SIR,—I think the Association owes a great
debt to Dr. J. G. Hamilton, Professor F. E. Stock,
and Mr. H. H. Langston for so effectively letting the cat out of the bag and confirming, as reported (Supplement, 2
March, pp. 52, 53), what Stock so much feared: "... the Representative Body did positive harm to the
Association." Mr. Langston: "... would like to see its powers rather similar to those of the House of Lords in Parliament over
ruling everything that is decided by the
Council."

I admire their courage in throwing down the
guantlet to the Representative Body, particularly as it is proposed that most members of Council should be
elected by that very body which they hold in
such low esteem. But I dislike their views, and I believe it was most ungracious of them to condemn out of hand, and before
it had even met, the remodelled Representa-
tive Body decided upon last year, which will
have new procedure and representative repre-
sentation with adequate spokesmen for the
hospital junior staff and other minority fields
served in the past. But these revelations—the words of these three and the actions of others (a proposed
size of 300 for the Representative Body, etc.)
—do raise a very serious issue which we must
face. Our cherished democracy seems rather
a myth, our liberties are at stake—in fact
not in theory. Whatever the Representative Body decides, about anything from free
school milk to the size of the Representative
Body, is as water upon a duck's back; the
committee will tend to press on regardless. It
is time we re-appraised the status of the
Representative Body and its decisions. Either
to be scrapped out and we have an openly
acknowledged oligarchy or dictatorship,
or else the Representative Body must
take up the gauntlet and assert its rights on behalf of the members as a whole and ensure
that henceforth the Council and the
committee act constitutionally. The present
constituted is not. It is time that adequate safeguards are
challenged by referendums (Article 40 (2))
any supposedly irresponsible decision of the

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30 March 1968