The authors take issue with me that those who inherit porphyria variegata and avoid the drugs that can precipitate an acute attack of porphyria remain in good health except for increased sensitivity of the light-exposed skin. The evidence for this is that the forebears of porphyric families in South Africa in the seventeenth, eighteenth, and nineteenth centuries had just as large families as average—and the average family was large, usually 8 to 15 children—which is why the porphyrics increased in number *pari passu* with the descendants of the rest of the small nucleus of early South African Free Burghers. If they were having attacks of acute porphyria and died from the attacks before the advent of modern drugs their descendants would not have increased as rapidly as they did. Furthermore, here in the Eastern Cape there is not a doctor with a general practice of any size who has not among his patients men and women who have inherited porphyria variegata, and they can confirm that their porphyric patients do not have attacks of acute porphyria except after taking drugs, usually a barbiturate.

In my last letter I ended on the kindly note that their claim was "not proven." This time I shall end more firmly by promising to "eat my hat" (a paper one) if the authors can produce convincing evidence that they are right.—I am, etc.,

Port Elizabeth, South Africa. GEOFFREY DEAN.

REFERENCE

1 Waldenström, J., *Acta med. scand.*, Suppl. No. 82, 1937, pp. 70, 72, 73.

SIR,—It was suggested in your leading article (6 January, p. 2) that evidence of porphyria in James Edward Stuart and his descendants would be worth seeking, as, if found, it might dispose once and for all of the allegation that substitution was practised at his birth. Such an investigation, whatever its other difficulties, would involve only a small number of individuals, while, as Charles Edward secured the legitimation of his daughter Charlotte Stuart in 1783, all the descendants of James Edward are legitimate and easily traced. (Incidentally, Sir Compton Mackenzie[1] records Charlotte's death in 1789 as being due to a malady brought about by a fall from a horse.)

The position, however, in the House of Hanover would seem to be very different. Not only are the numbers much greater, but the illegitimate members of a generation greatly outnumbered the legitimate at times—for example, in 1817, as Dr. D. L. Gullick (20 January, p. 178) points out. Nevertheless, as regards the "royal malady" of haemophilia, J. B. S. Haldane[2] was able to conclude that the most probable place and time for the mutation which led to its appearance in European royal families was in the nucleus of one cell of Edward, Duke of Kent, in the year 1818, and he gives reasons for that probability as regards place, but not (in that edition) as regards time, except that Edward's only child of that marriage, the future Queen Victoria, was born in the following year, 1819. Presumably Edward's other children, born earlier, were investigated by Professor Haldane and found to be free from haemophilia, and he states (loc. cit.) that Victoria's half-brother, son of the Prince of Leiningen, was not haemophilic. He showed that two of Queen Victoria's daughters were heterozygous for haemophilia, and transmitted haemophilia to (among others) the royal families of Spain and Russia, as did her haemophilic son Leopold to some of his descendants. If Queen Victoria's father was not only the unwitting *fons et origo* of those calamities but a victim of porphyria as well, as suggested in the very interesting study by Dr. Ida Macalpine and her colleagues (6 January, p. 7), he would seem to be unfortunate indeed. That he and no fewer than three of his brothers should all suffer from porphyria and yet be followed in the next generation by only one case—Princess Charlotte—might seem surprising, but investigation of their other children, whether legitimate or otherwise, this time for porphyria (as Dr. Gullick suggests in the case of the Fitzclarences) might reveal a very different state of affairs.

A second hiatus on the Hanoverian side is the long gap of five generations in the direct line from James VI and I to George III without known clinical evidence or discoloration of the urine. Here Dr. M. Duddle's letter (20 January, p. 178) about George I's death might help, and Sir Compton Mackenzie's account (loc. cit.) that George died in Osnabrück at midnight following a surfeit of melons on top of a heavy supper confirms at least that abdominal symptoms were prominent at the end.

Further investigation of the House of Hanover for porphyria would seem very much more difficult than a study of the later Stuarts—but potentially more rewarding.—I am, etc.,

Stepps, Glasgow. A. F. MACLEAN.

REFERENCES

1 Mackenzie, C., *Prince Charlie*, 1932, London.
2 Haldane, J. B. S., *Keeping Cool*, 1940, London.

Was it a Drug?

SIR,—Is it not time that Regulation 16 of the National Health Service (Service Committees and Tribunal) Regulations, 1956, was abandoned?

Every week one hears of a substance being decreed not a drug or medicine which the executive council feels bound to provide, and the general practitioner is fined the cost of the preparation. Frequently the product has been prescribed on the advice of a consultant. The general medical practitioner is in the position of having to give all proper treatment on the one hand, and to anticipate the decision of some distant referee on the other. It is made clear that the adjudication in one particular case is not binding on any other.

This cause of resentment can easily be removed. Abandon Regulation 16.—I am, etc.,

Sutton Coldfield, Warwicks. R. C. BROWN.

Blood for Sale

SIR,—Your leading article (20 April, p. 129) rightly points out the medical disadvantages of adopting a commercial attitude to blood transfusion. There is another aspect equally important. The urge to altruism is an integral part of normal human personality. The satisfaction of doing something for another out of pure disinterestedness and without hope of personal gain is difficult to achieve in a sophisticated society where everything has its price. That blood donation has proved so widely accepted a means of fulfilling this yearning underlines its value. If the money likely to be spent on buying blood were devoted to publicity there would be a ready response from a public starved of the avenues for social dedication previously offered by war, voluntary hospitals, and the poor, all of which appear to be fading away from the contemporary scene.—I am, etc.,

Huddersfield, Yorks. S. L. HENDERSON SMITH.

Hiatus Hernia

SIR,—One of the methods necessary for the alleviation of symptoms of hiatus hernia is to raise the head end of the bed some four to six inches (10 to 15 cm.). This has usually been done by using bed blocks.

A very simple and efficient way of achieving the same object is to remove the castor-bearing feet from the lower end of the bed and to fix the castors directly to the base.—I am, etc.,

London W.1. WILLIAM W. FOX.

Dealing with Bedsores

SIR,—Having read the review in the *B.M.J.* (6 April, p. 40) by Professor H. Ellis on Mr. B. N. Bailey's textbook *Bedsores*,[1] I feel constrained to make one comment.

While a large part of the text is both valuable and unexceptionable, certain aspects are contrary to the practice and teaching of this unit. In view of Professor Ellis's last sentence I feel I must dissociate myself and this unit from some of the recommendations in Mr. Bailey's book.—I am, etc.,

J. J. WALSH,
Director,
National Spinal Injuries Centre.
Stoke Mandeville Hospital, Bucks.

REFERENCE

1 Bailey, B. N., *Bedsores*, 1967. London.

Colour Coding

SIR,—The increasing practice of colour coding of National Health Service general-practitioner records makes it essential that, when new needs for such coding arise, such a code is allocated nationally.

The new situation with regard to measles vaccine highlights the need for each patient in the age group liable for vaccination who has had measles to be clearly colour-coded. It is suggested that 1 in. (2.5 cm.) by ½ in. (1.25 cm.) black and white chequered Sellotape be fixed to the top left-hand corner of the N.H.S. record—that is, when the open end is upright facing the observer—of those patients who do not require measles vaccination. It is realized that this will be a temporary need for the next five years, but full computerization of medical records which would obviate this need is not likely to be achieved during this time.

It should be possible to build up such a coded population by questioning parents or searching through the patients' N.H.S. record envelope for the recorded entry of "measles" at an appropriate parent and/or patient contact.—I am, etc.,

Royal College of General Practitioners, London S.W.7. E. V. KUENSSBERG.

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