patients with bony secondaries visible on x-ray were excluded.

Mr. M. R. C. (in April, p. 109) objects to the statement that the production of gastrin by pancreatic tumours cannot be called "ectopic." It is agreed that the non-aryrophil α cells, or β cells are identical in structure with gastrin-producing cells of the fundus of the stomach, but have 8 cells been proved to secrete gastrin under normal circumstances?

I am fully in sympathy with Mr. Keynes's difficulty with nomenclature, particularly with the use of the term "ectopic," but no really appropriate adjective has yet been suggested; "para-endocrine" seems preferable to "ectopic." The term "Cushing's syndrome" is often employed—for example, by Dr. Azzopardi—to describe the consequences of production of corticotrophin by tumours, but its use in this context is inadmissible, as it is not the syndrome described by Harvey Cushing. The presence of "ectopic" production of corticotrophin by tumours is usually suspected initially by the presence of hypokalaemic alkalosis, which is very uncommon in classical Cushing's syndrome. Again, the majority of cancer patients with corticotrophin production, particularly when due to out-cell carcinoma of the lung, may live long enough to develop the physical features typical of classical Cushing's syndrome. The hormonal syndromes are best classified in terms of the hormones they secrete, rather than by benign diseases they resemble to a greater or lesser extent.—I am, etc.,

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6 Williams, R. D., Murask, A. M., and Hone, R. C., Journal of Clinical Pathology, 1968, 21, 263.

Cytomegalovirus Oesophagitis

Sir,—Although the protein clinical manifestations of cytomegalovirus in the adult are now well recognised we should like to draw attention to severe ulcerative oesophagitis occurring as a presenting feature. A 35-year-old fitter was admitted in a cachetic state with a month's history of progressive difficulty and pain on swallowing. A diagnosis of Hodgkin's disease had been established 10 years earlier on cervical lymph node biopsy and subsequently he had received treatment with radiotherapy, steroids, and cytotoxic agents. On examination he was wasted, febrile, and wasted, and febrile. There was no oral moniliasis. He had bilateral pleural effusions and gross leg oedema. The liver and spleen were palpable. There were crops of petechiae and subcutaneous nodules over the whole of the trunk. A barium swallow showed gross irregularity of the oesophageal mucosa with three prominent ulcer crater and numerous other tiny ulcers. The appearances were considered to be highly suspicious of mononuclear oesophagitis, but there was no improvement with nystatin. His condition continued to deteriorate and he died three weeks later.

The main findings at necropsy included those due to invasive Hodgkin's disease and those attributable to disseminated cytomegalovirus infection. The distal third of the oesophagus and the fundus of the stomach showed confluent elevated white plaques up to 3 cm diameter. Microscopically, the epithelium was denuded and there was a non-specific mononuclear infiltrate in the lamina propria. Large numbers of degenerative cytomegalic cells were present (Fig. 1).

In seriously debilitated patients such as those with advanced malignant disease or those on immunosuppressive therapy opportunistic infection with cytomegalovirus is not uncommon and organs such as lungs, adrenals, spleen, pancreas, and kidneys are frequently involved. Lesions of the gastrointestinal tract, excluding the liver, are rare, and it is often difficult to define the specific role of the cytomegalovirus in their production.

Levine, Warner, and Johnson1 have described patients with cytomegalic inclusions in ulcers of jejunum, ileum, and colon, and a similar lesion in the anus and rectum has been reported in a woman dying from primary cytomegalovirus infection. Previous comment has been made of oesophagitis in cytomegalovirus infection2 and it seems likely that the gross ulcerative change in the oesophagus of our patient was due primarily to cytomegalovirus infection. It is possible that other forms of apparently non-specific ulceration of the gastrointestinal tract in debilitated patients might be related to cytomegalovirus infection. We are, etc.,

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Tropical Splenomegaly, Sickle-cell Trait, and P. falciparum Infection

Sir,—The diagnosis of tropical splenomegaly (T.S.S.) is of much straightforward as Dr. Marianne Janosi (4 March, p. 628) implies. She points out a number of features, but there are recent series with a number of anomalies by her criteria. For instance, the size of the spleen may be variable, and macroglobulinaemia has not been a constant finding. In the series of Stuiver et al. there are 7 out of 29 cases with spleens palpable less than 10 cm below the left costal margin including some with only 2 or 3 cm spleno-

gemaly. Although Lowenthal et al. found only two cases of 19 in Zambia with normal IgM, a normal IgM was reported in four of eight cases from Uganda by Ziegler et al.2 Our patient was small. He weighed 45 lb (20.5 kg) and was 46 in (117 cm) tall. Consequently, his spleen, palpable 7.5 cm below the left costal margin, was proportionally large for his age. We excluded Hbs-βthalassaemia, as HbA was the major component, and HbA2 and HbF in the prothromboplastin and his two siblings were normal. Dr. Janosi draws attention to some of the difficulties in diagnosing T.S.S. It is only really stated that T.S.S. is a diagnosis by exclusion.3 Sagoon4 suggested more rigid criteria for diagnosis. If Dr. Janosi and her colleagues also recognize a series of positive diagnostic features, may be invited to invite her to report them. We are, etc.,

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Duodenal Ulcer and Gastric Cancer

Sir,—Eight male cases of gastric cancer in men have been found in this average size practice since 1961. Four of these had a long-standing history of duodenal ulceration. All smoked heavily and developed chronic bronchitis and emphysema. Three were seen in men of them was gastric cancer