patients in both relapse and remission were upper respiratory tract infections (URTIs). Other factors associated with relapse were stress (2), *Escherichia coli* urinary tract infection (1), and gastroenteritis (1).

For patients with CD, 18 relapses were observed during the 61 clinic attendances. Of these 18 relapses, 13 were associated with a precipitating factor (table). Of 43 attendances of patients with quiescent disease, only 10 were associated with a precipitating factor (P < 0.0005). Most of the precipitating factors were again URTIs. One patient who was in relapse had begun divorce proceedings in the previous month.

Even when upper respiratory tract infections were considered alone, patients with a relapse of either UC or CD were significantly more likely to have had an infection in the previous month than those in remission (UC relapse v remission P < 0.01; CD relapse v remission P < 0.005). No patient with an URTI had received an antibiotic during the previous month.

**Comment**

The present study has shown that there is a highly significant association between URTIs and a relapse of either UC or CD. Thus 60% of patients with UC with a relapse had had an URTI during the previous month compared with 22.7% of patients who presented in remission. A similar relationship was present in patients with CD. Of the other precipitating factors investigated, none appeared with sufficient frequency to enable meaningful results to be obtained.

The reasons why URTIs should be associated with a relapse of either UC or CD are uncertain. One hypothesis is that circulating immune complexes resulting from the infection may be deposited in the diseased intestine. In rabbits deposition of immune complexes in the colon may cause colitis. Since animals infected with upper respiratory tract viruses may have circulating complexes, similar complexes occurring in human URTI may localise to the diseased bowel and lead to a relapse.


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Presumed ataxia-telangiectasia in a man

Ataxia-telangiectasia is a complex, multisystem genetic disorder. It is usually fatal from uncontrollable infection in adolescence, though it shows some variability in severity, age of onset, and rate of progression. We report an unusual case of the condition, resembling Friedreich’s ataxia, in a man.

**Case report**

The patient is a 37-year-old Italian lawyer with two children, who had been diabetic from the age of 35. His parents were first cousins, and there had been consanguineous marriages in previous generations. From infancy he had had recurrent infective diarrhoea and subsequently recurrent respiratory and urinary infections. He had had two operations for hypospadias in infancy, but his early development had otherwise been normal. Neurological symptoms began in his late teens, with weakness and wasting beginning distally in legs, later spreading proximally. Progressive ataxia developed later, though on 30 October 1977 he still walked unaided. He complained of “hypersensitivity” of the skin of the feet and legs.

His paternal grandfather and great-grandfather had had progressive walking difficulty and required wheelchairs in old age. In 1976 his father, though asymptomatic, had impaired proprioceptive sensation in the legs and an absent ankle jerk.

The patient had telangiectases in both popliteal fossae, ganadal atrophy, bilateral pes cavus, and normal intellect. He had fine, phasic horizontal nystagmus on lateral gaze bilaterally; the eye movements were otherwise normal, as were the remaining cranial nerves. There were no bulbar con- junctival lesions. The arms showed symmetrical mild intention tremor and diminished tendon reflexes; the legs showed symmetrical weakness and wasting, mainly distally. Posterior column sensation was absent and spinothalamic sensation impaired in both legs below the knees; knee jerks were absent, ankle jerks absent, plantar responses flexor. His gait was ataxic and Romberg’s sign positive. There was no peripheral nerve hypertrophy.

Serum 

The patient had had URTIs during the previous month compared with 22.7% of patients who presented in remission. A similar relationship was present in patients with CD. Of the other precipitating factors investigated, none appeared with sufficient frequency to enable meaningful results to be obtained.


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