common pathogens in an immunosuppressive environment.

The choice of antibiotics in our case was governed by the sensitivity pattern of the initially unisolated GNB. It was felt necessary to continue antibiotics until the brain-scan and E.E.G. had reverted to normal. In view of possible toxicity with long-term gentamicin the patient was discharged on ampicillin—thought by some authorities to be the antibiotic of choice in listeria infections.1,2 Both in initial diagnosis and in assessing improvement the brain-scan proved invaluable as a non-invasive technique.—We are, etc.,

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T.S.H. Level and Thyroid Function

Stir— I should like to raise some points about the patients described by Dr. W. M. G. Tunbridge and others (13 July, p. 89) as showing a persistently elevated thyroid-stimulating hormone (TSH) level but not found to be hypothyroid on clinical examination. It was considered an attempt to release hormone (TSH) response (in the patients so tested), and the return of the TSH to normal on thyroid substitution are all consistent with the diagnosis of hypothyroidism. Because the choice of a particular diagnostic term tends to determine one’s further approach to a given problem, I feel that the term “euthyroid” in relation to these patients, with whatever qualifications, is most appropriate.

With a more complete understanding of the regulation of thyroid hormone and with the availability of better ways of separating the, at present, clinically not discernable forms of hypothyroidism from euthyroidism, it would seem timely to use diagnostic terms reflecting the progress in the field. The normal range for all the presently measurable criteria for characterizing thyroid status are adequately defined. It would seem that any one of these measurements falls outside the normal range the use of the term “euthyroid” is no longer acceptable. Thus the term “subclinical hypothyroidism,” mentioned in the discussion of the patient, would seem to be a more physiologically more correct way of referring to such patients. I find “compensated hypothyroidism” actually preferable; it expresses both the thyroid pathology and the mechanism whereby it is corrected, quite possibly only temporarily. By emphasizing the presence of a thyroid abnormality rather than the absence of this abnormality are, for the present, clinically not recognized (quite possibly for lack of obtaining the relevant information) both the interest of the patient and progress towards an understanding of their condition would be better served.

In a subsequent article by Dr. A. D. Toft and others (20 July, p. 152) evidence is presented that the elevated TSH in “euthyroid” patients may be a useful guide in selecting those who can be expected to develop clinically manifest hypothyroidism. Thus it would appear that the biological and clinical significance of the persistently elevated TSH may be established, at least in this respect.

There is little firm clinical evidence and considerable controversy about the extra-thyroidal effects of TSH-1 and TRH-2 in man. It would seem certain appropriate and desirable to look for ways of detecting the effects of the kind in patients who are exposed to supraphysiological concentrations of these substances over prolonged periods of time.—I am, etc.,

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1. Arboe-Hansen, G., American Journal of Medicine, 1959, 26, 470.
5. Prange, A. W., Lancet, 1974, 1, 598.

Myeloblastic Transformation

Stir—In their paper on acute transformation of chronic granulocytic leukaemia (C.G.L.) (13 July, p. 77) Dr. A. D. S. Spier’s and his colleagues discuss the rapidly progressive form of metamorphosis. They also emphasize the difficulties of definition and classification in this field.

Acute transformation is also seen in polycythaemia rubra vera (P.R.V.) and in myeloblastosis. Of the 18 patients seen at the London Hospital with acute transformation since 1968, six had a diagnosis of C.G.L., we have diagnosed seven cases of myeloblastic transformation in the myeloblastic group two patients originally had C.G.L. and three originally had P.R.V.

In the C.G.L. group the mean survival after transformation was 6 months with a range of 4 to 10 months. Two patients were treated with mercaptopurine or prednisone only; one of these achieved a complete remission and was maintained for six months with mercaptopurine and intermittent methotrexate. During the remission the patient was well and required no transfusions, his peripheral blood having the appearance of C.G.L. When he relapsed two courses of triple drug therapy (thioguanine, cytosine arabinoside, and prednisone) were given. The patient failed to produce another remission and by this time he had developed leukaemia. In the other patient the white cell count and blast count were reduced, but there was little real benefit. Four patients received three drugs or more as soon as the diagnosis of acute transformation was made, and three complete remissions were obtained—two with cytosine arabinoside, thioguanine, cytosine arabinoside, hydroxyurea, asparaginase, vincristine, adriamycin, and prednisone as the drug used. The other two patients were treated with mercaptopurine alone in full remission 13 weeks after diagnosis, the remission having been achieved with three courses of thioguanine (40 mg/kg) and prednisone. The other three patients have died; none achieved a full remission or partial remission. In each case the patient improved symptomatically, required no blood transfusions for at least two months, and was able to return to home. One patient was able to return to work. Most patients received between three and five courses of treatment, but one patient received a five-dose combination at the end of his illness. Thus we have had one surprisingly long remission (28 months) and some limited success with multiple drug therapy less aggressive” than TRAMPOC(L).—We are, etc.,

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Screening for Rickets

Stir—Nutritional rickets is not uncommon in British paediatric practice, especially in the industrial areas with concentrations of Asian immigrants. It is important to place the role of sunlight and skin pigmentation, socioeconomic factors, and low vitamin D intake or food faddism and the high phytate content of chappatis. On two occasions a Pakistani child (one aged 14 and the other four) had been found to have rickets the whole family was screened radiologically. Two more cases of rickets (in a girl of 17 and a child of one)