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LEADING ARTICLES

Sir Henry Dale page 261 **Testing for Allergy** page 262 **Neurology of Depression** page 263 **Bacterial Interference in the Nursery** page 264 **Renal Damage in Chicken-pox** page 264 **Doctor or Social Worker?** page 265 **Penetrating Wounds of the Abdomen** page 266

PAPERS AND ORIGINALS

Some Unusual Developmental Heterotopias R. A. WILLIS 267

Detection of Allergy to Penicillin and Other Antigens by In-vitro Passive Sensitization and Histamine Release from Human and Monkey Lung E. S. K. ASSEM AND H. O. SCHILD 272

Controlled Comparison of Tetracycline and Furazolidone in Cholera N. F. PIERCE, J. G. BANWELL, R. C. MITRA, G. J. CARANASOS, R. I. KEIMOWITZ, J. THOMAS, AND A. MONDAL 277

Immunological Aspects of Intrauterine Transfusion W. R. JONES 280

Survey of Haemorrhagic Erosive Gastritis C. E. R. THOMPSON, P. M. ASHURST, AND T. J. BUTLER 283

Resistance to Suppression by Dexamethasone of Plasma 11-O.H.C.S. Levels in Severe Depressive Illness B. J. CARROLL, F. I. R. MARTIN, AND BRIAN DAVIES 285

Viral Antibody Levels and Clinical Status in Acute Exacerbations of Chronic Bronchitis: a Controlled Prospective Study A. C. STENHOUSE 287

MEDICAL MEMORANDA

Paraquat Poisoning Treated by Forced Diuresis F. KERR, A. R. PATEL, P. D. R. SCOTT, AND S. L. TOMPSETT 290

Recovery from Paraquat Poisoning W. I. MCKEAN 292

Carcinoma Arising in a Lipomatous Pseudohypertrophic Pancreas R. SALM 293

MIDDLE ARTICLES

Vietnam Scrapbook DEREK MEYERS 305

Medicine and the Computer
VI—Hospital Information System 309

M.R.C. Annual Report 310

Personal View M. F. A. WOODRUFF 311

BOOK REVIEWS

..... 302

NEWS AND NOTES

Epidemiology 322

Parliament 323

Medical News 324

CURRENT PRACTICE

Crohn's Disease G. SLANEY 294

Today's Drugs Aminoglycosides 299

Any Questions? 301

CORRESPONDENCE

..... 312

OBITUARY NOTICES

..... 318

SUPPLEMENT

Area Health Boards 95

Hospital Pay-beds 95

General Practice Finance Corporation 96

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Correspondence

Letters to the Editor should not exceed 500 words.

Choosing Medical Teachers. R. R. M. Porter, F.R.C.S.ED. 312
Cancer and Sex Chromosomes. P. E. Polani, F.R.C.P. 312
Thyroid Asymmetry. Jan D. Wiener, PH.D., and P. Roos, M.SC. 312
Chemotherapy of Tuberculosis. J. Batten, F.R.C.P. 313
Propranolol in Hypertension. S. N. Tewari, M.B. 313
Antibiotic Cover in Dentistry. R. J. Vecht, M.B., and Celia M. Oakley, M.D. 314
Hypothyroidism and ^{131}I Therapy. F. Ellis, M.D. 314
E.E.G. Signs of Death. I. Haider, D.P.M., *and others.* 314
Ozaena and Iron Deficiency. I. Bernát, M.D. 315
Unusual Cause of Haematemesis. A. P. R. Aluwihare, F.R.C.S. 315
G.P. Obstetric Beds. W. R. Edwards, F.R.C.S.ED.; G. Lloyd, M.R.C.O.G.; J. M. Gate, F.R.C.S.ED. 315
Phenmetrazine Psychosis. Eugenia Negulici, M.D., and D. Christodorescu, M.D. 316
Pancreatic Extracts in Cystic Fibrosis. Lieutenant-Colonel N. G. Kirby, F.R.C.S. 316
Pain in the Face. J. Braham, M.D. 316
Oral Contraceptives and Post-partum Symptoms. P. S. Nemetz, M.D. 316
Barbiturate Poisoning. J. W. Todd, M.D. 317
Immediate Coronary Care. T. W. Preston, M.D. 317
Medical Practice Overseas. J. Fry, M.D. 317
Hospital Career Structure. H. H. Langston, F.R.C.S. 317
An Ingenious Munchausen. D. R. Seaton, F.R.C.P. 317

Choosing Medical Teachers

SIR,—Professor Dorothy Russell's "Personal View" (27 July, p. 248) touches on matters of vital importance to the future members of our profession.

The fact that there is no proper test of ability to teach, and no instruction in teaching methods either demanded from, or offered to, candidates for medical teaching posts, shows an indifference for the welfare of the student which would not be tolerated by any education authority in this country. I was (many years ago) myself pitchforked into a professorship of surgery in India, in the middle of a university term with only a few days' warning, and almost no experience of teaching. This could hardly happen in Britain, but I have since been a humble member of committees advising on professorial and on consultant appointments in this country, and the discussion was mainly on research done, and a few questions on hobbies. In a committee advising on consultant appointments I have been ridiculed when I said that the main consideration was the ability to treat patients skilfully. Research was invariably the deciding factor. I have known only two members of such committees who always took the trouble to read or look up the research articles written by candidates. For the others the "list" seemed to be sufficient.—I am, etc.,

Aberdeen. R. R. M. PORTER.

Cancer and Sex Chromosomes

SIR,—I would like to draw attention to one other important relationship between sex chromosomes and tumours and/or malignancy arising at the site of the gonad (6 July, p. 5). In females with a Y chromosome in some or all of their cells, there is a possibly considerable risk of neoplasm, malignant or not, forming at the gonadal site and alleged to arise from testicular remnants (which cannot always be confidently identified when a tumour is present) which may exist by virtue of the presence of a Y chromosome, structurally normal or otherwise. In some cases the presence of a Y chromosome may be only presumptive, as for instance when a structurally abnormal chromosome—for example, a ring or a small fragment not quite clearly recognizable as a Y—may, on sex-chromatin and phenotypic grounds, be plausibly assumed to be one.

The frequency of these females is not known, though, among subjects with ovarian dysgenesis and allied conditions, they may be about 2–3%,[1] and I estimate that their prevalence in the general population *may* be of the order of one in ten thousand females. They may present with ovarian dysgenesis, pure gonadal dysgenesis, Turner's syndrome, mixed gonadal dysgenesis, testicular feminization, male pseudo-hermaphroditism of other types, or as true hermaphrodites; or they may present with a gonadal tumour. The frequency of neoplastic change is not well known and may vary in the different clinical conditions. For testicular feminization of the classical type it has been estimated at 5% or as high as 22%.[2]

Most of us with experience of these cases feel that when a Y or presumptive Y is found in a female with one of the above conditions, exploration and gonadectomy, which may mean the removal of streak tissue, is the operation of choice in most cases, with serial or semi-serial histological study of the removed gonad. However, a masculinized male pseudo-hermaphrodite, reared as a male, whose testicular tissue is working well and whose gonad could be replaced in the scrotum, may require special consideration. In the case of testicular feminization, some feel that removal of the testes should take place as soon as the diagnosis is made. Others suggest gonadectomy after natural puberty has taken place, with breast development, etc., but no sex hair nor, of course, menarche. Argument in favour of procrastination is that for the patient spontaneous puberty is psychologically preferable to the artificially induced changes and that the risk of malignancy before puberty is small. Two such cases, however, are known to the writer, though unfortunately an actual risk figure cannot be given.

In all these conditions the question of what to tell the patient and/or when and what to tell the parents is important. No rules can be laid down and much depends on the nature of the case, the manner of presentation, knowledge and profession of patients and parents. Nurses and doctors, for instance, may require a different handling from the average patient. However, as a generalization, the mention of the word "testis" to these female patients should be avoided where "gonad" would well do. Also the details of the sex-chromosome make-up—namely, the presence of a Y, though not necessarily the fact that there is a chromosome anomaly—need not be divulged, for the obvious reason that full comprehension of the implications of this, and full acceptance, may be very difficult.

May I end by saying that, in contrast, the purely XO female ovarian dysgenesis or Turner's syndrome does not *seem* to be at an excessive risk, though, if in such a case abdominal exploration is undertaken for other reasons, prophylactic gonadectomy may well be carried out.[3]—I am, etc.,

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2 Mishell, quoted by Volpé, R., Knowlton, T. G., Foster, A. D., and Conen, P. E., *Canad. med. Ass. J.*, 1968, **98**, 438.
3 Goldberg, M. B., and Scully, A. L., *J. clin. Endocr.*, 1967, **27**, 341.

Thyroid Asymmetry

SIR,—Thomson[1] and Orr and Ingham[2] recently drew attention to the remarkable frequency with which asymmetrical thyroid scans are encountered in subjects without evidence of thyroid disorders. In most of these cases the right lobe was larger than the left lobe. Artagaveytía *et al.*[3] reported that single non-toxic cold, warm, and hot thyroid nodules occurred more frequently in the right than in the left lobe (62.8 and 24.4%, respectively, of 408 cases). The same was found to a lesser extent in cases of toxic adenoma.[4–6] In thyroid hemiaplasia, the left lobe was absent in 20 out of 26 cases.[7]