including at least three sets of identical twins.[3] The pattern of aggregation in these families has suggested an inherited basis for a proportion of patients with vesicoureteric reflux, but no uniform pattern of inheritance has been apparent. In Christchurch we have investigated the immediate family of 42 patients with reflux nephropathy and in 12 of these families there were one or more affected members.[4]

To assess whether there may be an easily delineated genetic marker for reflux nephropathy we have looked at the tissue typing of all patients presenting recently to our departments with chronic renal failure due to reflux nephropathy and compared this with the tissue types of patients with renal failure due to other causes. The results are shown in the accompanying table and indicate that HLA-B12 is occurring with significantly greater frequency in patients with reflux nephropathy.

Presence of HLA-B12 in patients according to aetiology of renal failure

Cause of renal failure	No of patients	No with HLA-B12
Reflux nephropathy	19	9
All other causes	46	8

χ^2 test with Yates's correction: $\chi^2 = 4{\cdot}9$; $0{\cdot}02 < P < 0{\cdot}05$.

In larger centres it may be possible to confirm whether this is a valid observation and therefore possibly a genetic marker for a disease that not infrequently results in end-stage renal failure.

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Paranoid psychosis with indomethacin

SIR,—I read with interest the case report by Dr M W P Carney (15 October, p 994). I would like to report a somewhat similar case in which psychosis was thought to be related to indomethacin.

An 80-year-old woman was admitted with a two-day history of swollen and tender left lower extremities. The initial impression was that of cellulitis, for which she was treated with dicloxacillin and mini-dose heparin. The following day aspiration of joint fluid from her left knee revealed calcium pyrophosphate crystals. Indomethacin 25 mg thrice daily was prescribed for presumed pseudogout. The patient received her first dose at 2 pm. That evening at about 10 pm, she became verbally hostile, hallucinated, and paranoid, fearing that people were trying to kill her. This reaction required the administration of chlorpromazine intramuscularly, to which she responded. Since this patient had no previous history of psychiatric disturbances and was not receiving any other medications associated with such reactions the question was raised whether indomethacin could be the cause.

A literature review revealed that investigators have observed a variety of psychic disturbances.[1-3] The response from the manufacturer was that their files on indomethacin contain reports of psychic changes of various types. The symptomatology reported includes depersonalisation, anxiety, agitation, depression, and paranoid behaviour. These responses have generally occurred early in therapy, most frequently after one or two doses.

While the possibility that this reaction was due to the drug was being investigated the patient received a second dose of indomethacin without complication. Subsequently, she continued to receive the drug for five days without incident.

In this case, although the time sequence and literature led one to a cause-and-effect relationship, the reaction was probably unrelated to indomethacin. Nevertheless, health care professionals should be aware that various psychic disturbances can be seen with indomethacin. These effects are generally transient and disappear when the drug is discontinued.

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Syntometrine as a possible cause of neonatal jaundice

SIR,—Newborn babies often become jaundiced even when there is no prematurity or blood-group incompatibility. This so-called "physiological" jaundice has become very much commoner than it was 20 years ago and in some cases the bilirubin levels rise high enough to threaten mental impairment so that replacement transfusion has to be performed. The use of oxytocin infusions in the first stage of labour has been thought to explain some of the cases and breast-feeding has also been blamed, but these explanations are unsatisfactory.

I think the main reason may well be the almost universal use of oxytocics to expedite placental separation. If Syntometrine (synthetic oxytocin + ergometrine) is given soon after the baby's head is born the uterus usually contracts tightly while the placenta is still inside and before the umbilical cord is clamped. The placenta is squeezed like a sponge and the baby may receive a blood transfusion which it does not need. One would expect this surplus blood to be haemolysed and that could well be the source of the bilirubin which is causing anxiety to our paediatric colleagues.

We are starting an investigation here to try to prove or disprove the idea. It may have been suggested before, but if so I have not seen it. The benefits of active management of the third stage are, of course, very great and alarming postpartum haemorrhages are now quite rare, so the method is much favoured by obstetricians and midwives.

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Philadelphia-chromosome-positive childhood chronic myeloid leukaemia

SIR,—You recently published a report by Drs Angela Boque and R G Wilson of adult-type chronic myeloid leukaemia (CML) in a 5-month-old infant (26 November, p 1397). We have already reported a similar case in an 11-month-old child.[1] This case was Philadelphia-chromosome-positive and resembled the adult-type CML.

An interesting finding was that the leukaemic cells were consistently terminal deoxynucleotidyl transferase (TdT) positive, a characteristic usually associated with leukaemias of T-cell origin.[2 3] More recently we have shown that the leukaemic cells also possess high levels of *N*-alkaline phosphatase (*N*-APase) (assayed by Dr H Neumann, Weizmann Institute of Science, Israel), another "lymphoid" characteristic.[4 5]

The child responded well to therapy and is very well and growing normally with no evidence of blastic crisis $2\frac{1}{2}$ years after diagnosis. Apart from the detectable levels of the two enzymes (TdT and *N*-APase) the case is very similar to adult CML. Whether the presence of TdT and *N*-APase in this case is general for adult-type CML in such young children or is due to other factors remains to be determined.

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Bell's palsy and herpes simplex

SIR,—Although increasingly, as I get older, I am prepared to believe that magic has a place in the practice of medicine, its value in clinical virology must still be limited. Dr P Grout's letter (3 December, p 1480) does not provide any evidence that his case of Bell's palsy was caused by herpes simplex. The lack of "numerical information" is indeed very important. The antibody titres (it is not stated whether they are neutralising or complement-fixing antibody titres) to herpes simplex virus (HSV) and varicella zoster (VZ) are both given as $\geqslant 1280$. Although my experience of zoster of necessity is limited (I have not yet seen my five thousandth case), it is not true that seventh nerve palsy is uncommon in zoster. About 2% of the many patients referred to me each year with zoster have facial zoster. A complement-fixing titre of $\geqslant 1280$ is suggestive of recent infection with VZ virus. Unless the patient had chickenpox, and I assume it is unlikely that the lesions were confined to the mouth, the patient must have had zoster. Occam's razor usually only has one edge in this country and it is not unreasonable to assume that the patient had motor zoster of the seventh nerve. Herpes simplex infection may precipitate zoster, as may any other febrile illness. It is possible that Dr Grout's patient had primary herpetic gingivostomatitis. One cannot make a firm diagnosis without viral cultures. I agree that recurrent herpetic gingivostomatitis is uncommon, but this makes it so much more important that paired sera should have been taken because we do not know whether the episode was one of a primary infection.

I submit, then, that Dr Grout's case is not proved.

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