chlamydial infection, thus making laboratory diagnosis difficult, but will not eradicate the disease. Neomycin is not active against chlamydia, but is reasonably effective against bacterial infections and should be the initial antibiotic of choice until swabs can be taken and examined for chlamydia. The persistence of conjunctivitis after neomycin should lead the clinician to investigate the possibility of chlamydial infection in both the infant and its parents.—We are, etc.,

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1 Gordon, F. B., and Quan, A. L., *Proceedings of the Society for Experimental Biology and Medicine*, 1965, **118**, 354.
2 Hobson, D., *et al.*, *Lancet*, 1974, **2**, 555.

New Curriculum

SIR,—Dr. M. F. Green (9 November, p. 344) wishes medical students to receive instruction in geriatric medicine but fears that "a multiplicity of professorial departments might defeat the object... as research would proliferate and staff would probably be lured away from other teaching and non-teaching centres." I think Dr. Green's fears can be allayed. As yet only a fraction of British medical schools have established university departments of geriatric medicine, and many medical students who are graduating today and who will still be in practice well into the 21st century have received no formal instruction in the principles and practice of geriatric medicine. The proliferation of research in geriatric medicine can hardly be a bad thing, especially if the research remains closely related to improvements in clinical practice, as has been characteristic of a great deal of the research published by geriatric physicians and indeed of the important contributions made by Dr. Green himself. It is true that university departments will tend to attract the best members of the profession, but that is surely nothing to fear. They will then be in a position to influence future graduates to enter this progressive and rewarding specialty. Dr. Green is of course correct to say that the teaching of medical students in geriatric medicine and in other branches will benefit greatly from the contribution of all practising geriatric physicians as well as from that of general practitioners and members of the health professions with whom geriatric physicians are accustomed to work so closely.—I am, etc.,

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Tuberculosis and Renal Amyloidosis

SIR,—We concur with the observation of Professor A. C. Kennedy and others (28 September, p. 795), who described pulmonary tuberculosis as the leading cause of renal amyloidosis in the west of Scotland. Renal amyloidosis is still considered to be the second commonest cause of nephrotic syndrome in India, especially in Delhi (36·2% of cases),[1] and despite earlier detection and treatment of tuberculosis this disease will remain the commonest aetiological association of amyloidosis for some time to come in developing countries like ours.

Out of 200 cases of renal amyloidosis confirmed by biopsy seen by us in the past 10 years tuberculosis (pulmonary 125, lymphadenitis 12, spinal 8, and intestinal 5) was the commonest cause (75%). Other causes were suppurative lung diseases (13%), rheumatoid arthritis (5%), ankylosing spondylitis (3%), and metastatic adenocarcinoma of liver and lung, multiple myeloma, Hodgkin's disease, and leprosy (1% each). Most of the patients (70%) were men and their ages ranged from 20 to 72 years (mean 38 years). Most of the cases progressed to renal failure; hypertension was observed in 6% and renal vein thrombosis in 1%.

We find renal biopsy the best method of clinching the diagnosis of renal amyloidosis and when this is impossible rectal biopsy is advisable. A liver biopsy may appear normal, despite enlargement due to fatty infilteration, and hence is not always dependable. Most of our patients died within two to three years. A few still survive after more than four years. Two patients showed a regression of amyloid material in the glomeruli on serial biopsy after adequate treatment of the underlying disease and high doses of vitamin C. In established renal amyloidosis careful search may reveal tuberculous lymphadenitis, intestinal tuberculosis, occult malignancy, or sometimes healed tuberculosis. By and large the duration of the underlying disease correlates well with the severity of the amyloidosis and the prognosis.[2]—We are, etc.,

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1 Vaishnava, H., *et al.*, *Journal of the Association of Physicians of India*, 1969, **17**, 641.
2 Gulati, P. D., *et al.*, *Postgraduate Medical Journal*, 1970, **46**, 137.

Medical Centre for Unsettled Young People

SIR,—Dr. Patrick J. Day's Personal View (9 November, p. 340) described a refreshing "professional" approach to a group whose relations with standard medical institutions are deficient, to say the least. The evidence suggests to us that unattached young people, many of whom are less settled than the community Dr. Day lived with, are increasing in number. This is certainly so in London.

A working group representative of the New Horizon Youth Centre, the Soho Project, Centrepoint, the Standing Conference on Drug Abuse, and the Student Health Service is working through the Campaign for the Homeless and Rootless with various medical personnel to produce proposals for a medical centre for young people in central London. As the proposals stand it would be an extension of the Health Service providing, at street level, a walk-in clinic whose staff and procedures would be finely tuned to the needs of the patient. Not least of its assets would be its referral function, introducing young people to appropriate sources of care and treatment. The clinical function would be relatively basic, providing first aid and medical advice and, when possible, linking up the patient with a general practitioner, whose numbers in central London are declining. Social workers at voluntary projects working with mobile young people have more and more difficulty in finding a doctor to accept cases.

The initial responses from the area health authority and from social services departments have been very encouraging and we hope for a sympathetic hearing from the Department of Health and Social Security when we present our proposals in the new year.—I am, etc.,

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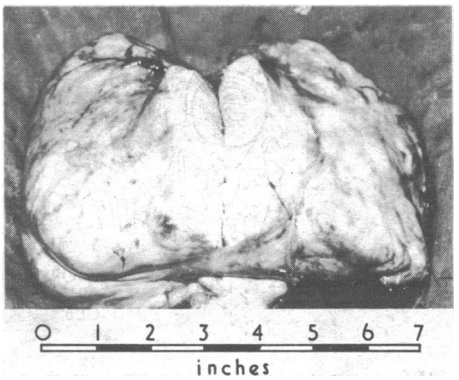
Hypoglycaemia Associated with Intrathoracic Mesothelioma

SIR,—The association of hypoglycaemia with neoplasms other than islet cell tumours is probably underdiagnosed.[1] In Hong Kong hypoglycaemia in association with carcinoma of liver in 30% of cases has been well recognized.[2] When an intrathoracic mesothelioma close to the right hemidiaphragm is associated with hypoglycaemia the displaced and apparently enlarged liver may cause diagnostic difficulty.[3] Prompt thoracotomy may not only settle the diagnosis but also remove the cause of hypoglycaemia,[4] as the following case shows.

A woman aged 64 years was admitted to hospital with a short history of dizziness in the morning followed by coma. On admission her blood sugar was 16 mg/100 ml. It fluctuated between 6·30 mg/100 ml over the next two weeks. A chest radiograph showed a large opacity in the right lower zone merging into the liver shadow. As the liver was palpable a diagnosis of carcinoma of liver had to be considered, but owing to the severity of the condition a thoracotomy was decided on. This was performed with the patient in coma despite an intravenous 10% dextrose infusion. A large, well-encapsulated tumour was found in the pleural cavity attached by a few small pedicles to the mediastinal pleura and the right lower lobe (see fig.). Histology showed features of mesothelioma.



The patient made a smooth recovery. The blood sugar stayed consistently above 100 mg/100 ml. There was no recurrence up to six months.—We are, etc.,

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1 Unger, R. H., *American Journal of Medicine*, 1966, **40**, 325.
2 McFadzean, A. J. S., and Yeung, T. T., *Archives of Internal Medicine*, 1956, **98**, 720.
3 Maier, H. C., and Barr, D., *Journal of Thoracic and Cardiac Surgery*, 1962, **44**, 321.
4 Spry, C. J. F., Williamson, D. H., and James, M. L., *Proceedings of the Royal Society of Medicine*, 1968, **61**, 1105.