much by attention to the details of failure as to the details of success, and it is in an attempt to avoid a future tragedy from the same causes that this report is made.

I am grateful to Dr. R. A. B. Dikko, Permanent Secretary, Ministry of Health, Northern Nigeria, for permission to publish this letter.

—I am, etc.,

Regional Malarial Unit, P.M.B. 2106, Kaduna, N. Nigeria. J. S. DODGE.

Hookworm Anaemia

SIR,—I have read with great interest your leading article on hookworm anaemia (14 November, p. 1216).

I would like to make one comment about your statement, "These larvae develop only if the faeces of such persons contaminate warm moist earth, and normal sanitary arrangements—and often the weather—in Britain preclude this." In Oxford, Dr. S. C. Truelove and myself have carried out some experiments on faeces infected with hookworm ova.[1] In one of these experiments a part of the infected faeces was covered with moist earth in a flower-pot and left in the open (the garden of the Radcliffe Infirmary), under a classic English weather in June and July for six weeks. We were able to identify three stages of hookworm larvae, of which the third one was a typical filariform infective larva.

We have pointed out that such infection can occur in Great Britain if bad sanitary conditions are allowed to exist, particularly among immigrants. We have also drawn the attention of the public health authorities and the physicians in this country to be aware of the condition, emphasizing the point that the English weather is not a strong barrier against the spread of the disease.—I am, etc.,

S. N. SALEM.

Nuffield Department of Clinical Medicine, The Radcliffe Infirmary, Oxford.

REFERENCE

1 Salem, S. N., and Truelove, S. C., 1964, in press.

Hodgkin's Disease Limited to the Liver

SIR,—It is well established that the liver may be involved in Hodgkin's disease. However, Hodgkin's disease affecting the liver alone is very rare, and the following case was therefore thought worth while reporting.

The patient, a 15-year-old girl, was first seen at St. Thomas's Hospital in October 1963 with a two-week history of malaise, night sweats, and slight weight loss. On examination at that time there were no physical abnormalities; she was afebrile, and investigations showed: Hb 85%, E.S.R. 3, chest x-ray normal. She was not seen again until November 1963, when she was admitted to the ward with a three-week history of swelling of the legs and abdomen. On examination she was febrile and had tense ascites. No intra-abdominal masses were palpable, but there was considerable ankle and sacral oedema. Investigations at that time showed slight anaemia and thrombocytopenia.

At this stage investigations were unhelpful and laparotomy was performed. At operation the liver and spleen were seen to be enlarged, the former having a mottled grevish appearance. There were no enlarged glands. Attempt at portal venography on the table was unsuccessful owing to technical reasons. A splenunculus and liver biopsy were taken for histology.

Microscopically the splenunculus was normal, but the liver showed round-cell infiltration predominantly in the portal tracts, with liver-cell necrosis. The histological picture at this stage did not show conclusive evidence of lymphoma, and the diagnosis rested between this and an inflammatory process.

Post-operatively she was given antibiotics and transfused with intravenous albumin, which temporarily raised her serum-albumin level (which had been only 2.9 g./100 ml.) to 4.3 g./100 ml. However, she remained unwell with swinging fever, jaundice appeared, and the ascites reaccumulated. Further investigations in December 1963 showed among other things: bilirubin 1.9 mg./100 ml., and alkaline phosphatase 85 units.

As she remained so ill the diagnosis of malignant reticulosis became more likely, and she was treated with prednisone, 20 mg. four times a day, and vinblastine, which had to be discontinued after two weeks owing to progressive leucopenia. The steroids had no effect on either her fever or liver-function tests. She died on 12 January 1964.

At necropsy the liver was grossly enlarged, all the hepatic tissue being replaced by yellowish firm tissue. The portal vein, hepatic vein, and inferior vena cava were all fully patent. The spleen was grossly enlarged with a deep purple cut surface. There were enlarged lymph-nodes along the aorta and pancreas.

Post-mortem histology showed evidence of lymphocytic and histiocytic infiltration with irregular giant cells and increase of fibrous tissue in both the glands and liver. The diagnosis was that of a malignant reticulosis allied to Hodgkin's disease.

Liver involvement is quite common in Hodgkin's disease,[1,2] and indeed liver biopsy may be used to make the diagnosis.[3] However, only two cases have been reported of Hodgkin's disease affecting only the liver.[4,5] Possibly the liver as a primary site is more common than is realized, as by the time that most patients come to necropsy the disease has become widespread.

I am indebted to Dr. H. K. Goadby for permission to publish this case and to Dr. R. Kittermaster for reporting on the sections.

—I am, etc.,

St. Thomas's Hospital, London S.E.1. C. A. LOEHRY.

REFERENCES

1 Levitan, R., Diamond, H. D., and Craver, L. F., *Amer. J. Med.*, 1961, 30, 99.
2 —— —— —— *Gut*, 1961, 2, 60.
3 MacLeod, M., and Stalker, A. L., *Brit. med. J.*, 1962, 1, 1449.
4 Goia, I., *Sang*, 1935, 9, 367.
5 Symmers, D., *Arch. intern. Med.*, 1944, 74, 163.

Inheritance in Gaucher's Disease

SIR,—We have recently described[1] typical Gaucher cells in the bone-marrow of *both* clinically normal parents and a normal sister of two children with overt Gaucher's disease. This finding had, to our knowledge, previously not been reported. We have regarded our findings as an indication of heterozygosity (incomplete recessivity).

Meanwhile we have been able to examine parents and siblings of another patient with Gaucher's disease. This 17-year-old patient suffers from clinically and histologically proved Gaucher's disease and underwent splenectomy eight years ago. Parents, two sisters (9 and 11 years old), and one 16-year-old brother are clinically normal. In the bone-marrow of *both* parents and sisters typical Gaucher cells could be demonstrated. The bone-marrow of the brother was normal.

We therefore differ from the views of Klein and Franceschetti[2] but agree with Hsia's[3] opinion that the recessive mode of inheritance isthe most frequent one in Gaucher's disease. —We are, etc.,

H. GERKEN.
E. GRAUCOB.
H.-R. WIEDEMANN.
Paediatric Department, Christian-Albrecht's University, Kiel, Western Germany.

REFERENCES

1 Gerken, H., and Wiedemann, H.-R., *Ann. paediat. (Basel)*, in press.
2 Klein, D., and Franceschetti, A., in *Handbuch der Humangenetik*, 1964, vol. IV, edited by P. E. Becker. Thieme, Stuttgart.
3 Hsia, D. Y. Y., Naylor, J., and Bigler, J. A., *New Engl. J. Med.*, 1959, 261, 164.

Another Television Hazard?

SIR,—"Emergency—Ward 10" had just finished when my 50-year-old patient developed sudden giddiness, while sitting in his viewing-chair. An hour later he was still chair-bound and afraid to move his head, as this increased his vertigo.

He was found to have a normal heart and blood-pressure. Abnormal findings included a phasic nystagmus, unsustained to the right, but sustained with a rotary component to the left; a poorly moving palate; an equivocal right extensor plantar response; and minimal incoordination of his right leg. There was definite loss of appreciation of pin-prick over his left face, right limbs, and trunk. These findings were felt to be strongly suggestive of vertebro-basilar insufficiency. He made a good recovery over the succeeding week.

Reconstructing the events prior to the incident, it was found that his chair was positioned at an approximate angle of 60° to the plane of the screen. This meant that for comfortable viewing a compensatory head rotation of some 30° was required. There was an additional tendency to extend the head over the top of the back-rest for greater comfort. One or both these factors may well have jeopardized the vertebral arterial flow in the manner shown by Brain.[1] The post-prandial state, modified by the presence of an old partial gastrectomy, may have provided the backcloth of temporarily reduced arterial flow to the brain against which the above postural factors played a critical role.[2]

A repetition should be less likely if the patient in future pays special attention to his head posture, assuming, of course, that he still cares for television.—I am, etc.,

London W.11. KLAUS HEYMANN.

REFERENCES

1 Brain, Lord, *Brit. med. J.*, 1963, 1, 771.
2 Williams, D., ibid., 1964, 1, 84.

Professional Patients

SIR,—Dr. T. L. Dunn's suggestion (3 October, p. 879), that a study be made of those who choose to play the role of patient in order to avoid the responsibilities expected from healthy people, is timely. Our experience leads us to conclude that such people are only a few of those who are not prepared to accept the task of fulfilling an adult role in society. We are also of the opinion that doubt need not be cast upon the choice being conscious by the qualification "almost." Such manipulative behaviour is often considered "neurotic" and regarded as sickness by the medical profession, whereas it is behaviour designed to lead unsuspecting