Correspondence

The place of birth

Sir,

I was intrigued by John Davis's passing reference in his annotation¹ to 'one set of assumptions leading to eugenics as the other points back towards what is called social Darwinism', although I am not sure about the aptness of the contrast. The term 'social Darwinism' is widely interpreted² and social Darwinists have included advocates both of collectivism and competitive individualism.

However, nowadays it is variation in planned family size rather than in fecundity and infant and childhood mortality that provides the opportunity for genetic change. Eugenic, or dysgenic, trends depend in developed countries on the minority of couples who have more or fewer than the 2 children, which are now the target of a majority.^{3,4} There will always be some men and women who are infertile; some who, for one reason or another have no liking for children, or for medical or genetic problems or fear of nuclear war feel they should not have any children. This provides the opportunity for some couples to aim at a third or fourth child, without the birth rate exceeding replacement rate.

It is to be hoped that the families of more than 2 children will be those in which the children will, in Professor Davis's phrase, 'achieve maturity and independence as a result of good genes, good fortune, and a good upbringing'. There are indications that such hopes are fulfilled once family size is effectively planned throughout the community. This is to be expected, since on the whole men and women enjoy doing what they do well. This includes rearing children as well as the practice of trade, sport, or hobby. So it is mainly those who enjoy the rearing of their first 2 children who will want to plan a third and fourth. This process might well be called social Darwinism, natural selection operating in the context of the planned family.

References

- 1 Davis J A. The place of birth. *Arch Dis Child* 1982; 57: 406-9.
- 2 Jones C. *Social Darwinism and English thought*. Sussex: Harvester Press, 1980.
- 3 Woolf M. *Family intentions*. London: HMSO, 1971.
- 4 Office of Population Census and Surveys. *The general household survey: introductory report*. London: HMSO, 1973.

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Klinefelter's syndrome in adolescence

Sir,

We read with interest the paper by Ratcliffe *et al.*¹ and should like to add some of our own observations, some of which have been published but seem to have escaped the attention of the authors. Klinefelter's syndrome can be diagnosed in early age not only in mentally-retarded children or by screening for abnormal karyotypes, but also by performing a buccal smear on any child who presents with hypogonadism² or cryptorchidism.³ We have followed up 24 boys with Klinefelter's syndrome, 18 of whom were diagnosed prepubertally throughout puberty into adulthood.⁶ Onset of puberty, as judged from testicular enlargement and presence of pubic hair, occurred between 11 and 14 years in the 18 patients. By age 17 years pubic hair, penile length, and height had reached the adult stage in all patients, but arrest of testicular growth was noted at mid-puberty, 13 years, with maximal mean ($\pm$ SD) volume attained being 3.5 ± 1.5 ml. The first conscious ejaculation was reported to have taken place between 13 and 16 years in ten patients and in the remaining four between 17 and 18 years of age. Sperm counts obtained after age 18 showed azoospermia or severe oligospermia in every patient, except one who had a sperm count of 30×10^6 /ml. This man fathered 2 children.⁴ The hypothalamic-pituitary-gonadal axis, assessed by luteinising hormone-releasing hormone and human chorionic gonadotrophin stimulation tests, was found to be normal in prepuberty and during early pubertal stages. From mid-puberty the basal levels of plasma follicle-stimulating hormone and the response to luteinising hormone-releasing hormone showed a gradual increase above the normal. Towards late puberty (>15 years) basal and peak levels of luteinising hormone were above normal with a concomitant decrease in the basal level of testosterone and in its response to human chorionic gonadotrophin.

In many subjects the syndrome is benign and the patient can lead a normal life including army service and marriage.⁵

References

- 1 Ratcliffe S G, Bancroft J, Axworthy D, McLaren W. Klinefelter's syndrome in adolescence. *Arch Dis Child* 1982; 57: 6-12.
- 2 Laron Z, Hochman I H. Small testes in prepubertal boys with Klinefelter's syndrome. *J Clin Endocrinol Metab* 1971; 32: 671-2.
- 3 Dickerman Z, Landman J, Prager-Lewin R, Laron Z. Evaluation of testicular function in prepubertal boys by means of the luteinizing hormone-releasing hormone test. *Fertil Steril* 1978; 29: 655-60.
- 4 Laron Z, Dickerman Z, Zamir R, Galatzer A. Paternity in Klinefelter's syndrome—a case report. *Arch Androl* 1982; 8: 149-51.