For the past 10 years we have treated more than 50 patients with 2 mg/kg day of prednisone in the first week and alternate day treatment with decreasing dosage for another five weeks. All responded with decrease of erythrocyte sedimentation rate and improved clinical condition. None of the patients had side effects related to steroid treatment, and no weight gain or Cushingoid facies were noted.

We recommend, therefore, that all patients with active rheumatic fever with carditis receive alternate day steroid treatment for a period of six weeks.

References

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Publication of abstracts

Sir,

I would like to endorse strongly Professor Strang's observations concerning the need for abstracts to be published.1 The abstract is a most important source of information to any investigator actively pursuing the latest information in his field. If he is unable to attend the relevant meeting to hear a presentation, he would have to wait until the work was fully published—usually a substantial period of time, often months, sometimes years. If he lives in centres geographically remote from Europe and North America, for example Australia and New Zealand, and is thus infrequently or never able to attend scientific meetings in the northern hemisphere, he will be considerably disadvantaged in relation to current research in his field of interest, having to rely on published work alone. It seems to me to be an unacceptable elitism for those working in countries with relatively small distances for travel and ease of access to scientific information, to restrict exchange of information by failing to publish abstracts as the editor of Archives recommends.

There is no doubt that at present many abstracts are shoddy and inadequate. Surely what must be done is not to censor abstracts by failing to publish them, but to edit them appropriately to ensure a free exchange of ideas around the world. Finally, to forbid reference to abstracts is quite unreasonable. This means primacy of observation may be overridden by a secondary group who, having heard work presented may quickly repeat it and upstage the original by rapid publication. I would urge that high standard abstracts continue to be published.

References

Correspondence

Cleft palate and gonadotrophin deficiency

Sir,

We read with interest the paper by Tuohy and Franklin.1 Their patient had 'some degree of hyposmia' in addition to a cleft lip and palate, bilateral cryptochidism, and isolated gonadotrophin deficiency.

We submit that these features correspond to the Kallmann syndrome, described in 1944.2,3 In this disorder, a developmental defect of the olfactory lobes is combined with an isolated gonadotrophin deficiency. Other defects include cryptochidism, midline craniofacial abnormalities (cleft lip, cleft palate, or both) and deafness. The condition is classified by McKusick4 as either autosomal recessive, dominant or X-linked, with variable expression.

References

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Drs Tuohy and Franklin comment:
The subject's hyposmia was at worst mild when formally tested, whereas most males with the so-called Kallmann syndrome have severe olfactory impairment. He was not eunuchoid, deaf, colour blind, or mentally retarded; nor did he have syndactyly. The case was sporadic and no first degree relative had any of the associated abnormalities. The possibility that the degree of hyposmia could be a complication of the subject's nasal pathology, together with the lack of supporting evidence, detract from the diagnosis of Kallmann's syndrome.