The variability of the h regions can not be determined precisely when G bands are present. Consequently, this defeats the object of the exercise. In our experience, the Q-C sequence is the most satisfactory and highly reliable (fig 2).

**References**

reports are the same. Hence, it is now possible to add large testes, as well as small ones, to the list of indications for chromosome studies.

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SIR,

I am writing to point out the marked similarity between the patients reported by Wadia et al† and subjects with the Robinow ‘fetal face’ syndrome. The features described in the patients reported by Wadia et al† namely hemivertebrae, rib defects, mesomelia, short stubby fingers, hypertelorism, depressed nasal bridge, and teeth anomalies are all features of the Robinow syndrome, as is the small penis reported in case 1. There also appears to be marked overall facial similarity to the Robinow syndrome, although the article does not contain good close-up photographs.

The x-ray changes in the spine, ribs, and forearms are all entirely consistent with the Robinow syndrome; in particular, the changes at the elbow in fig 6 are almost identical to the changes shown in fig 4 in an article by Waddington et al‡ which describes four cases of the Robinow syndrome. Although an autosomal dominant inheritance was suggested in the original description of the Robinow syndrome on the basis of two affected generations, Waddington et al‡ described a sibship containing two affected subjects with normal parents and postulated autosomal recessive inheritance with occasional manifestation in the heterozygote. The mode of inheritance in the family reported by Wadia et al† would be consistent with this theory.

**References**

Familial X-linked mental retardation with an X chromosome abnormality and macro-orchidism.
G R Sutherland, C G Judge and S Wiener

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