and isochromosome for the long arm of 21 were excluded by the clinical findings, dermal patterns (Walker index), and the size of the abnormal chromosome. Trisomy 22 with a G/G translocation was ruled out by the size of the abnormal chromosome. Trisomy 16 with monosomy G was excluded because the abnormal chromosome was always metacentric and slightly bigger than the number 16. Trisomy 17 with 17/G translocation or monosomy G with isochromosome for short arm of one of the group C or group B chromosomes remain possibilities.

At present, classification of this karyotype is inadvisable, especially in view of inconclusive autoradiographic studies and inadequate banding pattern of the chromosomes. Perhaps similar cases will be reported.

Summary

We report the case of an unusual-looking infant with multiple congenital anomalies such as coloboma of the iris, corneal opacities, congenital heart defect, hepatosplenomegaly etc, who had an abnormal karyotype which appears to be unique and remains unclassified.

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Corrigenda

On the Pathogenesis of Favism by Ernesto Sartori, December 1971, vol. 8, pp. 462–467.

The last sentence in the section on the X-linked and haemolytic predisposition (p. 465, column 2) should read:

For instance, a difference ranging between 0·198 and 0·290 for G6PD deficiency corresponds to a difference ranging between as little as 0·107 and 0·120 for favism in Seneghe and Lodé respectively

Four Patients with Trisomy 8 Identified by the Fluorescence and Giemsa Banding Techniques by Torjbörn Caspersson, Jan Lindsten, Lore Zech, Karin E. Buckton, and William H. Price, March 1972, vol. 9, pp. 1–7.

The 10 cells counted and analysed from both the father and the mother of case 4 contained 46 chromosomes and not 47 as shown in Table I (p. 1).