Correspondence

possible that separate entities, caused by single gene disturbances, exist.

We thank Dr B Hamel (Nijmegen, The Netherlands) for making the x rays of family 4 of Majewski et al available for us.

RAOUL C M HENNEKAM AND ED J P LOMMEN
Clinical Genetics Center Utrecht,
PO Box 18009, 3501 CA Utrecht;
and Sint Josephziekenhuis,

References


Fryns syndrome

SIR,

The review of Fryns syndrome (J Med Genet 1987;24:271-4) prompts me to point out that this review omitted the first case of this syndrome which was described by Fitch et al (J Med Genet 1978;15:399-401), one year before Fryns' original report was published. Our infant had the coarse face with the broad, flat nasal bridge, large nasal tip with anteverted nostrils, thin upper lip, macrostomia, missing nails on the fifth fingers and hypoplastic nails on all other digits, hypoplasia of the terminal phalanges, absent left hemidiaphragm, and cerebral malformations. The parents were second cousins.

N FITCH
Lady Davis Institute for Medical Research,
The Sir Mortimer B Davis–Jewish General Hospital,
3755 Chemin Côte Ste Catherine,
Montreal, Quebec, Canada H3T 1E2.

Alpha, antitrypsin deficiency

SIR,

In their paper in Journal of Medical Genetics (1987;24:52-9), Cox and Mansfield attempt to estimate the risk of severe liver disease in a fetus of genotype PI ZZ given the severity of liver disease in the proband. The estimates are derived from pooling data from several studies in the United States, Canada, Norway, and Great Britain. The authors give point estimates of the risk, which appear to be different in the two groups, with the suggestion that this information will be useful for families seeking counselling.

The difficulty with the presentation is that the conclusion is based upon a very small sample, with 15 sibs of probands having resolved or no liver disease and 20 with severely affected probands, as shown in tables 4 and 5. Although the estimates are 13% and 40% respectively, it is doubtful that these represent different rates. I constructed a 2×2 table and used the SAS procedure FREQ which produces a number of statistics to accommodate different analytical viewpoints. None of the hypothesis testing probabilities suggests rejecting the null hypothesis of equal rates in the two groups, whether one considers χ² with or without continuity correction, a Fisher exact test, or a Mantel-Haenszel χ². If one prefers to use an epidemiological approach, the odds ratio is 4·33 for a severe proband to have a severely affected sib; however, the 95% confidence interval runs from 0·80 to 23·4. This interval clearly includes 1, so that the conclusion of a difference in risk cannot be supported. For the time being, the mean risk of severe liver disease appears to be 29%, with a 95% confidence interval between 14·6 and 46·3. This appears to be different from the 7% risk estimate of the Swedish study. Clearly, more data