associated with mental delay and characteristic facial appearance and behaviour. It was first described in 1965 by Dr Harry Angelman, a paediatrician who noted several children with jerky ataxic gait who tended to laugh excessively and frequently protruded their tongues and who suffered microbrachycephaly. Many suffered from epileptic fits with severely abnormal EEG's.

There are approximately two hundred known cases in the United Kingdom, but there is probably a much larger number because the apparent clustering of this syndrome seems to be associated with awareness of the condition by certain paediatricians. The syndrome seems to be associated with a deletion on chromosome 15.

A large percentage of these children suffer from drooling. However, I believe it is important that surgeons who are requested to carry out anti-drool procedures should be aware of the fact that some of these children appear to grow out of their problem. At the support group meeting I took a straw poll on the percentage of cases who suffered from drooling and the number of those who drooled who seemed to grow out of it by the age of ten. It would appear that about two thirds of cases suffer from drooling and that of these about one third grow out of it. I therefore recommend that anti-drool procedures should not be undertaken at too young an age and probably not before the age of eight or nine.

The operation as described by Varma *et al.*[1] has been carried out in two cases and has been entirely successful.

Yours faithfully,

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Reference

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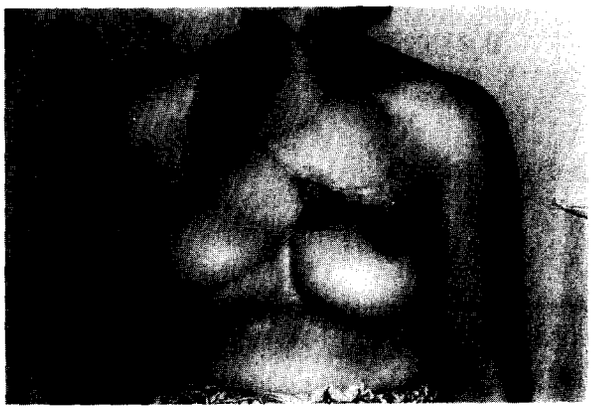
Necrotising fasciitis in the head and neck region

Sir,

In their recent paper Maqbool *et al.* (*British Journal of Plastic Surgery*, **45**, 481) highlight the severe problems caused by this condition, although for their patient there appeared no obvious primary site of infection. However necrotising fasciitis of the neck has previously been recorded and the literature closely reviewed.[1] In our patient, a young woman, the infection originated in a tooth with sepsis spreading to cause severe systemic toxicity, and resulting in extensive necrosis of skin, fat and muscle of the neck and anterior chest wall. Several surgical excisions were required including a right mastectomy and partial left mastectomy.



Once the patient was over the acute illness, she underwent initial skin grafting to the neck and chest wall, and subsequently reconstruction with two pedicled latissimus dorsi myocutaneous flaps—one to release the neck contracture, and one to reconstruct the right breast (followed by tissue expansion of the flap and silicone gel breast prosthesis insertion) (Fig).

The need for appropriate antibiotic treatment and aggressive adequate debridement can be confirmed, but extensive reconstruction may, as in our patient, pose significant problems of staged surgery.

Yours faithfully,

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Reference

1. McAndrew P G, Davies S J, Griffiths R W. Necrotising fasciitis caused by dental infection. Br J Oral Maxillofac Surg 1987; 25, 314.