Book review

Atlas of Orthopaedic Pathology with Clinical and Radiological Correlations. By P.G. Bullough and V.J. Vigorita. Pp. 278. £49.50. Butterworths, London. 1984.

This is an impressively produced book in an atlas format, but offering more than the usual atlas in its content. As well as colour photographs of the naked eye appearances of various conditions and the histological appearances there are numerous highly relevant radiographs and clearly drawn colour diagrams. A simple but effective expedient is the use of simple line drawings beside the photographs instead of labelling the actual pictures and x-rays. This gives clarity and at the same time enables the reader to pick out features in x-rays or in illustrated microscope fields for themselves. The standard of colour illustration is in general high.

The text is slightly variable in that some important topics, for example, the mucopolysaccharidoses, are dealt with only briefly, and of necessity most topics are described in general terms. It would be simple to pick out for criticism individual small points, but some defects must result inevitably from the constraints of length of text, and there are other important comments which reflect the considerable experience of the authors in this field: for example, the statement that the differentiation of aneurys-

mal bone cyst and telangiectatic osteosarcoma may be difficult is helpful and reassuring to the reader facing that problem for the first time.

The contents of the book are set out in what sometimes leads to anomalous groupings. There are chapters on 'Normal bone,' 'Disturbances in formation and breakdown of bone' (two), 'Injury and repair,' 'Deposition of metabolic products and haematologic disorders,' 'Arthritis' (three, including the spine), 'Infections,' 'Hamartomas and benign tumourous conditions' (two), 'Neoplasms' (two), and 'Miscellaneous orthopaedic conditions.' Within these headings multiple enchondromata, for example, appear under hamartomas/tumorous conditions, while solitary enchondroma is a neoplasm, and osteoid osteoma is similarly under hamartomas/tumorous conditions, while osteoblastoma is a neoplasm. The bibliography gives a few references to further reading matter rather than a comprehensive literature review, which would in any case not be appropriate to this type of book.

Students and trainees in orthopaedics, radiology, pathology, and oncology will find this a helpful introduction to an area in which it is difficult to obtain basic information. The use of large numbers of radiographs is especially appropriate to the subject matter, and there are clinical photographs and pictures of macroscopical appearances which should prove useful to those unfamiliar with orthopaedic pathology.

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Rheumatoid arthritis and malignant histiocytosis of the intestine

SIR, We were interested to read the convincing evidence of an association between rheumatoid arthritis and tumours of the reticuloendothelial system.^{1 2} Malignant histiocytosis of the intestine is a rare reticuloendothelial tumour recently characterised as being of true histiocytic derivation,³ originating in the lamina propria of the small intestine. In its classical form it is a distinctive disease most usually complicating prolonged coeliac disease; none the less, cases are encountered in which previous enteropathy is not detectable. The condition has not hitherto been described in association with rheumatoid arthritis. We describe a case of malignant histiocytosis of the intestine arising in a woman with long-standing seropositive rheumatoid arthritis, in whom no evidence of pre-existing or concomitant coeliac disease could be found.

A 59-year-old woman with a 10-year history of seropositive rheumatoid arthritis, treated with a cumulative dose of 800 mg of gold sodium thiomalate, presented with iron deficiency anaemia. Barium studies showed no evidence of

malabsorption, and jejunal biopsy no abnormality; gastroscopy revealed a small prepyloric ulcer. She was treated with cimetidine and iron replacement, but was readmitted nine months later with recurrent iron deficiency and upper gastrointestinal blood loss. Repeat gastroscopy suggested a chronic gastric ulcer, and a laparotomy for vagotomy and pyloroplasty was performed. At operation a large circumferential ulcerating and haemorrhagic tumour was resected from the terminal ileum, with enlarged mesenteric lymph nodes. Histology showed the typical features of malignant histiocytosis of the intestine. Histological review of the previous jejunal biopsy again failed to identify any abnormal features.

We have subsequently reviewed six further cases of malignant histiocytosis of the intestine, presenting at Southampton hospitals over a five-year period (four male, two female). Coeliac disease had been previously diagnosed in four cases. None had clinical or radiological evidence of rheumatoid arthritis, but two patients were rheumatoid factor and antinuclear factor positive. The chronic immune stimulation hypothesis referred to by Prior *et al.*¹ is not in our view an adequate explanation for the increased incidence of reticuloendothelial malignancy in patients with rheumatoid arthritis. The association of a