Drs. B. S. Rose and I. M. Prior presented further results on "Gout and Other Metabolic Maladies of the Maori":

Previous surveys of four Maori tribes were reviewed, and the high prevalence of gout was related to the similar frequent occurrence of obesity, diabetes, and hypertensive, renal, and degenerative cardiovascular disease. Serum uric acid distribution curves showed more hyperuricaemia than in local European populations, with skewing and a tendency to bimodality. A working hypothesis was postulated on the basis that a single gene was responsible for hyperuricaemia with a high degree of polymorphism, environmental (dietary) factors allowing marked manifestation of this latent trait; and other genetic factors influencing the familial incidence of gouty arthritis itself.

Dr. Ray Robinson spoke on "Indomethacin, a New Anti-inflammatory Agent".

This was used on a series of 79 patients suffering from various forms of relentlessly progressive or continuously painful rheumatic diseases—all of whom had failed to respond adequately to standard treatment with rest, physical therapy, and drugs over a 9-month period.

The erythrocyte sedimentation rate and haemoglobin were not materially affected. No toxic effects were in the haemopoietic, renal, or hepatic systems. Epigastric pain, nausea, and two cases of gastro-intestinal bleeding were recorded, one in a patient with a quiescent peptic ulcer. Headache, occasionally very severe, was troublesome, but many patients elected to continue despite this. Psychological disturbance, a detachment from reality, was seen in one patient who had been basically unstable before treatment. Another had two epileptic attacks after freedom for 20 years after the initial episodes. Osteo-arthritic lesions and neck and arm pain were not satisfactorily relieved. The dose recommended at first was far too high, and this influenced the figures unfavourably. The following schedule was suggested: 25, 50, 75, and 100 mg. for 2 days each leading to a gradual increase to 150 or 200 mg. daily as necessary. On this routine very little trouble was experienced.

A tendency for the disease to break through this anti-inflammatory barrier was noted in some cases after 6 months or more of adequate control.

It was possible, in many cases, to withdraw or to reduce corticosteroid to a minimum.

Dr. J. J. R. Duthie discussed some features of the aetiology of rheumatoid arthritis, including a short account of the current serological and biochemical investigations at Edinburgh and preliminary data on the demonstration of viable bodies in rheumatoid synovia. The very wide and important implication of this work occasioned great interest and the further development of this work will be eagerly awaited.

Drs. I. C. Isdale, K. R. Ridings, and P. W. Tapsell discussed the indications for rheumatic disease surgery, advocating the team approach of physician, surgeon and anaesthetist. They briefly reviewed their results in a series of 180 patients and outlined their indications for various methods of anaesthesia in individual patients.

Other papers presented were:

Dr. R. Howes: "Recent Impressions of London Rheumatic Centres."

Dr. R. Ensor: "Some Points of Rheumatic Pathology."

Dr. R. A. Wigley: "Joint Manifestations of Regional Enteritis."

A group of cases were presented for discussion.

CORRIGENDUM

It is regretted that in the paper by K. Ennevaara and M. Oka (*Annals*, 1964, **23**, 131), in Table II (p. 135), showing serological changes in eleven cases in the course of 2 to 36 months, a confusion arose between Waaler-Rose tests "not done" and those which gave a nil result. The correct readings in Cases 10, 12, 14, and 15 are as follows:

Case No.	Waaler-Rose Titre 1st examination	Interval (mths)	Waaler-Rose Titre 2nd examination
10	Nil	12	Nil
12	32	12	Nil
14	Not done	36	Nil
15	250	24	Nil

Elsewhere in the Table, 0 = Not done, as stated in the footnote.