

530 Correspondence

and the presence of gold in the cellular mass; and (3) the finding that ABO blood group and rhesus type has no influence on whether gold is bound to erythrocytes.

Taken together these 2 studies, using different highly sensitive and precise techniques to measure gold, confirm that a large proportion of RA patients have gold in blood cells, and that erythrocyte gold binding is similar with aurothioglucose and gold sodium thiomalate.

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Sir, We were interested to read the observation of Van de Stadt and Abbo-Tilstra¹ that significant amounts of gold were incorporated into the blood cells of 45% of all the patients they studied during treatment with gold salts for rheumatoid arthritis. As part of an investigation into the distribution of gold we have made observations on 9 patients who were being treated long term with Myocrisin (sodium aurothiomalate). Blood samples were taken immediately prior to a subsequent administration of the drug, and from these cellular samples were obtained by centrifuging. The gold content of 10 μ l samples of whole blood were compared with that of cells from the same volume by neutron activation analysis. The values of the ratio of cell content to whole blood content of gold we found are, in ascending order, 0.02, 0.03, 0.03, 0.05, 0.06, 0.06, 0.17, 0.21, and 0.40. The uncertainty of each ratio is estimated to be about \pm 0.02.

These results seem to show 2 distinct groups, with one-third of the patients being in the group with the large quantity of gold associated with the cells. This is in good agreement with the observations of Van de Stadt and Abbo-Tilstra. Like them we also find no correlation between high gold content and any clinical feature.

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Reference

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Conference proceedings wanted

Sir, May I appeal through your columns once again for the following conference proceedings which we still lack in the Heberden Library? I have endeavoured to make a full collection of all the rheumatological International, European, Seapal, and Pan-American congresses since they started, and we still lack the following:

9th International Rheumatological Conference 1957. Toronto. Vol. 1.

European Congress, Wiesbaden 1979 (not yet donated). Pan-American Congresses—the 5th Congress 1970, Uruguay (Pta d'Este); the 6th Congress 1974, Toronto; the 7th Congress 1978, Bogata.

Seapal Congresses, we still lack the 3rd Congress proceedings 1976 (Singapore) and those of the 4th (1980) in Manila.

I would be very grateful for gifts of any of these proceedings. The completion of this collection will make a unique reference resource for scholars in this field.

E. G. L. BYWATERS
Honorary Librarian, Heberden Society

Haemophilus influenzae tenosynovitis

Sir, We read with interest the report of Drs Bansal, Magnussen and Napodano describing infectious tenosynovitis caused by *Haemophilus influenzae*.¹ We have recently reported a case of a healthy 51 year old black male with multiarticular *Haemophilus influenzae* arthritis associated with tenosynovitis of the dorsum of the hand.² We have subsequently observed another patient with *H. influenzae* tenosynovitis, a 39-year-old black male alcoholic with dorsal tenosynovitis of the hand and arthritis involving both knees, a wrist, and a first metatarsal phalangeal joint. Two additional cases of adults with *H. influenzae* arthritis and evidence of tenosynovitis have been reported.^{3,4} In our patients the tenosynovitis has resolved uneventfully over several days of antibiotic therapy, somewhat more rapidly than the associated joint infection.

In the light of the published reports and our own experience we agree with Bansal *et al.* that *Haemophilus influenzae* infection should be considered among the diagnostic possibilities in acute tenosynovitis. Interestingly, although *Haemophilus influenzae* arthritis and *H. influenzae* infections in general are more common in young children, all of the aforementioned cases are adults. We know of no reports of *H. influenzae* tenosynovitis in children.

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Conference proceedings wanted

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