personal slant to the relevance of the approach and results from chosen areas of research'. The editors have arranged the papers in logical sequence: immunogenetics, lymphocyte function, rheumatoid factors, autoantibodies, immune complexes, complement, macrophages, and the pathogenesis of joint destruction.

I found almost all parts of this volume of intense interest. Rapid advances in understanding of the role of the HLA DR loci in rheumatoid arthritis provide the background for expert discussions on the part played by T lymphocytes in synovial disease and the role of lymphokines. The possibility of rheumatoid factor as a product of a response against antigen cross-reacting with IgG, the biological and chemical properties of anti-IgG antibodies and the immune response to the collagens are among topics criticised and appraised. Although the formation, deposition, and behaviour of immune complexes also provoke fascinating discussion, as do the role of complement and macrophages. I was particularly attracted to the accounts of the part that may be played in protease activation and inhibition by lymphocytes and by the concept that collagenase inhibitors may come to have an increasingly important therapeutic significance.

No one concerned with the rapid advances that are taking place in studies of rheumatoid arthritis should neglect Panayi and Johnson's book. The practising rheumatologist will find it stimulating and thought-provoking; the laboratory worker will turn to it for recent information.

D. L. GARDNER

Correspondence

Radiation synovectomy with yttrium—90 silicate

Sir,

The article 'Radioactivity studies on two synovial specimens after radiation synovectomy with yttrium-90 silicate' by Drs Dunscombe and Ramsey raised more questions than provides answers. In order to assess the weight that can be placed on their findings it is necessary to know the answers to the following questions.

1) In their autoradiographic study of the 2 synovial membranes, they found a very uneven distribution of activity over the synovial membranes. This uneven distribution may well have been due to the presence of surface fibrin over the synovial membrane in certain areas preventing uptake of isotope by the synovial membrane (or transport in cells through the synovial membrane). Was there any evidence of surface fibrin on the synovial membranes at synovectomy or at possible previous arthroscopy?

2) Intra-articular fibrin bodies of varying size are thought to take up radioisotope, which would not then come into contact with the synovial membrane. Was there evidence of operation of intra-articular suet or rice?

3) Did either patient have Baker’s cysts? It is well known that up to 50% of injected isotope may accumulate in a Baker’s cyst.

4) A synovial membrane of thickness 3 mm is not the usual thickness that one would expect in a hypertrophied rheumatoid synovial membrane removed at synovectomy. Was there evidence of chronic inflammatory synovitis on the histological examination of these synovial membranes and, in particular, of the foreign body reactions associated with the use of silicate as noted by G. Loewi (unpublished observations).

5) Presumably the surgical synovectomies were of the anterior and accessible part of the synovium only. Bonneton noted that much of the injected yttrium radiocolloids collected in the posterior part of the knee in experimental animals. Without information on how much radioactivity would have been in those parts of the synovium that were not removed the figures on retention are relatively meaningless.

(6) Have the authors any evidence for suggesting that further leakage should not occur after the 6th day? Leakage is not normally measured after 6 days because the amount of radioactivity remaining is negligible compared with the first 3 days. Extrapolating in their second patient from a loss of 14% at 6 days, it is not unreasonable that only 10% was found in the anterior synovial membrane 6 weeks later. If the loss continued as an exponential decay, the expected retention in the entire knee would have been 34%. What happened to the yttrium-90 in their first patient is debatable, but I would expect that a fair amount of it was on fibrin bodies within the cavity of the knee and on the synovium over the femur, tibia, and ligaments and in the posterior cavity of the knee.

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References


Sir,

Most of the questions asked by Dr Gumpel in his letter are concerned with pathology. We were particularly concerned, however, with utilising the opportunity of making measurements of excised synovial membrane
from patients who had been treated with radioactive colloid and to relate the observations with studies made previously in this department on the movement of radioactivity in patients following knee injections. Comments on the points raised are as follows.

1) The synovial membranes, as received for measurement, showed no evidence of surface fibrin. Clearly if isotope is deposited on fibrin this may contribute to uneven uptake by the synovial membrane itself.

2) Uptake of radioisotope by fibrin bodies would decrease the total amount available for uptake by the synovial membrane but would not by itself cause uneven uptake. Obviously uptake on fibrin bodies would reduce the total radioactivity found on portions of synovial membrane subsequently excised; to what extent it is impossible to estimate.

3) The same argument applies. In fact, neither patient had sizeable Baker’s cysts.

4) Without doubt a considerable portion of synovial membrane was not removed at surgery, but, as pointed out in the paper, this could hardly account for finding only 10% of what would be expected, allowing for decay, in the synovial membrane which was removed.

5) We did not suggest that further leakage does not occur after the sixth day, and our findings indicate that it may indeed occur. However, we have found from measurements on several patients that the knee activity tends to approach a stable value by about the sixth day and that the escape is not exponential after about the fourth day.

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Notes

15th International Congress of Rheumatology

The 15th International Congress of Rheumatology will take place in Paris on 21–27 June 1981. The principal themes will be: inflammatory rheumatism in adults, juvenile chronic arthritis, collagen diseases, arthropathy of the limbs, microcrystalline arthritis, metabolism osteopathy, abarticular rheumatism, and mechanical spinal column pathology. Special sessions will be devoted to the activities of the standing committees of the International League against Rheumatism and the results of the scientific and applied research work of the pharmaceutical industry. A scientific exhibition will give an opportunity for the presentation of posters, films, and collections of slides. The official languages will be English, Spanish, and French, with simultaneous translation. The final date for sending in abstracts is 31 January 1981. Further information from Congrès International de Rhumatologie B.P. 443–08, 75366 Paris, Cedex, France; and, on the scientific programme only, from Professor J. Villiaumey, Service de Rhumatologie, Hôpital Henri-Mondor, 94010 Creteil Cedex, France.

Spanish postgraduate course in rheumatology

A postgraduate course in rheumatology will be held in Barcelona on 23–27 February 1981. Details from the Course Secretary, J. J. Molina, Plaza Eguilas 14 (esq. calle Buigas), Barcelona 17, Spain.

Clinical trials

The combined annual scientific sessions of the Society for Clinical Trials and the eighth annual symposium for Co-ordinating Clinical Trials will be held on 11–13 May 1981 at San Francisco, California. The sessions will focus on the design, organisation, management, and analyses of clinical trials. Abstracts must be received by 1 January 1981. Information from Christian R. Klimt, MD, Secretary Society for Clinical Trials Inc., 600 Wyndhurst Avenue, Baltimore, Maryland 21210, USA.
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J M Gumpel

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