Book review


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 aneurysmal 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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Correspondence

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.4 is not in our view an adequate explanation for the increased incidence of reticuloendothelial malignancy in patients with rheumatoid arthritis. The association of a
true histiocytic (rather than B-cell) malignant neoplasm with the disease represents further evidence in support of this viewpoint.

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References

Synovial fluid complement levels in Behçet’s disease

Sir, We are interested in the study of Yurdakul et al.1 on the arthritis of Behçet’s disease (BD). Circulating immune complexes are known to be present in approximately 50% of patients, especially in those with uveitis, arthritis, and central nervous system involvement.2 These may arise in the serum or at the site of local pathology, and are probably involved in the pathogenesis of the arthritis.

We have studied synovial fluid and serum complement levels simultaneously in 15 patients with BD, 17 patients with rheumatoid arthritis (RA), and in 100 control sera. The total complementary activity was measured by the technique described by Mayer, and C3 and C4 fractions by radial immunodiffusion using C3 and C4 monospecific antisera.

Thus it was shown that serum complement levels were the same in BD and RA, but that synovial fluid total haemolytic complement and C3 and C4 levels were significantly higher in BD than in RA (respectively p<0.001, p<0.01, p<0.001) (Table 1).

The ratio of serum/synovial fluid CH50 and C4 levels remained constant and, for each patient, equalled 2 in BD and ≥ 4 in RA, the difference being significant (respectively p<0.001, p<0.01). The ratio of serum/synovial fluid C3 was also 2 in BD but was difficult to determine in RA because of the probable existence of degradation products which gave aberrant results.

Some previous studies on complement levels in synovial fluid in BD have been published, but these did not include comparison with serum complement levels.3-5 In our study we conclude that the ratio of serum to synovial fluid complement levels helps to distinguish the arthritis of BD from RA. Therefore, these two diseases seem to have different pathogenetic mechanisms.

Table 1 Results of tests

<table>
<thead>
<tr>
<th></th>
<th>CH50</th>
<th>C3</th>
<th>C4</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>(U/ml)</td>
<td>(mg/dl)</td>
<td>(mg/dl)</td>
</tr>
<tr>
<td>Behçet’s disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serum</td>
<td>56.3±7-6</td>
<td>144.5±38</td>
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<tr>
<td>Synovial fluid</td>
<td>30-15±6-9</td>
<td>76-09±25-9</td>
<td>32-32±15-08</td>
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<tr>
<td>Rheumatoid arthritis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serum</td>
<td>45-8±18-3</td>
<td>141-6±45</td>
<td>40-5±14</td>
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<tr>
<td>Synovial fluid</td>
<td>11-51±7-75</td>
<td>43-7±32-41</td>
<td>14-56±11-53</td>
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<tr>
<td>Controls</td>
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<tr>
<td>Serum</td>
<td>43.3±18-2</td>
<td>123-5±41</td>
<td>34.5±17-8</td>
</tr>
</tbody>
</table>

Service de Medicine Interne (Section Rhumatologie) et Laboratoire d’Immunologie, Hopital Charles Nicolle, Tunis, Tunisie.

References
Rheumatoid arthritis and malignant histiocytosis of the intestine.

C Cooper and M I Cawley

Ann Rheum Dis 1984 43: 766-767
doi: 10.1136/ard.43.5.766-b

Updated information and services can be found at:
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