ABSTRACTS

This section of the ANNALS is published in collaboration with the two abstracting Journals, ABSTRACTS OF WORLD MEDICINE and OPHTHALMIC LITERATURE, published by the British Medical Association. The abstracts selected for this Journal are divided into the following sections:

Acute Rheumatism
Chronic Articular Rheumatism
(Rheumatoid Arthritis, Osteo-Arthritis, Spondylitis, Miscellaneous);
Disk Syndrome
Gout
Pararheumatic (Collagen) Diseases
Non-articular Rheumatism
General Pathology
ACTH, Cortisone, and Other Steroids
Other General Subjects

At the end of each section is a list of titles of articles noted but not abstracted. Not all sections may be represented in any one issue.

The section "ACTH, Cortisone, and Other Steroids" may include abstracts and titles of articles dealing with research into the scope and modus operandi of steroid therapy.

Acute Rheumatism


Working at the Irvington House After-Care Clinic, New York University School of Medicine, the authors have studied the effect of physical activity on the progress of rheumatic heart disease in 216 patients who were followed up for an average of 21 years after an attack of rheumatic fever. In 26 (12 per cent.) of these patients the "objective cardiac status", evaluated by means of standard criteria for the findings on auscultation and fluoroscopy, deteriorated. In fifty (23 per cent.) there was improvement. In 140 (65 per cent.) there appeared to have been no change.

These percentages remained essentially unchanged when the findings were analysed according to the enforcement or absence of restrictions upon the patients' physical activities, during their school life, at home, or in later life after leaving school. The results suggest strongly that no really useful medical purpose is served by many of the physical and other restrictions which are often imposed upon patients who are known to have suffered from rheumatic fever, but who present no symptoms, whether or not they have developed any cardiac lesion. Such restrictions do not appear to influence cardiac deterioration either favourably or otherwise. Moreover, it was found in this series that adverse psychological reactions developed in 34 per cent. of the 141 patients whose school activities were restricted, but in only 6 per cent. of the 75 whose activities were not interfered with.

W. S. C. Copeman.


The prolonged use of prophylactic penicillin treatment for children who had had an attack of rheumatic fever was not introduced into the practice of the München-Schwabing Children's Hospital until 1955. By then many favourable reports had been published from American sources. After introduction of the measure, the incidence of relapses fell steeply, and among 64 cases treated by this method between 1955 and 1961 only one relapse was seen. This was contrasted with a control group of sixty other patients who were not given such prophylaxis [but who were not strictly comparable controls] and in whom seven relapses were noted. Finally, in fifteen children who were treated with penicillin after an attack of rheumatic fever only if they had tonsillitis, three severe relapses were observed. [A belated discovery.] John Lorber.


Chronic Articular Rheumatism  
(Rheumatoid Arthritis)

Rheumatoid Heart Disease: a Study of the Incidence and Nature of Cardiac Lesions in Rheumatoid Arthritis.  

The authors, working at the Lemuel Shattuck Hospital, Boston, have studied the nature and incidence of heart disease in rheumatoid arthritis. The records of 254 patients (51 male and 203 female), all of whom had typical rheumatoid arthritis as judged by accepted criteria, were investigated. For comparison the records of 254 patients matched for age and sex were chosen at random. Cases of primary heart disease or disease of the lungs, kidney, or cerebral vascular system associated with cardiac failure were excluded from the control series. Of the patients with rheumatoid arthritis, 88 (34·8 per cent.) had signs of organic heart disease compared with 37 (14·6 per cent.) of the controls.

The types of heart disease identified were classified under four headings:

(A) Patients with evidence of hypertension—defined as a blood pressure of not less than 160 mm. Hg systolic or 90 mm. Hg diastolic—and radiological evidence of left ventricular enlargement.—There were twenty such patients (7·9 per cent.) in the study group and nineteen (7·5 per cent.) in the control group.

(B) Cases of coronary arterial disease as evidenced by angina pectoris or electrocardiographic (ECG) changes.—There were eighteen (7·1 per cent.) cases in the study group and four (1·4 per cent.) in the control group. In addition, it was estimated that a further eighteen (7·1 per cent.) of the study group had probable evidence—including ECG changes—of coronary disease compared with eight (3·2 per cent.) in the control group.

(C) Patients with cor pulmonale or amyloidosis.—There were three in the study group and two in the control group.

(D) Cases of indeterminate heart disease and patients with unusual cardiac findings such as ECG or radiological evidence of enlargement of the left or right atrium or of the right ventricle, diastolic murmurs, and unexplained disorders of conduction.—There were twenty-nine such patients (11·4 per cent.) in the study group and only four (1·6 per cent.) in the control group.

Necropsy was performed on fifteen of the study group (including five of Group D). Pericarditis was observed in six of these cases and in seven instances rheumatoid lesions were found in the heart. In all of the five patients in Group D rheumatoid lesions were present in the heart.

The authors point out that the higher incidence of heart disease among the patients with rheumatoid arthritis is statistically significant. Commencing on the high incidence of indeterminate lesions, they consider that the necropsy findings in the five cases so far examined are highly significant and leave little doubt that these indeterminate lesions are due to rheumatoid and not to rheumatic heart disease.  

William Hughes.

Acute Pericarditis: with Subsequent Clinical Rheumatoid Arthritis.  

The authors review the literature concerning the occurrence of cardiac lesions in rheumatoid arthritis and describe three cases of pericarditis complicating the disease which were seen at Vanderbilt University Hospital, Nashville, Tennessee.

(1) A 17-year-old male had initial symptoms of chest pain and positive electrocardiographic (ECG) signs of acute pericarditis. The leucocyte count was 11,200 per c.m., the C-reactive protein test gave a 3+ positive result, and the serum antistreptolysin-O (ASO) titre was less than 50 Todd units. There was a swinging temperature up to 103° F. (39·4° C.), which gradually decreased over 3 weeks.Thoracentesis yielded 150 ml. of inflammatory exudate. Rapid improvement followed treatment with isoniazid, but a relapse occurred 4 months later, when an exploratory thoracotomy revealed the presence of pericarditis. Biopsy of the pericardium, pleura, and left lung showed acute and chronic types of inflammatory cellular exudate with occasional giant cells. No tubercle bacilli were found. Fever continued in spite of isoniazid therapy, but abated after steroid therapy. The ASO titre was increased to 500 Todd units and remained high for the next 2 years. Spindling of several metacarpophalangeal joints and arthritis of the right elbow-joint developed, but the patient remained ambulant.

(2) A 47-year-old male started with an influenza-like type of fever and signs of a pleural effusion on the left side. Positive ECG and radiological signs of pericarditis with effusion were observed and 400 ml. fluid was aspirated from the chest. There was no leucocytosis and lupus erythematosus (L.E.) cells were not found. The pericardial effusion subsided after the institution of steroid therapy. One month after the patient's discharge from hospital he relapsed and was re-admitted. After exploratory thoracotomy, sections of the lung, pleura, and pericardium revealed no specific changes. Cultures yielded no tubercle bacilli, and no L.E. cells were demonstrated. He subsequently developed nodules about the elbow and pain in the spine, shoulders, elbows, and interphalangeal joints, with some swelling about the proximal interphalangeal joints.

(3) A 53-year-old woman developed fever and leucocytosis with positive radiological and ECG evidence of pericarditis. No L.E. cells were found in the blood, and blood culture was negative. On thoracentesis 200 ml. sterile, straw-coloured fluid was withdrawn. The condition improved and the patient was discharged but relapsed after 4 months, with enlargement of the interphalangeal and knee joints.

In summarizing their findings, the authors note that pericarditis with effusion was followed after an interval of several months in these three cases by clinical manifestations of rheumatoid arthritis. They point out,
however, that the cases are still under observation and it may be that in time they will develop other forms of collagen disease.  

William Hughes.

Chloroquine and Rheumatoid Arthritis.  


Chloroquine does not appear to be a proven effective therapeutic agent for rheumatoid arthritis and because of the risk of visual complications its administration must be questioned.  

Ronald Lowe.

Rheumatoid Arthritis and Silicosis.  


Reumatismo, 14, 171.  

Maria Barbara.

Morphological and Dynamic Aspects of Chronic Rheumatic Inflammation.  

(Aspetti morfologici e dinamici della flogosi reumatica cronica.)  


2 figs, 21 refs.

Clinical Aspects of Polycharthritis in the Goat.  

(Klinische Aspekte der Ziegen-Polyarthritis.)  


5 figs.

Intra-articular Thio-tepa in Rheumatoid Disease of the Hands.  


Rheumatism, 18, 70.  

1 fig., 15 refs.

Management of Suppurative Arthritis.  


Rheumatism, 18, 74.  

4 figs, 5 refs.

Band-shaped Keratitis in Juvenile Rheumatoid Arthritis.  


Acta rheum. scand., 7, 169.

Still’s Disease and its Diagnosis.  

(Considerazioni sulla sindrome di Still e sulla sua nosografia.)  


Reumatismo, 14, 141.

Lesions of the Heart Valves in Rheumatoid Arthritis.  

(Die Herzklappenfehler bei der primär-chronischen Polycharthritis.)  


Munch. med. Wschr., 104, 1875.  

Bibl.

(Osteo-Arthritis)

Treatment of Osteo-arthritis of the Hip by Interstitial Cobalt 60 Irradiation.  

Robson, P. N., and Van Miert, P. J. (1962).  


23 figs, 16 refs.

The authors’ method of treatment is based on the view that much of the pain in osteo-arthritis of the hip is due to congestion and edema in the cancellous bone of the femoral head and neck.  

The evidence for this view is stated, and the vascular anatomy within the bone is described.  

Irradiation in suitable doses can reduce vascularity, and interstitial irradiation from a source centrally placed in the femoral head is the only practical way of achieving the required dose.  

Attempts to relieve pain by conventional irradiation from external sources have not been conspicuously successful.  

An isodose diagram shows how insertion of a 2 mm. diameter radioactive cobalt (60Co) source of 55 to 90 mc. centrally in the femoral head enables a very high central dose, falling off to no more than 1,400 r. at the surface of the head, to be given in 5 to 10 hours.  

This dose has proved safe and free from complications.  

The 60Co is inserted through a drill hole after the fashion of a Smith-Petersen pin.  

Extreme accuracy of centering is necessary and the procedure is described in detail.  

It is carried out under careful x-ray control, and the dose rate is calculated from the final radiograph.  

There have been no operative deaths and no cases of wound sepsis in the series described.

The report is based on the first 100 cases treated, 95 of them at least 2 years ago, at the Royal Victoria Infirmary, Newcastle upon Tyne.  

The average age of the patients (38 male and 62 female) was 62 and many were in poor general condition.  

Severe pain, but not limitation of movement alone, was considered to be a suitable indication.  

The cases were divided into three groups according to the degree of severity, and the results were assessed as:

(1) Completely satisfactory relief of pain;

(2) Substantial relief of pain, but pain still felt on moderate activity;

(3) Slight or no improvement.

After 2 years the results in 60 per cent. of the patients were found to correspond to (1) and in only 27 per cent. to (3).  

The results were best in the younger patients and in those in whom the disease was less advanced.  

Comparing their results with those in a published series treated by simple forage—that is, drilling of the bone to reduce tension—the authors find that the effects of irradiation are better and appear to last longer.

E. Stanley Lee.

Early Osteo-Arthritis of the Hip.  

(Artritis precoz de las caderas.)  


2 figs, 5 refs.

Studies on Osteo-Arthritis.  

(Estudios sobre la enfermedad artrosica.)  


Med. clin. (Barcelona), 38, 422.  

12 figs, 4 refs.

(Osteo-Arthritis)

Progress and Developments in the Field of Ankylosing Spondylitis.  

(Progrés et inventions dans le domaine de la spondylarthrite ankylosante ou pelvispondylite rhumatismale.)  


Pyogenic Diskospondylitis.  

(Discoespondilitis piógenas.)  


16 figs, 22 refs.


Disk Syndrome


Gout


In laboratory animals griseofulvin, an antifungal antibiotic with a chemical structure similar to that of colchicine, has been found to cause arrested mitosis in metaphase. Clinically, a good response has been obtained in fourteen out of twenty patients given griseofulvin for acute gout at the Jewish Hospital, Brooklyn, New York. Griseofulvin was given by mouth in a total dose varying from 6 to 10 g. according to body size; usually 2 g. was given 4-hrly until the total dose had been taken. Of the twenty patients, fifteen responded satisfactorily; two of the remaining five rapidly improved in response to colchicine. There was minimal evidence of toxicity, slight nausea occurring in three patients only. It is suggested that griseofulvin probably has a non-specific anti-inflammatory action rather than an action similar to that of colchicine.

B. M. Ansell.

Pararheumatic (Collagen) Diseases


The authors, at the University of Ferrara, Italy, have analysed sixty cases of idiopathic thrombocytopenic purpura and eight cases of systemic lupus erythematosus (S.L.E.). In one case of each group the disease gradually developed into the other, but otherwise little relationship was found. Thrombocytopenia is frequent in S.L.E. and cases of this disease sometimes have the appearance of thrombocytopenic purpura before being recognized. [There is an extensive discussion.] Arnold Pines.


From the University of Washington School of Medicine, Seattle, the authors review 191 pregnancies in 134 patients in whom either systemic or discoid lupus erythematosus (L.E.) was diagnosed. Of these, 49 pregnancies in 22 patients were studied personally or through the records of the Seattle hospitals, whereas information concerning the remainder was obtained as a result of a questionnaire sent to the members of District VIII of the American College of Obstetricians and Gynecologists.

The cases were divided into three clinical groups: acute and subacute systemic, chronic systemic, and discoid. In approximately two-thirds of the patients suffering from acute, subacute, or chronic systemic L.E., pregnancy had no apparent effect upon the course of the disease, but in approximately one-sixth the course was aggravated. The effect of acute L.E. upon the pregnancy was more marked than was the case with chronic L.E., and in the patients with discoid L.E. the pregnancy differed little from that in normal subjects. Of the patients with acute L.E., 25 per cent. had toxoaemia of pregnancy, while in 12 per cent. stillbirth, and in 10 per cent. spontaneous abortion occurred. The total foetal wastage was 25 per cent. After toxoaemia, renal disease, due either to nephritis or to nephrosis, was the second most frequent cause of complications. Therapeutic abortion was attempted in twelve cases of acute systemic L.E.; three of the patients died. There were nine deaths in the whole series, eight patients dying post partum. It is suggested that termination of the pregnancy may have aggravated the condition. It is further suggested that this may be due to the removal of the suppressive influence of the corticoids produced during pregnancy, and in consequence the authors recommend the continual use of heavy doses of steroids, not only during pregnancy, but also for several weeks after delivery.

R. E. Tunbridge.

In this paper from the University of Southern California School of Medicine and the County Hospital, Los Angeles, four cases of systemic lupus erythematosus are described [three in convincing detail] in which massive dosages of corticosteroids were given. Cortisone in a dosage up to 2-3 g. daily appeared to control the disease in three patients, although vertebral collapse and psychoses were seen. In the remaining case corticosteroids in a dosage up to 3-6 g. daily did not prevent death within 3 months. This patient had had lupus erythematosus for 11 years and an exacerbation for 6 months. The author emphasizes that a “Cushingoid” appearance is usually noted, even with very large dosage, only when remission has been induced; the dosage is therefore increased until the features of the Cushing syndrome are apparent. Central nervous system involvement was thought to be due to vasculitis in the brain or spinal cord or, in two cases in the series, to water intoxication. In one case there was a remission of 8 years’ duration, the patient being maintained on small (25-mg.) doses. This case was remarkable for the “complete architectural recovery of the vertebral” from “advanced osteoporosis with multiple compression fractures”. 

E. G. L. Baywasser.


The authors, writing from Warsaw Medical School, Poland, set out to show that in the condition they term “diffuse scleroderma” or “acroscleroderma” with coexistent Raynaud’s phenomenon the prognosis is neither as favourable as maintained by some workers nor as grave as claimed by others. [The condition referred to is now usually known in Britain as diffuse sclerosis.]

Of a series of 33 patients, the condition was described as severe in seventeen and mild in sixteen. In nine of those with the severe type the age at onset was over 40 years. The interval between the onset of Raynaud’s phenomenon and the development of skin changes showed some prognostic significance. When the interval was more than 10 years (twelve female patients) the course of the illness tended to be slow and extended over many years. In the five patients (females) in whom Raynaud’s phenomenon preceded “scleroderma” by more than 5 years, but less than 10, the condition was worse. The oesophagus and heart or the oesophagus, heart, and lungs were affected in four patients in the latter group.

The authors discuss the value of capillaroscopy and the significance of sensory chronaxies. They state that the prognosis may be grave owing to very frequent visceral involvement (in 27 of the 33 patients). [This does not support their opening observations concerning prognosis.]

S. T. Anning.


Unity or Plurality of Collagen Diseases. (Unidad o pluralidad de las colagenosis.) VACCAREZZA, R. F. (1962). Pren. méd. argent., 49, 545. 4 figs.


General Pathology


The authors, from the University of Colorado, Denver, report their attempts to elucidate the nature of the factor in rheumatoid arthritis serum which causes fixation of γ-globulin-coated latex. The basis of agglutinating reactions in rheumatoid arthritis is a particle coated with aggregated γ-globulin molecules. The authors have modified the latex fixation test to measure photometrically the optical density of the supernatant, and thus provide objective quantitative data over a wide range of dilutions of rheumatoid arthritis serum. It has been shown that γ-globulin aggregated by heat or by antigen-antibody complexes will adsorb the rheumatoid factor. By incubating Cohn Fraction II (a commercial preparation of lyophilized human γ-globulin), human γ-globulin (HGG), and bovine serum albumin (BSA) successively with latex suspension, the authors were able to show that the protein-latex bond was stable. Once a protein was adsorbed it could not be removed by repeated washing or eluted by dilute sodium hydroxide. One protein will not displace another, nor is there any evidence of exchange when excess protein of the same

The author, working at the University of Lund, Sweden, studied the agglutination of autoclaved Group A \(\beta\)-haemolytic streptococci by the sera of patients with rheumatoid arthritis. This agglutination was inhibited by Cohn Fraction I of retroplacental serum. This was demonstrated by incubating the streptococci with the Cohn fraction at room temperature followed by washing and addition of serum. Incubation at 37° C. or with Cohn Fraction I from normal serum caused little inhibition. Agglutination of live and autoclaved streptococci was inhibited by hyaluronic acid of mammalian origin and autoclaved synovial material. These inhibition studies suggest that antibodies against mesenchymal tissue occur in rheumatoid arthritis and raise the question whether the sera contain antibody against some part of the hyaluronic acid molecule. In the light of these findings the author suggests that in rheumatoid arthritis a primary abnormality of the enzyme systems involved in the metabolism of mesenchymal tissue gives rise to degradation products which are antigenic. Tissue damage then results both from the altered enzyme activity and from auto-immunity.

G. L. Asherson.

Comparison between Serological Reactions in Hyaluronidase-Treated Joint Exudate and Whole Sera from Patients with Rheumatoid Arthritis. [In English.] THULIN, K. E. (1962). Acta rheum. scand., 8, 10. 6 refs.

The author has previously shown that the factors in the serum of patients with rheumatoid arthritis which agglutinate live and autoclaved streptococci are different from the rheumatoid (haemagglutinating) factor which agglutinates sensitized sheep erythrocytes. He has now studied the distribution of these factors in joint fluid and serum. Joint fluid was obtained from 45 patients with joint injuries, sera from 100 healthy subjects, and joint fluid and serum from 62 patients with active rheumatoid arthritis. The streptococcal agglutination tests gave negative results in all joint fluids from patients with joint injury, even after treatment of the fluid with hyaluronidase. The rheumatoid factor occurred in a titre of 1 : 20 in three patients. After treatment with hyaluronidase, 21 fluids showed a titre of 1 : 20 or higher. Titres of 1 : 20 of the rheumatoid factor and agglutinating factors for streptococci were found in 9 to 15 per cent. of sera. Only 3 to 4 per cent. showed titres of 1 : 40, and no higher titres were found. On the basis of these figures streptococcal agglutination in joint fluid was regarded as positive if the titre was above 1 : 20 and in serum if it was above 1 : 40. For rheumatoid factor the limits were respectively 1 : 80 and 1 : 40.

In the sera of patients with rheumatoid arthritis, a positive reaction to the streptococcal agglutination test occurred in 40 to 50 per cent., and to the haemagglutination test in about 70 per cent. The figures for joint fluid were 20 per cent. and 35 per cent., but these rose to between 65 per cent. and 74 per cent. after treatment with hyaluronidase. When the patients were classified according to the severity of the radiological changes in the joints, it was found that the incidence of the haemagglutinating factor and the antibody to live streptococci increased with the severity of the disease. Antibody to the autoclaved streptococci was not associated with severity. However, the incidence of positive reactions in joint fluid increased with the severity of the disease for all three factors. In cases observed over several years, the haemagglutination factor usually appeared before the streptococcal agglutination factor and the
streptococcal agglutination factor fluctuated, perhaps because of variation in the level of (hypothetical) serum inhibitors. Of the sera from patients with rheumatoid arthritis, 31 per cent. agglutinated human erythrocytes coated with anti-Rh antibody. None of the joint fluids were active.

The author draws attention to the higher incidence of positive streptococcal agglutination reactions in the joint fluid as compared with the serum, and suggests that the joint factors may be different from the serum factors and that the lower incidence in serum may be related to inhibitors. He concludes that the haemagglutination factor is distinct from the streptococcal agglutination factor and presumably has different clinical significance.

G. L. Asherson.


This third paper provides further evidence for the distinct nature of the streptococcal agglutinating factors and the rheumatoid factor. Absorption with live streptococci of hyaluronidase-treated joint exudate from a patient with rheumatoid arthritis removed the streptococcal agglutinating factors, but left the rheumatoid factor unaffected. Absorption with autoclaved streptococci removed only the antibody to autoclaved streptococci. Absorption of six sera with heated human γ-globulin removed the rheumatoid factor, but left the streptococcal agglutinating factors almost unaltered. When the sera of six patients with rheumatoid arthritis were dialysed against distilled water the rheumatoid-factor activity was found entirely in the euglobulin precipitate, while the streptococcal agglutinating factors were found only in the supernatant. When six joint exudates treated with hyaluronidase were fractionated, the rheumatoid-factor activity was found in both the euglobulin precipitate and the supernatant, but no streptococcal agglutinating activity was recovered.

The author concludes that the streptococcal agglutinating factors and the rheumatoid factor react with distinct antigens and differ in their physicochemical properties.

G. L. Asherson.


**ACTH, Cortisone, and Other Steroids**


This paper from the Postgraduate Medical School of London reports an investigation of the dexamethasone suppression test in the diagnosis of Cushing’s syndrome. From the subjects studied the urine was collected for two consecutive 24-hour periods. They were then given dexamethasone in doses of 0.5 or 1 mg. every 6 hours for 7 days. Further 24-hour collections of urine were made on the 6th and 7th days of the period during which dexamethasone was given. 17-ketogenic steroid excretion was estimated in all the 24-hour collections of urine.

In nine normal subjects, seven patients with idiopathic hirsutism, and four patients with menstrual disorders, the 17-ketogenic steroid excretion had fallen to 2 mg. or less per 24 hours on the 6th and 7th days of dexamethasone treatment. In 24 obese subjects a similar fall in 17-ketogenic steroid excretion was noted, but eight of these patients required the higher dose of dexamethasone before the level of ketogenic steroid excretion fell to 2 mg. or less per 24 hours. In six patients with Cushing’s syndrome there was a much smaller decrease in 17-ketogenic steroid excretion. Only one patient showed a level of less than 10 mg. per 24 hours on the 6th day and in this case the level was 11 mg. per 24 hours on the 7th day. After implantation of radioactive gold into the pituitary fossa four of the patients with Cushing’s syndrome showed a good clinical remission. In these four the suppression test revealed levels of 17-ketogenic steroid excretion of 1 mg. or less per 24 hours. One patient showed only a partial clinical remission and suppression with dexamethasone produced 17-ketogenic steroid excretion of 7 and 6 mg. per 24 hours on the 6th and 7th days. One patient did not improve with radioactive gold implantation and the 17-ketogenic steroid excretion on the 5th and 6th days after dexamethasone therapy was 16 and 17 mg. per 24 hours.

The authors conclude that the dexamethasone suppression test is of value in the diagnosis of Cushing’s syndrome.

Charles Rolland.


The keystone to a favourable outcome of a surgical operation in steroid-treated patients is to make sure that such patients without exception are registered as “a steroid case” before operation. It was found advantageous to let the responsibility of obtaining information about previous medication and of prophylactic corticosteroid treatment rest with the anaesthetist in charge of the case.

During the last 4 years the following scheme was adopted at Ullevål Hospital. Patients who had received corticoids within the last 4 weeks before operation were given additional hormones according to a standard schedule. In the other “steroid cases” no coverage was given, but these patients were carefully observed for signs of impending circulatory insufficiency. In the 78 patients treated with cortisone or cortisone-like steroids, this system worked out satisfactorily. There were no fatal cases, and no serious complications occurred, either in the 48 cases receiving prophylactic cortisone, or in the thirty “steroid cases” in which such treatment was omitted. The prophylactic steroid treatment followed the same standard scheme in all cases, consisting of heavy doses of cortisone. None of these patients showed any signs of delayed wound healing or wound infection.

—[Authors’ summary.]


This report from the University of Hamburg concerns fourteen patients in whom a diagnosis of bilateral adrenal hyperplasia was made by study according to the method of Tamm and others *(Acta endocr. Kbh.*, 1961, 37, 253) of the 17-hydroxycorticosteroids in the plasma and in the urine during a standardized infusion of 50 i.u. adrenocorticotropic hormone. There were seven males and seven females and their ages ranged from 16 to 53 years, the majority being between 30 and 40. In six cases one adrenal gland (in five cases the left) was removed; in eight cases both glands were removed in one operation, which was carried out with the patient in the ventral decubitus and by means of a dorsally approach and resection of the eleventh ribs. In the six patients (five females, one male) who had unilateral adrenalectomy there was no permanent improvement.

A boy aged 16 developed signs of an intrasellar tumour which, together with the signs of the Cushing syndrome disappeared after pituitary irradiation (5,400 r) 7 months after the operation. One woman (aged 32) died a month later from pulmonary embolism; another woman (aged 34) died, 11 months after the operation, following physical exertion, the symptoms of Cushing’s disease...


Other General Subjects


A sialograph of the parotid duct was studied in four cases of Sjögren's syndrome and, as controls, five cases of symptomatic kerato-conjunctivitis sicca. The dilatation of the globular shadow within the gland parenchyma is characteristic for Sjögren's syndrome. Topical application of an artificial tear produced by the author (Wakadenin) brought about considerable improvement in the ocular symptoms. Treatment with Estriol and Parotin was followed by definite systemic improvement.

Y. Mitsui.


Pathological and anatomical investigations were carried out on a 60-year-old woman with Sjögren's syndrome. There were changes in the salivary and lacrimal glands of an inflammatory and blastomatous nature. Inflammatory changes in the skeletal muscles and changes in the heart valves also suggest an allergic rheumatic condition.

A. Huber.


A case report of a patient with Sjögren’s syndrome who had multiple cranial nerve palsies and diffuse peripheral neuropathy. These neurological lesions are similar to those reported in rheumatoid arthritis. Thus, the relationship between Sjögren’s syndrome and rheumatoid arthritis is further substantiated.

T. H. F. Chalkley.

Report of a patient with exophthalmic goitre treated with $^{131}$I who developed hypothyroidism associated with increased exophthalmos, hypertrophic osteo-arthropathy, and pretibial myxoeedema. B. Jay.


Two cases are described wherein the retinopathy was observed to develop from clear fundi concurrently with chloroquine therapy, but remained on withdrawal of the drug. Ronald Lowe.


The toxic effects of chloroquine are described briefly. Ronald Lowe.

Case of Behçet's Disease with Neurological Signs and Pulmonary Symptoms. [In Turkish.] Kerimoğlu, S., and Aktin, E. (1961). Oto Nöro Oftal. (Istanbul), 16, 225. 27 refs.


