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
Rheumatoid Arthritis
Still's Disease
Osteo-Arthritis
Spondylitis
Inflammatory Arthritides
Gout
Bone Diseases

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.

Acute Rheumatism


To illustrate some of the difficulties in diagnosing atrial septal defects (ASD) in adults, the findings in eleven patients (9 females and 2 males) aged 37 to 63 years with defects of the ostium secundum type are analysed in this paper from the San Diego County Heart Center, San Diego, California. Although a heart murmur had usually been noted in the second or third decade, symptoms were rare until later life. Six patients were said to have had rheumatic fever in childhood.

Dyspnoea, fatigue, bronchitis, and palpitations were the most common complaints. The findings on physical examination were similar in most cases. The jugular veins were usually distended and precordial pulsation was prominent over the right ventricle and pulmonary artery, with a palpable closure tap; an apical systolic thrill was palpable in two patients, both of whom had mitral regurgitation. On auscultation the second sound was widely split, with an accentuated pulmonary component; a pulmonary ejection murmur was present in all but one case and a murmur of pulmonary insufficiency was heard in seven. Significant mitral incompetence was present in six cases and tricuspid incompetence in seven. The electrocardiogram showed right bundle-branch block in ten cases and right axis deviation in all. There was evidence of right ventricular hypertrophy in ten cases, but left ventricular hypertropy was evident only in the case of one patient with systemic hypertension. On radiographic examination all had marked cardiac enlargement with massive right atrial dilatation and considerable left atrial enlargement was also present in seven instances. [This last is unusual in ASD.] Cardiac catheterization was carried out on ten patients. The pulmonary arterial pressure ranged from 40/18 to 114/65 mm. Hg; in two patients the condition was considered to be inoperable because of advanced pulmonary vascular disease with a minimal (10 per cent.) left to right shunt or reversal, but the other eight all had left-to-right shunts ranging from 44 to 73 per cent. of the pulmonary blood flow for which operation was advised and, in seven cases, was carried out.

The authors were impressed by the high incidence of mitral and tricuspid incompetence in these patients. The latter is often seen in ASD and is readily explained by dilatation of the right ventricle and tricuspid valve ring but this does not account for the presence of the former. The authors believe that the mitral incompetence is related to progressive dilatation of the left atrium because of increased pulmonary blood flow which produces displacement of the posterior mitral leaflet. They infer that the history of rheumatic fever in some of their cases was misleading, as confirmation of a rheumatic origin for the mitral incompetence was obtained in only one of the four patients with such a history who came to necropsy. They also consider that long-standing mitral incompetence or stenosis from any cause can lead to incompetence of a valvular foramen ovale with a resultant left-to-right shunt.

[Left atrial enlargement is seen only when an ASD is small. In eight of the ten patients in whom operation or necropsy was performed the ASD measured less than 3 cm. so that they formed a distinctly unusual group of older patients with ASD.]

C. M. Oakley


The haemodynamic data are reported in 151 infants in whom the sole diagnosis was ventricular septal defect, and who underwent cardiac catheterization before the age of 1 year [at the Hospital for Sick Children, Toronto]; 78 per cent. had pulmonary to systemic flow ratios over 2:1, and in 16 per cent. the low pulmonary blood flow (flow ratio under 2:1) was due to a small defect. 59 per
cent. of the patients had low or normal total pulmonary vascular resistance, and in only 25 per cent was the resistance increased above normal for this age group. 25 of the patients were recatheterized subsequently, and it was found that in three the defects had achieved functional closure. Two patients who were in the group with low flow and high resistance at the time of the first study had lower resistance later. Of the fourteen patients who demonstrated increasing pulmonary vascular resistance, ten had low or normal resistance earlier.

The authors suggest that progressive pulmonary vascular obstruction is a sequel to high flow and low vascular resistance in the pulmonary circulation and is not present from the time of birth. It is proposed that such patients be subjected to serial study in order to define those who are reacting to the pressure-flow stimulus in this way.

[Authors' summary.]


This paper from Yale University School of Medicine discusses the natural history of ventricular septal defect associated with aortic incompetence with reference to twelve patients, eight of whom underwent cardiac surgery. Of these patients, who were aged from 2 months to 11 years when first seen and were followed up from 5 to 13 years, six complained only of progressive tiredness and dyspnoea; five of them were below the third percentile in weight and height and three were at the tenth percentile. The predominant physical signs were a harsh pansystolic murmur heard best at the lower left sternal edge and a systolic thrill in the same area; the high pitched diastolic murmur of aortic insufficiency appeared at the mid-left sternal border in seven cases while the patients were under review. A pulse pressure of greater than 60 mm. Hg was noted in nine of the patients and was accompanied by evidence of cardiac hypertrophy on the electrocardiogram and chest radiograph. Cardiac catheterization showed that two patients had a raised pulmonary arterial pressure, and six patients had a gradient of 15 to 46 mm. Hg across the pulmonary valve. The left-to-right shunt was small in all cases, the pulmonary systemic flow ratio being 1½ to 1 or less in each patient. Aortography revealed that the aortic incompetence was severe in four patients, moderate in four and mild in one.

Of the eight patients who underwent surgery, the defect was found to be small (less than 1 cm.) in six cases and large in one, and in the other was found to consist of a ruptured sinus of Valsalva into the right ventricle. In two cases progressive left ventricular hypertrophy was noted over the years, but the majority had no increase in symptoms or signs up to the time of operation. As the series is small no recommendations are made as to the optimum time for surgery, as this is still in question, but the risk of bacterial endocarditis, which is said to occur in 20 per cent. patients with aortic insufficiency and which precipitates a rapid downhill course, is a strong factor for earlier intervention than was previously thought ideal.

A. Breckenridge


Rheumatoid Arthritis


It had been suggested that signs of "glucocorticoid" excess might be less if the daily dose of corticosteroid was given at one time rather than spread through the day. In an attempt to confirm this, two similar groups of rheumatoid arthritic patients were given tablets four times a day. For one of the groups only the first dose contained the corticosteroid (prednisolone), and for the other group the prednisolone was divided between the four tablets. Initially, at least, neither physician nor patient knew which regime they were on. The number of tablets given each time was so adjusted as to provide a steady and similar suppression of disease activity. After 9 months the groups were changed round and then followed for another 9 months. The methods of assessing disease activity and side-effects were similar to those usually used, except that the erythrocyte sedimentation rate was not done and that signs of "toxicity" included a glucose tolerance test. No significant difference was found in "toxicity" between the two regimes, but difficulties were encountered in running the trial and there were variables (e.g. a wide scatter in dosage) the significance of which for the trial were difficult to evaluate. Nevertheless, it may be concluded that for rheumatoid arthritic patients there is no case for choosing a single daily dose of prednisolone on the grounds that it will produce less "glucocorticoid toxicity" than divided doses.

Any physician contemplating therapeutic trials for rheumatoid arthritic patients would do well to study this paper in detail.

H. F. West

ABSTRACTS


Still's Disease


Osteo-arthritis


Spondylitis


Inflammatory Arthritis


Gout


After critical reference to Galen's opinions on gouty eunuchs, such a patient is reported. He was a poor elderly Chinaman with undoubted tophaceous disease. He presented with acute gouty otitis externa, a complication which is due to the habitual use of a special wax-removing spoon.

Castration in China is reviewed. L. Hall


[At the Veterans Administration Hospital, Bronx, New York] 51 male patients received oral potassium supplementation in the form of potassium bicarbonate in the ratio of 19·2 mEq. potassium to each 25 mg. hydrochlorothiazide. After chronic administration, 94 per cent. of the entire group maintained normal serum potassium. In a subsequent study, a potassium-sparing diuretic, triamterene, was found to cause no hypokalaemia when used alone, but when it was used in a 1:1 combination with hydrochlorothiazide 11 per cent. of the patients developed hypokalaemia. Hydrochlorothiazide used alone caused hypokalaemia in 25 per cent. of the patients. Hyperuricaemia induced by chlorthalidone therapy was effectively reversed by treatment with 200 mg. sulphinpyrazone daily, despite continuation of diuretic therapy. This was statistically significant compared to the placebo-treated group. —[Authors' summary.]

Bone Disease


Non-articular Rheumatism


Pararheumatic (Collagen) Diseases


When some patients are treated with hydralazine hydrochloride, a clinical picture indistinguishable from systemic lupus erythematosus (SLE) may develop. The precise role of the drug in this connexion is uncertain, but the authors of this paper consider the evidence to favour there being a lupus diathesis before the administration of the drug.

The authors reviewed the records of fifty cases of reactions to hydralazine (including a series known to have had positive LE-cell preparations) seen at the Mayo Clinic between 1952 and 1963 and of 100 hypertensive patients of whom seventeen had been treated with the drug although none had had a reaction. Previous manifestations suggesting a possible lupus diathesis were found in 37 patients and in thirteen of the hypertensive controls. In thirteen patients reactions occurred after less than one month of treatment with hydralazine; the LE-cell phenomenon was positive in the only patient tested, and eight had a past history suggestive of lupus erythematosus. The other 37 patients had received hydralazine for periods lasting over 6 months and up to...
8 years; the LE factor was demonstrated in 32, instances while 29 had a suggestive past history. The family history was thought possibly to be relevant in seventeen patients, and five patients who had a family history of inflammatory rheumatic disease developed the hydralazine reaction. Only eight of the hypertensive controls were thought to have a relevant family history. There were twelve patients who were thought to have both a family and a past history of probable significance. Data were available on 35 patients after the drug had been discontinued, and in 24 it was noted that manifestations continued or appeared after the drug had been withdrawn.

It is postulated on the evidence of this study, that the hydralazine syndrome develops in those patients who have an underlying lupus diathesis which is uncovered by hydralazine, and that once uncovered it persists for years. The syndrome is not usually reversible as was previously believed although some improvement occurs when the drug is withdrawn. It was not possible to distinguish the reactions simulating rheumatoid arthritis from those which resembled lupus erythematosus. Because the hydralazine syndrome has been reported to occur in approximately 10 per cent. of hypertensive patients treated with high doses of hydralazine, the authors think that a lupus diathesis is present in a considerable proportion of hypertensive patients and perhaps of the general population.  

**Ann F. Tuxford**

Possible Relationship between Scleroderma and Toxoplasmosis. (Gibt es einen Zusammenhang zwischen der Sklerodermie und der Toxoplasmose?)  


It has been suggested by Dahn and Schinko (Arch. klin. exp. Derm., 1961, 212, 616) that there may be an aetiological relationship between scleroderma and toxoplasmosis. In the present study this possibility was investigated at the Medical Academy, Warsaw, in 27 patients with scleroderma and 24 control patients with other skin disorders. In all cases a complement-fixation test, the Sabin-Feldman dye test, and the intradermal toxoplasma test were performed, with the following results. Of the 27 patients with scleroderma eight gave a weakly positive complement-fixation reaction against toxoplasmosis, as compared with three positive reactions among the 24 control patients. The dye test was positive in eleven patients with scleroderma and in six of the controls. The intradermal test result was positive in only one patient with scleroderma, was doubtful in two others, and was positive in two controls. There was no apparent association between the severity of scleroderma and a positive test for toxoplasmosis. It is therefore concluded that this study provided no evidence of an aetiological relationship between scleroderma and toxoplasmosis.

**G. W. Csonka**

**Purpura Fulminans.** (Purpura fulminans.)  

**Lindner, R. (1965). Munch. med. Wschr., 107, 629. 15 figs, 18 refs.**

The author from the Medizinische Klinik der Staedt Krankenanstalten Heilbronn/Neckar briefly describes the clinical manifestations, diagnosis and aetiology of purpura fulminans in general terms and then presents two examples of this rare condition.

One was a woman aged 38 who had a history of rheumatic fever and repeated miscarriages. Following a miscarriage at 6 months, manual removal of the placenta was performed under antibiotic cover with supracillin, and within a few days blue-red discoloration and itching of the forearms and later of the shoulders occurred. Clinical signs of sepsis developed, the affected skin areas became painful, and the arms became the seat of blue-black, sharply circumscribed areas of haemorrhage; the thighs and face were similarly affected later. Clinical data relevant to this stage are given. Blood culture was sterile, and a skin biopsy showed intraepidermal vesiculation, fibrin thrombi, and perivascular cellular infiltration. In the subcutaneous fat there were extensive haemorrhages due possibly to allergic or infective damage of the vessel walls. Prednisone and supportive cardiac treatment was given. The skin lesions in the face regressed but on the arms and thighs bullous separation of the epidermis occurred, followed on the thighs only by suppuration and necrosis to the level of the underlying muscle. The lesions healed almost completely after 11 months, but severe scarring produced some limitation of movement. The author considered that induction of labour was the precipitating cause in this case, though sepsis following manual removal of the placenta might have been responsible. The intensive treatment also may have caused an allergic reaction.

The second example was a woman aged 74 years who was a cardiac patient recently treated with Diamox (acetylaminothioleasol sulphonamide). This treatment was followed by the progressive development of red blisters on the feet, legs, hands, and forearms. The arms developed blue-red blisters and one finger showed dry gangrene. The appearance of the skin biopsy resembled that of the one seen previously except that here there was evidence of organization of the thrombi. Antibiotic and cortisone therapy was given. The painless skin lesions became necrotic and were slowly healing, when the patient died suddenly 3 months after the beginning of treatment. The author assumes that the cause of the purpura in this case was the Diamox, although there was no direct evidence.

**F. Hillman**

**Lupus Erythematosus Cell Phenomenon in Patients with Chronic Ulcerative Colitis.**  


The association of systemic lupus erythematosus (SLE) with chronic ulcerative colitis is rare, the authors having found only eleven cases reported in the literature. They now report eight further cases seen at the Mayo Clinic since the LE cell was discovered in 1948 (Hargraves and others, Proc. Mayo Clin., 23, 25; Abstr. Wld Med., 1948, 4, 231). The age at onset of the ulcerative colitis ranged from 9 to 59 years and six of the eight patients were females. In six cases arthralgia and inflammation of other serous membranes developed and chronic hepatitis...
was noted in five. In all but one case the ulcerative colitis preceded the finding of LE cells by 8 months to 29 years. All the patients had at some time been treated with sulphonamides, and in seven of them the onset or an exacerbation of the manifestations of SLE occurred during this treatment. This leads the authors to suggest that patients with chronic ulcerative colitis may have an underlying lupus diathesis which is unmasked by sulphonamides. The preparation used in seven of the eight cases in the present series was salicylazosulphapyridine.

J. S. Malpas


Connective Tissue Studies


The case report of a patient who at the age of 57 years was found to have haemochromatosis. The serum iron was 246 μg per 100 ml, and liver biopsy showed extensive haemosiderosis. After 6 years of repeated venepunctures the serum iron was 100 μg per 100 ml and liver biopsy revealed little residual iron. During this period the patient suffered from mild joint symptoms in the neck, knees, ankles, and proximal interphalangeal joints. Radiographs (not illustrated) of affected joints showed osteoporosis and osteo-arthritis; in addition, there was marked calcification of the menisci of the knees. Tests for rheumatoid serum factor were negative. The blood urea was normal. At the time when the liver contained little iron, a knee-joint synovial biopsy revealed extensive iron deposits in the synovial lining cells but no inflammatory cellular infiltrations. The authors mention two other cases of haemochromatosis with no joint symptoms and no increase in synovial haemosiderin.

J. Ball


Involvement of the small intestine in progressive systemic sclerosis (scleroderma) has received increasing attention since 1944. Having found by peroral biopsy encapsulation by collagen of Brunner’s glands in the duodenum in one of their patients with systemic sclerosis, the authors decided to review the files of all patients at the Hartford and Grace-New Haven Community Hospital, Connecticut, who had undergone small-bowel biopsy. This produced one more case, and these two cases are described in full. Both showed collagenous encapsulation of Brunner’s glands as well as atrophy and fragmentation of the muscularis mucosa, but with normal villi. Peroral duodenal biopsies were subsequently performed on six patients with scleroderma, in each of whom the diagnosis had been confirmed by skin biopsy or oesophageal-motility studies. Of these, four showed collagen around Brunner’s glands in varying degrees. The findings, which are illustrated, were consistent with the type of histology found in the small intestine in scleroderma.

G. Loewi


Immunology and Serology


Polyarthritis is apparently a widespread disease among lambs in several of the western states of the U.S.A. Under natural conditions the morbidity is high and the mortality low, and anorexia, fever, stiffness, and lameness the symptoms of the disease. An agent of the psittacosis lymphogranuloma venerum (PLGV) has been isolated from the joints of affected animals. This is a study of the effect of injecting the agent into lambs by various routes. Lambs aged 5 to 6 months were inoculated intra-articularly, intramuscularly, or intravenously. Control lambs were injected intra-articularly with diluent only, and three 1-year-old sheep that had recovered from a previous natural infection were inoculated intramuscularly with the agent.

All the inoculated sheep became febrile within 24 hours. Those previously infected returned to normal within 3 days, while the others showed fluctuating fever for 7 to 10 days. Symptoms of polyarthritis appeared in all susceptible animals 5 to 6 days after inoculation, whichever route was used. The previously infected sheep and the controls showed no evidence of lameness.

Post mortem inflammatory changes were found in hip, knee, shoulder, and elbow, as well as in brain, heart, lung, liver, and kidney. The organism was cultured from the blood, the affected viscera, and the joints. The affected joints showed effusions, hyperaemia and thickening of the synovial membrane, inflammatory changes in periarticular tissues and ligaments, and tenosynovitis of adjacent tendons. Histologically the synovial cells were swollen and of variable size, the subsynovial connective tissue was oedematous and contained many focal accumulations of mononuclear cells. Haemorrhages were seen extending into the stratum fibrosum of the
joint capsule. Focal collections of mononuclear cells were also seen in kidney, heart, lung, liver, lymph nodes and ependyma. The synovial fluid cell count varied between 1,000 and 52,000/cu. mm. Numerous elementary bodies were seen in smears of synovial fluid and in monocytes and synovial cells. C. G. Beardwell


Some aspect of rheumatoid arthritis is present in 11 to 20 per cent of uveitis patients. Many patients with arthritis demonstrate the rheumatoid factor in their sera. This is a 19S globulin, and its presence is shown by the latex-fixation test. The authors show the rheumatoid factor to be present in 20 per cent of the sera of uveitis patients and also in the egulobulin fractions. It is concluded that the serum of patients who suffer from uveitis contains an abnormal macroglobulin, and it is suggested that this is not due to the uveitis but to some basic disease which elevates the serum gamma-globulin.

A. G. Cross


**Failure of Pretreatment with Glucocorticoids to modify the Phagocytic and Bacterial Capacity of Human Leucocytes for Encapsulated Type I Pneumococcus.** Allison, F., Jr., and Adcock, M. H. (1965). *J. Bact.,* 89, 1256. Bibl.

**Biochemical Studies**


**Therapy**


The author reports two clinical trials of indomethacin in the treatment of patients attending the Royal North Shore Hospital, Sydney, with a variety of inflammatory diseases of the locomotor system, and who had not responded to standard medical therapy. In the first trial the drug was supplied only in 100-mg. tablets, which did not allow a sufficiently flexible dosage schedule so that in many cases the dose of indomethacin was too great, a number of patients developing side-effects which necessitated the withdrawal of treatment. These included pounding headache, dizziness, and a “drunk” feeling in many cases. A peculiar emotional dissociation affected a few, and two patients suffered a sudden decrease in haemoglobin value, blood loss from the bowel being noted. The anti-inflammatory effect of the drug was unpredictable. In patients with acute gout the results were mostly dramatic, whereas in those with acute tenosynovitis of the wrist there was little response. However, there was some evidence that rheumatoid arthritis, Reiter’s disease, ankylosing spondylitis, late stages of Still’s disease, and acute gout responded well to the drug, but the results in patients with osteo-arthritis and traumatic lesions were less satisfactory.

The drug later became available in 25-mg. capsules, and a second trial was instituted with a more flexible dosage schedule. A dose of 25 to 50 mg. per day, with increments of 25 mg. every 2 or 3 days up to a maximum of 200 mg. daily, was found to be more satisfactory except in acute gout, for which larger initial doses of 150 to 200 mg. were given daily until remission occurred. In all, 193 patients with a wide range of locomotor diseases, including 116 with rheumatoid arthritis, were treated. Symptomatic remission occurred in 14 per cent., and a further 33 per cent. were maintained in a good or fairly good condition. Headaches still occurred, necessitating withdrawal of treatment in a number of cases; anti-histamines and serotonin antagonists were found to be of little value. Depression was marked in seven patients, one of whom committed suicide, and in four cases gastrointestinal bleeding occurred. Relief of symptoms was obtained in 70 per cent., but treatment could not be maintained in many cases because of side-effects.

In the long-term treatment of patients with rheumatoid arthritis break-through of the disease occurred in several instances, and the addition of steroid therapy at this point was sometimes satisfactory. Vasculitis, development of nodules, and tenosynovial lesions also occurred after long-term treatment of this condition. Reduction of corticosteroid dosage was possible in many instances, and there appeared to be a synergistic action when salicylates were given concurrently, with no increase in incidence of side-effects. An important feature in this group was the ease with which indomethacin could be withdrawn without the rebound exacerbation of the condition which often follows the withdrawal of steroids.

Deryck Thorpe
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In the absence of any specific remedy for rheumatoid arthritis a combination of methods of treatment must be used, and the author recommends the inclusion in this complex of manganese chlorate. To determine the effectiveness of this drug thirty patients with active rheumatoid arthritis between the ages of 30 and 50, 23 of whom were women, were treated with manganese only. A 1 per cent. solution of manganese chlorate sterilized in a water-bath at 100°C. for 30 minutes was given by intramuscular injection, starting with 0.1 ml. daily and increasing the dose by 0.1 ml. at a time to a maximum of 1.5 ml., a total of fifteen to twenty injections being given. Five patients reacted to the treatment with an increase of pain in the joints and ten with a slight elevation of temperature for 2 or 3 days, and in these cases the dose of manganese was increased very slowly. There were no toxic symptoms.

A clinical remission was achieved in 27 cases, with a reduction of pain and swelling and increased mobility of the joints, but laboratory tests gave no consistent indication of a reduction in activity of the disease. However, the author considers that the clinical effects were sufficiently satisfactory to warrant the use of manganesechlorate as an adjunct in the treatment of rheumatoid arthritis.

_H. W. Swann_


This paper first reviews the present state of our knowledge regarding the aetiology, pathology, and treatment of tennis elbow. This is followed by an investigation to compare the relative efficacy of various physical methods of treatment (manipulation, ultrasonic radiation, and short-wave diathermy) and local infiltration of the painful area with hydrocortisone. To achieve this, 38 cases treated by physical methods were compared with 37 cases treated with local steroid infiltration. The cure or improvement rate was highest for the hydrocortisone group, while the average duration of symptoms was smallest for this group. This, combined with the fact that hydrocortisone is far simpler and less time-consuming to administer than various physical methods of treatment, leads the author to conclude that this is the method of choice in the treatment of tennis elbow.

An analysis of the histories of these cases suggests that there is little evidence to support the commonly-held opinion that the initial lesion in tennis elbow is a tear between the tendinous common extensor origin and the periosteum of the lateral condyle, and the author proposes that the underlying lesion is more likely to be a chronic tendinitis or periostitis due to prolonged tonic contraction of the extensor muscles or direct trauma.

_F. N. Ghadially_


**Other General Subjects**


In recent years there have been a number of published reports of Hashimoto’s disease in association with other so-called “auto-immune” disorders. The associated diseases have included rheumatoid arthritis, systemic lupus erythematosus, Sjögren’s syndrome, pernicious anaemia, cirrhosis of the liver, Addison’s disease, and diabetes mellitus. To determine whether there is any statistically significant association between these disorders and Hashimoto’s disease an extensive study was carried out of 74 cases of Hashimoto’s disease diagnosed at necropsy at the Johns Hopkins Hospital, Baltimore, and a series of 74 carefully-matched controls.

In both patients and controls, disseminated lupus erythematosus, diseases of the reticulo-endothelial system, endocrine disorders, and “other” diseases occurred with similar frequency. There were two minor
differences—generalized myocarditis was found in six of the cases of Hashimoto’s disease but not in any of the controls, and fourteen of the former group and 24 of the controls had hyperplasia of the bone-marrow. The number of recorded admissions to hospital, the causes of death, and the incidence of several major disorders not associated in the literature with Hashimoto’s disease were similar in the two groups.

The authors discuss the reasons for the difference between their findings and the reported findings of others and suggest that inadequate statistical analysis, lack of proper controls, and the bias inherent in hospital selection may all contribute to the discrepancy. They emphasize that their study was based on necropsy material from patients who had had diffuse thyroiditis, and that their findings may not relate directly to any possible association between focal thyroiditis and autoimmune disorders.

J. A. McBride


There is an overlap in the incidence of autoimmune thyroiditis and the connective tissue diseases, and this paper from the Royal Infirmary, Glasgow, describes an immunological investigation of first-degree relatives of patients with these diseases. A total of 95 relatives was available, and of the 41 patients fifteen were suffering from autoimmune thyroiditis and 26 from connective tissue disorders: rheumatoid arthritis (11); systemic lupus erythematosus (8); progressive systemic sclerosis (7).

The investigations performed on the serum of the probands, relatives, and controls included precipitin tests, tanned red-cell haemagglutination tests, and complement-fixation tests for thyroid antibodies, with Hyland latex-agglutination tests for rheumatoid factor, precipitin tests for auto-antibodies against cellular constituents, the lupus erythematosus (L.E.) cell test, the Hyland latex-agglutination test for antinucleoprotein, and fluorescent antibody methods for antinuclear factor. It was found that there was an increased prevalence of thyroglobulin antibodies and antinuclear auto-antibodies in the relatives of patients with both autoimmune thyroiditis and connective tissue diseases. However, the occurrence of a particular autoantibody in a relative was not obviously associated with its occurrence in the proband. Female relatives were affected more frequently than male, although no particular degree of relationship was involved.

It was concluded that further work was required to determine the relative role of genetic and environmental factors.

B. M. Ansell


In this paper from the Hôpital Sédillot, Nancy, two cases of sarcoïdosis presenting with acute polyarthritis, pyrexia, erythema nodosum, and bilateral hilar adenopathy (Löfgren’s syndrome) are described. It is noted that sarcoïdosis with acute onset has not been frequently reported in France, Crinquette (*J. franç. Med. Chir. thor.*., 1962, 16, 5) having found only eighteen previous cases, compared with 180 in Scandinavia. A point of special interest was the behaviour of the tuberculin reaction in one of the present patients, a man aged 22 years, who had received BCG vaccination 7 years previously; on admission to hospital his tuberculin test was at first positive, but became negative 18 days later. After 4 months, however, when the patient had completely recovered, the tuberculin test reverted to positive.

A. J. Karlish


Galileo is thought to have suffered from a severe febrile illness, probably caused by the cold and exposure entailed in making astronomical observations. From letters still extant, the onset of the illness would appear to have been in October, 1606. Following the initial acute phase of the illness, Galileo seems to have been subject to chronic progressive rheumatoid disease, with iritis, iridocyclitis, and corneal degeneration.

D. F. Cole


The relationship between rheumatism and eye diseases has been overestimated in the past. Definite ocular affections are found in cases of Still’s disease, Reiter’s disease, Bechterew’s disease, and in Sjögren’s syndrome; but whether these diseases can be classed as rheumatic affection is questionable. In typical rheumatic general diseases, no striking involvement of the eyes is observed.

K. Hruby


Late Obliterating Arteriopathy in Rheumatic Subjects.  
(Le arteriopatie obliteranti tardive dei reumatici.)  
Cardiol. prat. (Firenze), 15, 489.  8 figs, bibl.

Surgical Considerations for Rheumatoid Disease in the Forearm and Wrist.  
Amer. J. Surg., 109, 361.  13 figs, 24 refs.

Progress and Prospects in Rheumatic Disease.  

Chondrocalcinosis Coincidental to Other Rheumatic Disease.  
Arch. intern. Med., 115, 680.  3 figs, 11 refs.

Sjögren’s Syndrome.  
BLOCH, K. J., BUCHANAN, W. W.,  
Medicine (Baltimore), 44, 187.  15 figs, 181 refs.

Sjögren’s Syndrome and Hashimoto’s Thyroiditis.  
(Sjögren-Syndrom und Struma lymphomatosa Hashimoto,)  
Schweiz. med. Wschr., 95, 763.  17 refs.

Skin Manifestations in Rheumatic Disorders.  

Sjögren’s Syndrome associated with Chronic Thyroiditis.  
(Sindrome de Sjögren asociado a tiroiditis cronica.)  
REMOLAR, J. M., ROISENBLIT, A., and BROWN, L. N.  