(1961) who first described this reflux nor Cook *et al.* (1970) equate the late reflux directly with ineffective erythropoiesis. Pollycove and Mortimer (1961) felt that it was much too great to be entirely accounted for by ineffective erythropoiesis and suggested that it arose from the free non-haem iron which is reversibly bound to the cell membrane. In rheumatoid arthritis iron metabolism is known to be abnormal, and in particular, exogenous isotopically labelled iron is handled differently from endogenous iron (Bennett *et al.*, 1974). This may affect the results obtained from ferrokinetic data.

In order to clarify the role of ineffective erythropoiesis in the anaemia of rheumatoid arthritis we are planning a larger study of such patients, using two different methods of estimating ineffective erythropoiesis.

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Penicillamine in seronegative polyarthritis

Sir,

In the letter entitled 'Failure of D-penicillamine to affect peripheral joint involvement in ankylosing spondylitis or HLA B27 associated arthropathy' (Bird and Dixon, 1977) the authors report negative results in 7 patients with B27-associated arthritis who were negative for IgM rheumatoid factor. In my experience, 5 patients with classical ankylosing spondylitis treated with D-penicillamine showed no therapeutic response, in complete accord with the reported findings. Further support for the lack of efficacy of penicillamine in ankylosing spondylitis has been published in France (Leca and Camus, 1975).

The authors then suggest that since there have been no placebo controlled trials which have shown that seronegative polyarthritis responds to penicillamine, it remains a possibility that seropositivity is a prerequisite for a favourable response. While it is correct that no such trial has been performed, many investigators engaged in the treatment of rheumatoid arthritis (RA) with penicillamine have reported characteristic favourable responses to penicillamine in seronegative patients who otherwise fulfil the criteria for RA. Albeit anecdotal, no one has reported that seronegative RA patients as a group are nonresponders. Although no placebo was used, penicillamine and gold were found to be equally effective in the management of *seronegative* juvenile chronic polyarthritis (Hall and Ansell, 1977). Surely every effort should be made in 'seronegative RA' patients to exclude B27 arthritis, systemic lupus erythematosus, sarcoidosis, bowel disease, etc. It would, however, seem unjustified to exclude a patient with classical RA from penicillamine therapy simply because of the absence of IgM rheumatoid factor.

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Allergy and arthritis

Sir,

The recent public disclosure (*National Enquirer*, 1977) that rheumatoid arthritis is caused primarily by food allergy is impressive, based on 20 000 cases treated with 50–92% success. This has immediately created an immense backlog of food allergy cases whose prompt treatment is vastly beyond current medical capability. It is hoped that the medical profession will now rise to the occasion, especially since arthritis patients have already been abused enough. Allergists have been reporting food allergy as a cause of the disease for 28 years. In 1949, Zeller reported four cures with reversal of seemingly irreversible joint damage; this report was included in his major textbook on food allergy in 1951. One patient remained cured by avoiding lettuce, potato, and string bean, while another merely had to avoid beef! 28 additional cases were given by Rowe (1972) in a revision of his food allergy textbook. In the same year, a compelling medical review by Millman strongly implicated food allergy. In 1976, Randolph summarized his experience with 200 cases in a monumental symposium on environmental allergy edited by L. D. Dickey who has also treated many arthritis patients.

All these authors are allergists who have published their work in sources read primarily by other allergists. Thus there has been a large communication gap, but there has also been a tremendous gap created by provincialism and prejudice (Randolph 1976). Arthritis patients deserve better.

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Although some scepticism may be felt about this topic and the uncontrolled observations relating thereto, one of the functions of the *Annals* is surely to help to close any 'communication gap' which may exist in the field of rheumatic diseases, and we are therefore pleased to bring Dr. Catterall's views, and the references he cites, to the attention of our readers. *Editor.*

Note

Satellite symposium of the 7th International Congress of Pharmacology, Paris and Brussels

Scientific Committee: Prof. J. P. Giroud, Prof. D. A. Willoughby, Prof. J. Reuse, and Dr. J. P. Famaey. Official languages: English and French. The number of participants will be limited to 450.

Saturday, July 22, 1978, Paris

A meeting on ' Anti-inflammatory and Antirheumatic Drugs' will take place at Espace Pierre Cardin, 1–3, avenue Gabriel, 75008 Paris. For information, contact Prof. J. P. Giroud, Dept. of Pharmacology, Hôpital Cochin, Pavillon Gustave Roussy, 27 rue du Faubourg Saint-Jacques, 75674 Paris Cedex 14.

Monday, July 24, 1978, Brussels

A meeting on 'The Inflammatory Process' will take place at the Free University of Brussels, 'Campus plaine', Brussels, Belgium. For information contact Dr. J. P. Famaey, Service de Rhumatologie et Physiothérapie, Hôpital Universitaire Saint-Pierre, 322 rue Haute, 1000 Bruxelles, Belgique.