# Thrombocytosis and thrombocytopenia in rheumatic diseases

SIR, In their interesting abstract on platelets and rheumatoid arthritis[1] Farr *et al.* call attention to the frequent presence of an inflammation-related thrombocytosis in rheumatoid arthritis (RA). They point out that such a finding is not specific of RA. In fact they found thrombocytosis related to disease activity also in patients affected with Crohn's disease.

We reached the same conclusions by the analysis of platelet counts found in a wide series including patients with RA, juvenile chronic arthritis (JCA), Sjögren's syndrome (SS), progressive systemic sclerosis (PSS), polymyalgia rheumatica with or without Horton's arteritis (PMR-HA), ankylosing spondylitis (AS), psoriatic arthritis (PA), and gout.[2 3] We suggested that in the above mentioned diseases thrombocytosis should be considered as a nonspecific inflammation index, even if less useful than those commonly investigated. The clinician must therefore not be surprised to find thrombocytosis in a patient suffering from one of the above mentioned diseases. On the contrary, thrombocytopenia must lead to a careful evaluation.

Actually we never found thrombocytopenia in patients with JCA (n=49), PMR-HA (n=14), AS (n=32), PA (n=36), SS (n=10), or gout (n=20). As regards RA we found only in 5 out of 162 patients a relatively low platelet count (between 120 and 150 $\times$ $10^9$/l). Finally we found a relatively low platelet count (between 120 and 150 $\times$ $10^9$/l) in only 3 out of 83 patients with PSS, in one of whom this finding coincided with the appearance of malignant hypertension.

Therefore a finding of significant thrombocytopenia (platelet count less than 100 $\times$ $10^9$/l) in a patient suffering from a rheumatic disease must make us suspect either adverse effects of drugs or a rheumatic disease different from the above-mentioned ones such as systemic lupus erythematosus and Felty's syndrome, or, as regards PSS, some particular conditions, such as intravascular coagulation occurring in scleroderma malignant hypertension or a recently described autoimmune thrombocytopenia.[4]

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**References**

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# Conan Doyle as rheumatologist

SIR, In view of the recent interest in Arthur Conan Doyle as a doctor rather than as the creator of that greatest of diagnosticians, Sherlock Holmes, it might interest readers to know that he had written to the editor of the *Lancet* on the subject of gout in 1884.[1] Jonathan Hutchinson had shortly before this delivered the Bowman lecture before the Ophthalmological Society of the United Kingdom on 'The relation of certain diseases of the eye to gout',[2] and, though he wished to make a clear distinction 'between gout and rheumatism', Hutchinson had to confess that this was sometimes an impossible distinction. Hutchinson notes that 'for every unequivocal case of gout there are about half a dozen who are the subjects of minor symptoms', and he mentions slight pricking pains in joints as due to 'suppressed, undeclared or quiet gout'. 'There is', he writes, 'a condition to which, for want of a better name, I have for long been recognising as "hot eye". It is one of the many curious phenomena which attend quiet gout'.

Noting this, Dr A. Conan Doyle, writing from Southsea, reported that he had seen a patient, a Mr H, who had what seemed to be eczema and psoriasis. He gave him arsenic and later potassium iodide without much benefit. Shortly afterwards he saw Mrs B, the daughter of Mr H. She had intense pain in the eyes, with temporary congestion and partial blindness. He then discovered that her grandfather, the father of Mr H, had suffered from gout, and the scales fell from his own eyes. 'Recognising this to be a gouty symptom and bethinking me of the obscure skin disease which afflicted the father' he gave father and daughter colchicum and alkalies, with rapid improvement in both. His letter is headed 'Non-arthritic gout,' and he comments that this protean disease is spread here over 3 generations, manifesting itself in different ways. It is interesting that, although A. B. Garrod had 20–30 years before this demonstrated the essential features of gout and introduced the term 'rheumatoid arthritis' for this apparently different disorder, nowhere in the Bowman lecture is any such distinction made, 'gonorrheal rheumatism', 'gouty pneumonia',[3] 'gouty iritis', 'gouty reedy nails', and many other odd entities being widely quoted. J. Milner Fothergill, of the London Hospital for Diseases of the Chest, Victoria Park, asks, 'What is gout? Once the term was restricted to deformity of the small joints of the feet and hands', and he concludes[4] that 'each man had the gout in his own special way', an intermittent pulse, ridged nails, glistening conjunctivae, even gouty teeth suggesting this diagnosis.

Although Jonathan Hutchinson was a Fellow of the Royal