Obituary

Professor Gerald P. Rodnan

We were all shocked to hear of the sudden death of Professor Gerald Rodnan on 24 November 1983, especially as it came at a time when he was optimistic about his recovery from recent surgery and was in his usual enthusiastic manner full of plans and projects for the future.

Dr Rodnan was professor of medicine at the University of Pittsburgh and head of the Division of Rheumatology and Clinical Immunology for more than 28 years. He was an outstanding figure in rheumatology and the world's leading authority on systemic sclerosis and related disorders. His achievements were acknowledged by his election as president of the American Rheumatism Association in 1975-6 and to membership of the Association of American Physicians in 1983. He was also well known for his skill as a lecturer and teacher, and his commitment to this area included being editor-in-chief of the *Primer of the Rheumatic Diseases* and the *Bulletin on the Rheumatic Disorders*. He also participated as a member of the examining board for certification in rheumatology and enjoyed great popularity and success as a visiting professor.

There is hardly any aspect of scleroderma on which Gerald Rodnan and his team of investigators did not make a significant impact. Dr Rodnan in his publications made important observations on the natural history, pathogenesis, and clinical and laboratory features of scleroderma, but above all he filled others with his enthusiasm and infatuation for this bizarre disease. When asked how best to further our understanding of scleroderma, his advice was: 'Find other good individuals who can help with the task. The demands of a clinical practice in scleroderma are enormous. Patients with this difficult disorder require a great deal of a physician's time, so that few hours are left to pursue desperately needed research unless one is blessed with good assistants and collaborators.' He was indeed surrounded by good colleagues, and he trained 40 fellows who now work, teach, and are actively engaged in research in 16 States of the USA and six foreign countries.

Gerald Rodnan was a warm, cordial person with a particularly fine wit and wonderful panache. One of my happiest memories of him is sitting at the head of his 'family' of past and present fellows at their annual reunion at the ARA meeting in Boston with his famed cigar in hand and red braces on show 'fathering' his flock. So we take our leave of Gerald Rodnan with fond personal memories and the whole world of rheumatology mourning the loss of a fine physician.

C. B.

Correspondence

History of rheumatic or glandular fever

SIR, We have been struck by the number of patients presenting to our unit who have had an earlier diagnosis of rheumatic fever or glandular fever, and have received treatment for these diseases.

Rheumatic fever is now a rarity in Britain. In the last 15 years no new case has been seen in this unit. We therefore looked at 364 consecutive patients seen recently in this unit and noted their current as well as previous diagnosis. Our results are presented in Table 1.

Four of the patients with systemic lupus erythematosus (SLE) and 3 of the remainder suffered their initial illness (labelled as rheumatic fever) within the last 15 years. Some had signs suggesting rheumatic valve disease, but most of them (primarily in the SLE group) did not.

We collected similar data for those patients with an initial diagnosis of 'glandular fever' (Table 2). This had been made in all cases in the late teens or early twenties. It is not known how many were confirmed serologically at the time. In many the course of the 'glandular fever' was prolonged or 'atypical'.

These data are by their very nature selective. The distribution of 'current diagnoses' may represent to some extent the type of patients seen in our particular unit. It is probable that the 'rheumatic fever' and 'glandular fever' represented the earliest symptoms of these patients' diseases. It is apparent that, although rheumatic fever is extremely rare as a disease in Great Britain, the diagnosis lingers on.

Table 1 *Original diagnosis of rheumatic fever and current diagnoses*

	Number
<i>Previous diagnosis</i>	
Rheumatic fever	21
<i>Current diagnosis</i>	
Rheumatoid arthritis	7
Systemic lupus erythematosus	5
Arteritis	3
Seronegative arthritis	3
Polymyositis	1
Osteoarthritis	1
Subacute bacterial endocarditis	1
Total patients studied	364

Table 2 *Original diagnosis of glandular fever and current diagnoses*

	Number
<i>Original diagnosis</i>	
Glandular fever	9
<i>Current diagnosis</i>	
Systemic lupus erythematosus	3
Adult Still's disease	2
Dermatomyositis	1
Wegener's granulomatosis	1
Uncharacterised connective tissue disease	1
Reactive arthritis	1
Total patients studied	364

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