Royal National Hospital for Rheumatic Diseases we found differences between the seropositive and seronegative patients that to some extent paralleled our original Stanford experience and now the Italian data.[1]

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Reference

1 Lowthian P, Woolf A, Downes J, Gofton J P, Calin A. 'Seronegative rheumatoid arthritis' a distinct radiological entity: a controlled study versus seropositive disease. *Ann Rheum Dis* 1984; **43:** 117–8.

Vertebral rim lesions in dorsolumbar spine

SIR, I have read with interest the paper by Hilton and Ball[1] describing vertebral rim lesions in the dorsolumbar spine. It implies, inter alia, that transverse tears ('avulsions') of the annulus have not been mentioned before in the literature. However, such tears in the attachment region of the annulus were described and illustrated many years ago by Schmorl and Junghanns[2] and more recently by Vernon-Roberts and Pirie.[3]

Hilton and Ball[1] state, moreover, that 'The avulsed annulus may be recognised radiographically as a small translucency (clinically sometimes referred to as the vacuum phenomenon).[1] While I agree that the larger annular tears may sometimes be visualised on post-mortem radiographs of thin slabs of spine (the majority are detected by microscopic examination of stained sections), they are not responsible for the well-known vacuum phenomenon which may be seen on clinical radiographs[4] and which is associated with cleft formation[2] initially affecting the nucleus pulposus alone and extending to involve the annulus at a later stage.[3] Current evidence suggests that nuclear clefts, present in almost every spine after middle age,[3] are initiated by a primary degenerative process commencing in the nucleus. Clearly they should be distinguished from the less frequent annular clefts (avulsions) formed as a result of traumatic episodes or fatigue failure due to repetitive loading of the annular fibres. The excellent paper by Hilton and Ball[1] supports these important distinctions and is in accord with a personal view that detailed pathological studies of the spine can provide important clues to the pathogenesis of back pain.

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2 Schmorl G, Junghanns H. *The human spine in health and disease*. 2nd American edition translated and edited by E F Besemann. New York and London: Grune and Stratton, 1971.
3 Vernon-Roberts B, Pirie C J. Degenerative changes in the intervertebral discs of the lumbar spine and their sequelae. *Rheumatol Rehabil* 1977; **16:** 13–21.
4 Epstein B S. *The spine. A radiological text and atlas*. Philadelphia: Lea and Febiger, 1976.

'Seronegative spondarthritis'

SIR, Dr Malaviya and his colleagues[1] suggest the need for a name to include their ' "unclassifiable" seronegative spondyloarthropathies'. This semantic confusion would not have arisen had the editor of *Medicine (Baltimore)* been willing to accept the original title of our paper[2] on the subject, that is 'Seronegative spondarthritis', and instead of the somewhat cumbersome title under which it was published. One of the cornerstones of this concept was the degree of clinical overlap among the constituent diseases, and we have all seen over the years patients with an apparently unequivocal diagnosis of one of these conditions in whom the diagnosis then shifts as other features supervene, and also numerous examples of *forme frustes* of these diseases. There have also been semantic arguments about the diagnosis of Reiter's disease, especially if incomplete, and its relation to the reactive arthritides, and also additions to the group, including some cases of juvenile chronic arthritis. Fortunately the original concept of seronegative spondarthritis is sufficiently robust to accommodate all these variations, and I would suggest that Dr Malaviya and his colleagues adhere to the name 'seronegative spondarthritis' to describe his patients in the future.

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1 Prakesh S, Mehra N K, Bhargava S, Malaviya A N. HLA B27 related 'unclassifiable' seronegative spondyloarthropathies. *Ann Rheum Dis* 1983; **42:** 640–3.
2 Moll J M H, Haslock I, Macrae I F, Wright V. Association between ankylosing spondylitis, psoriatic arthritis, Reiter's disease, the intestinal arthropathies and Behçet's syndrome. *Medicine (Baltimore)* 1974; **53:** 343–64.

Unusual case of dermatomyositis

SIR, We would like to report an unusual case of dermatomyositis, the dermatological aspects of which have been reported elsewhere.

A 23-year-old female civil servant first presented to this hospital in 1948 with an erythematous eruption in the light-exposed areas, pain and weakness of the muscles of the limbs and Raynaud's phenomenon. A diagnosis of