preliminary results for ten of them. The amyloid found in annular ligament and perineural region in three cases and in fragments of villi of knee synovial fluid sediment in another seven cases were studied by means of immunohistochemical analysis using the peroxidase-antiperoxidase method, with anti β_2 microglobulin antibodies (Dako), confirming that they contain β_2 microglobulin.

As Ian Rowe points out 'although the biochemical nature of amyloid deposits in osteoarthritic joints has not been characterised, it should be possible to determine whether these or any other age related amyloid deposits contain β_2 microglobulin'.[7]

Until then, and considering all the above mentioned points, we think that there is no basis for considering that we are dealing with the same kind of amyloidosis.

Servicio de Reumatología — J MUÑOZ-GOMÉZ
Servicio Anatomía Patológica — M SOLÉ ARQUÉS
Hospital Clínico y Provincial,
Barcelona,
Spain

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Note

Symposium on antirheumatic drugs: basis for variability in response

A satellite meeting of the 10th International Pharmacology Meeting, Sydney, Australia will be held on 20–22 August, 1987 at Manly Pacific Hotel, Manly, Sydney, Australia. Details from Professor P Brooks, Department of Rheumatology, Royal North Shore Hospital, St Leonards, Sydney, NSW, Australia 2065.

Correction: Clinical vignette—The 'L4 syndrome' as a cause of obscure knee symptoms

In this vignette by Drs M I D Cawley and J C Robertson (*Ann Rheum Dis* 1986; **45:** 704) we regret that a word was omitted from the first sentence. This should have read 'The deep pain referral territory (sclerotome) of the fourth lumbar segment includes the knee and anterior tibial region.