arthritis involving *B. belli* and Cryptosporidium infestation in patients with AIDS are not yet well known. Further studies should help clarify these questions. We are not aware of any previous report of reactive arthritis after enteric infection due to *B. belli* and we believe this to be the first such report.

**Bence-Jones protein and vertebral osteoporosis**

We welcome the introduction of *Lesson of the Month* and read with interest the case report submitted by Dr Edgar and colleagues regarding the investigation of patients presenting with back pain. As the authors rightly point out, the exclusion of occult lymphoproliferative disorders in this group of patients is of the utmost importance. There are, however, several points of concern arising from the case particularly in relation to the clinical interpretation of monoclonal urinary free light chains.

The use of the term Bence-Jones protein (BJP) can cause confusion as it refers to the original heating test for the detection of urinary monoclonal free light chains. These are now best detected using the more sensitive techniques of immunoelectrophoresis or immunofixation. As this interesting case demonstrates, serum immunoglobulin levels can remain abnormal in a few cases, even in the terminal stages of disease. It is therefore imperative that paired serum and urine samples are sent for immunochemical analysis.

We feel it is potentially misleading to say that “… Tracis of urinary BJP in isolation can prove to be benign ...”. It is generally agreed that their detection is highly suggestive of underlying lymphoproliferative disease in the majority of cases and it iswise to dismiss such findings as benign. In addition the definition of “a trace” will depend heavily on the detection system employed in individual laboratories. An accurate quantitation of the free light chains should routinely be undertaken. Measurement of total urinary protein is less informative. These are the important lessons we must learn from cases of occult myeloma (or related processes) to be detected and successfully treated.

We would emphasise that in patients presenting in this manner, a more aggressive investigation is indicated, including early bone marrow examination and radioisotope scanning of bone. Only when negative results from these investigations are available would it be advisable to monitor the patient over time remembering that a repeat bone marrow examination is always an option at a later date.

**Antiphospholipid antibodies (aPL) in systemic lupus erythematosus. Are they specific tools for the diagnosis of aPL syndrome?**

We read with interest the paper by Ghirardello et al on antiphospholipid antibodies (aPL) in systemic lupus erythematosus (SLE) but would suggest that their conclusion, “lupus anticoagulant (LA) but not anticardiolipin antibody (aCL) positivity is a specific tool for the diagnosis of thrombotic complications…in SLE”, is interpreted with caution.

There are a number of methodological problems in setting up a study of this kind which should be highlighted:

1. This study was retrospective and it cannot be assured that the disease status for a patient is aPL +ve at the time of study, they were also aPL +ve at the time of diagnosis of SLE. In fact, the authors do not specifically state in reference to the 47 patients who had experience pregnancy, whether they were diagnosed as having SLE at that time. It is therefore likely that the recording of aPL complications using