ment of the rash, one had double otitis media, and one had a purpuric rash.

From this small number of cases it would appear that measles developing during the course of whooping-cough does not necessarily add to the severity of either disease, but the same cannot be said of the converse. Dr. B. L. Hodge (Aug. 7, p. 312) drew attention to a similar double epidemic, and his observations would appear to confirm this view.—I am, etc.,

Redhill, Surrey.

L. J. BARFORD.

Fibrositis

SIR,—I should like to take up cudgels with Dr. James Cyriax over his article on fibrositis (July 31, p. 251), as I feel he is showing indecent haste in interring this condition. The essence of his case is that symptoms commonly attributed to primary fibrositis are really caused by derangements of the spine, and to prove this he compares the symptoms with those of such conditions as lumbago and brachial neuritis due to disk lesions. From certain similarities he draws the conclusion that fibrositis represents the lesser degree of these and related conditions. In stressing the similarities he glosses over the differences.

Observations made on oneself may have an element of bias in them, but as an occasional sufferer from both lumbago and fibrositis I have had opportunity to study both conditions at leisure. With regard to lumbago I am in entire agreement with Dr. Cyriax. The onset, after what one might term postural indiscretions such as an afternoon's gardening, lifting heavy weights off the ground, etc., followed by diffuse aching pain in the lumbar region combined with inability to fully extend the back—the whole lasting several days or weeks—bears the hall-mark of a spinal derangement.

Primary fibrositis, on the other hand, has a curious tendency to occur with changes of climate, but bears no relationship to exercise or posture. Subjectively its pain does not feel to be of the same quality as lumbago. It is a disease of tender spots, each of an area so small that it can be accurately localized with the finger tip. It is not only confined to the shoulder girdle or the lumbo-sacral region, but, when extensive, tender spots are found over the insertions of the muscles and their bellies throughout the trunk limb, over the scalp, and over the backs of the metacarpals and phalanges—in places, indeed, where there is no muscle interposed between skin and bone. The condition is bilaterally symmetrical to an extreme degree, and tender spots may be found in the territory of so many spinal nerve segments as to make one shudder for the integrity of one's vertebral column—should Dr. Cyriax's theory prove right.

The response to treatment does not suggest a spinal lesion, as marked and permanent relief may be obtained from massage and heat applied to the tender spots, and the condition will improve more gradually though nothing is done. The spine need not be touched to effect a cure, and one wonders if time may not be the chief therapeutic agent when spinal manipulation or traction is used.

Finally, as regards aetiology, this may be under discussion, but my own feeling is that the lesions lie in the fascial sheaths covering both muscular and bony structures, and that the muscle spasm which is such a feature of the condition is merely protective to avoid stretching a tender fascia.—I am, etc.,

London, N.4.

R. G. BENIANS.

SIR,—When Dr. James Cyriax (July 31, p. 251) calls primary fibrositis an imaginary disease he is in good company, but that fibrositis coming on for no apparent reason is always due to an articular lesion, as he states, seems open to doubt. I should like to quote the following case.

On Nov. 2, 1946, a district midwife, aged 24 years, recently married, no children, called at my house for advice regarding a neck stiffness which had developed two or three hours previously. On examination she had spasm of the upper margin of the left trapezius muscle, which was easily palpable and tender to touch. Obviously this was a true fibrositis, if the disease exists. Having some doubts about this, I made further inquiries. She admitted to having had a few colicky pains during the day, and on examination was found to be tender in the left fornix. A diagnosis of ruptured ectopic pregnancy was received by the patient with such incredulity as reflected

doubts on my sanity. However, the following day she had a laparotomy and was found by Mr. Theobald, who had seen her in consultation with me, to have a ruptured ovarian pregnancy, with free blood in the peritoneum. In this case the last menstrual period had started about 17 days before the illness, and any faith in fibrositis on the doctor's part would have caused the diagnosis to be missed. But this was *not* an articular lesion, nor was there an apparent reason for the fibrositis.—I am, etc.,

Shipley.

H. S. RUSSELL.

SIR,—In his article on fibrositis (July 31, p. 251) Dr. J. Cyriax has fallen upon a concept which has been promulgated in osteopathy for the last 70 years. The article, though condemning one aspect of the osteopathic theory, is essentially the theme of osteopaths for all these years—namely, that the spinal lesion is the cause of most local spinal and referred somatic pains.

The main difference now is that Dr. Cyriax stresses the intervertebral disk as being the faulty structure, whereas osteopathy stresses the apophyseal joint as being the site where significant changes have occurred. The probable truth is that both are to blame, sometimes one, sometimes the other, and frequently both together. It is, however, not possible to tell which part of the spinal joint is the offending structure except by inference, because, as Kellgren has shown, all deep pain is segmental in its manifestations.

With the advent of disk surgery and visible proof that prolapsed disks cause lumbago, sciatic pain, and brachial pain, the disk is now blamed for everything which happens to a spinal joint. But consider the pathology and the possible effect of manipulation. How can one manipulation, as suggested, normalize a torn cartilage? It might dislodge the offending piece from a sensitive structure, just as it is possible to manipulate a displaced cartilage in the knee and obtain relief straight away, but healing requires weeks. If one manipulation is effective, then the more rational explanation is that old adhesions in the capsule of the apophyseal joints have been snapped. The analogy of adhesions in a stiff knee is complete. One manipulation frequently cures, especially if the adhesions are old and brittle.

The osteopathic type of manipulation, while making use of specific forced movements for the purpose of breaking adhesions, does at the same time use gentle articulation of all the joints in the area of the lesion with the object of increasing local circulation and restoring normality there. The osteopath advocates a series of gentle manipulations without anaesthesia, and rhythmical traction is an important part of treatment. This probably assists in the healing of the intervertebral disk if and when it is damaged, and explains much of the success of their method.—I am, etc.,

London, W.1.

ALAN STODDARD.

SIR,—Dr. James Cyriax's statement (July 31, p. 251) that primary fibrositis is *imaginary* is rather startling. Does he think the following cases are due to intervertebral lesions and not primary fibrositis?

A male, 72, has physical lesions due to fibrositis in both feet, calves, thighs, at brim of pelvis, around the spines of the vertebrae, in the thoracic walls, and also panniculitis (fibrosis of fat) at lower regions of thorax and around and between the breasts; also physical lesions in the neck and temporal regions, no sepsis found; also no rheumatoid arthritis nor osteoarthritis present. His posture and carriage are excellent. Fibrositis commenced at the age of 16.

A woman, 56, had pain in lower back for 20 years, and recently pain in the left lower abdomen. She had seen two physical medicine specialists, an orthopaedic surgeon, a consulting physician, and received every imaginable treatment. She was found to have fibrosis of fat around the pelvis and hips and a mass of fibrosed fat in left lower abdomen. She received 19 treatments of deep massage and has remained free from pain for 2½ years. No sepsis, osteoarthritis or rheumatoid arthritis, nor the usual physical signs of fibrositis found.

Good-fitting dentures suddenly become painful and are eased, and when this process has been repeated several times the dentures are ruined. In many cases it is due to fibrositis of the upper and lower jaws and can simply be remedied by deep massage a few times.

Does Dr. Cyriax manipulate as a rule with or without a general anaesthetic? Surely it is very difficult to believe that any of these cases can be *due entirely* to intervertebral lesions. It should be mentioned that in the first case the fibrosed mass, already palpable, becomes bigger and more obvious when