Correspondence

Letters to the Editor should not exceed 500 words.

Efficacy of Intra-articular Steroid

SIR,—Professor J. L. Hollander (20 March, p. 794) has rendered a service to medicine in introducing intra-articular corticosteroids in the treatment of rheumatoid arthritis, a debt which we have acknowledged.¹ He has remained an enthusiastic advocate of this useful treatment, but he does not serve his cause well in depreciating the work of those who have sounded a cautionary note. He claims to have had more experience of intra-synovial steroid injections than we, without knowledge of the total experience we have in fact had. Indeed, one of us (S. J. H.) was carrying out intra-articular aspirations and injections using procaine lactic acid long before the cortisone era.

We were sorry to note that he could obtain no fluid from the approach to the knee-joint used by us in patients with osteoarthritis, since we find no such difficulty when fluid is present. The sweeping deduction that "no fluid can be obtained with this method from any osteoarthritic knees" is therefore a false generalization.

It is important to note what we did state in our papers rather than what we are claimed to have stated. We did not say that "intra-articular steroid therapy is not palliative in osteoarthritis." What we stated² was that "in the therapy of osteoarthritis of the knees, when the choice lies between short wave diathermy and intra-articular therapy, it would appear that short-wave diathermy should be given first." Nor have we suggested that "intra-articular steroid therapy . . . is so dangerous in rheumatoid arthritis that it should be abandoned." What we have in fact said³ is "intra-articular hydrocortisone acetate and

tertiary butyl acetate have a valuable role to play, particularly in patients with rheumatoid arthritis. If a course of such intra-articular therapy is contemplated, however, strict radiological supervision is essential." Since we have seen no facts to contradict the careful observations which form the basis of these conclusions, we have not retracted them.

May we also be permitted to add that because a paper is "studded with controls and statistical analyses" this does not detract from its value, as some might infer from Professor Hollander's letter. Indeed there are some who are of the opinion that a scientific approach to medicine demands careful control and statistical analysis, particularly in the assessment of treatment of diseases where bias and chance have so commonly led to favourable reports of remedies now discarded. We are not in fact completely out of line with all other reports, as Dr. Hollander's letter suggests, and we would draw his attention to a detailed study⁴ of 181 patients with osteoarthritis reaching conclusions similar to ours.—We are, etc.,

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Endomyocardial Thickening

SIR,—As Asher has wisely said, "The words used in clinical medicine have a tremendous influence on the subject they describe or purport to describe."¹

Dr. M. Black and Dr. J. M. Fowler, in their article entitled "Endomyocardial Fibrosis in Britain" (13 March, p. 682), have rightly drawn attention to the fact that fibrosis of the myocardium and endocardium are sometimes associated in the absence of coronary artery disease. In their summary they refer to "the disease": but which disease? Throughout their paper, and also in several of the earlier ones quoted by them, there is considerable confusion.

A usual cause of confusion is the lack of a common semantic referent. The terminology in this paper is a good example of this. The authors refer to Davies's review of disorders of mural endocardium² but ignore the help he offers in this difficult field of cardiology by his description of at least six forms of endocardial thickening,³ and by his insistence on the state of the elastic tissue as an indication

of whether the original endocardium has been merely thickened or else replaced by scar. Because of this their review of the literature contains papers describing a very heterogeneous collection of conditions—Becker's disease,⁴ endocardial fibro-elastosis,⁵ and probably Loeffler's disease,⁶ as well as the absolutely distinct clinical and pathological entity reported from East and West Africa and a few other places, and known to cardiologists as endomyocardial fibrosis.⁷ The papers they list from Britain alone describe possible examples of the last three of these conditions, which are all separable on histological grounds.⁸

It is perhaps unfortunate that for cardiologists the term "endomyocardial fibrosis" has come to have a meaning more specific⁹ than just fibrosis of the endocardium and myocardium; but it is so, and ignoring this merely adds to confusion. In their five interesting cases Dr. Black and Dr. Fowler state that "the elastic lamina of the original endocardial layer could usually be identified,"

and in two cases there was actually excess elastic tissue. In some there was considerable left ventricular hypertrophy without incompetence of the mitral valve. These features do not suggest endomyocardial fibrosis in the usual sense of the term.

When, as at present, disorders are emerging as separate entities from a perplexing confusion it is more helpful to be a "splitter" than a "lumper," so long as the "splitting" is based on sound distinctions. Only by "lumping" could all the five cases described by Dr. Black and Dr. Fowler be regarded as examples of endomyocardial fibrosis, or endomyocardial fibrosis be said to have a truly world-wide distribution.—I am, etc.,

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Testing for Phenylketonuria after Infancy

SIR,—While the scheme for the routine testing of urine of young babies for phenylpyruvic acid is proceeding reasonably well, there is evidence that this is not always carried out in routine urine testing of older children. Some hospital centres carry out the appropriate tests on routine samples of urine provided for tests for albumin and glucose, but this may only occur in selected clinics, usually in the general medical out-patient clinics or in the medical wards, and the practice is by no means universal, especially as fresh specimens are essential for the detection of the volatile phenylpyruvic acid. Certain categories of children are definitely at risk. These are children with eczema, fits, or mental retardation. Siblings of children known to have phenylketonuria should obviously be investigated, but they should have serum-phenylalanine estimations performed. Examination of urine for phenylpyruvic acid is too unreliable in this situation.

Perhaps one reason for neglecting to carry out tests in older children is the mistaken impression that nothing can be done for them. This is not a general experience. Some children after infancy will show a rise of 15 to 20 points in their intelligence quotients after they have been placed on a phenylalanine-restricted diet, and some do even better. This may lift them from being classified as unsuitable for education into the educationally sub-normal category. A few may even attend