Case No	Placebo or lymecycline*	Triggering agent	HLA-B27 present	Age (years)	Highest erythrocyte sedimentation rate (mm in first h)	No of swollen joints	Low back pain
1	Placebo	Yersinia	Yes	26	103	7	Yes
2	Placebo	Yersinia	Yes	27	138	6	Yes
3	Placebo	Yersinia	Yes	39	120	1	Yes
4	Placebo	Unknown enteritis	Yes	45	117	1	Yes
5	Placebo	Chlamydia	Yes	23	12	1	Yes
6	Placebo	Chlamydia	Yes	47	110	7	Yes
7	Placebo	Chlamydia	Yes	42	57	13	Yes
8	Placebo	Chlamydia	Yes	25	113	7	Yes
9	Lymecycline	Campylobacter	Yes	41	128	2	Yes
10	Lymecycline	Unknown enteritis	Yes	30	79	6	Yes

*In combination with non-steroidal anti-inflammatory drug.

two in the lymecycline group had radiological changes ($P=0.028$ by Fisher's exact test).² The table shows the clinical characteristics of the 10 patients. Because the x ray pictures were not taken during the course of the disease according to standard protocol, the finding is only preliminary and needs to be confirmed by standard methods and in more patients.

Our recent results suggest that the possible anti-inflammatory and anticollagenolytic potential of long term treatment with tetracycline or doxycycline in combination with a non-steroidal anti-inflammatory drug is not restricted only to post-venera arthritis^{2,5} as described by Svenungsson. I agree with Svenungsson that prospective case-control studies in patients with well defined disease are needed before antibiotic treatment for reactive arthritis can be firmly recommended. I suggest that the anti-inflammatory and anticollagenolytic aspects of combined treatment with tetracycline and doxycycline with a non-steroidal anti-inflammatory and their possible role in tissue destruction and radiological changes also be taken into account when large, possibly multicentre, studies on treating reactive arthritis are being planned.

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Women consultants

EDITOR,—Julia Cumberlege refers to the part time consultant scheme as a method of encouraging NHS managers to "consider the business advantages of part time appointments."¹ Readers might be interested in the details of the scheme: close analysis shows business disadvantages.

Firstly, the funding is restricted to three years but is not rolled over. Funding was available from 1 April 1993, but invitations to bid were structured so that candidates could not possibly be in post by that date. Our local services were invited to bid two to three months later, and the Department of Health made decisions towards the end of the

calendar year. We have now appointed someone to start next June, with only about half of the original funding currently available to us.

Secondly, in the scheme the Department of Health guarantees funding at the full level for only the first year, and it is hoped that funding will continue at the same level for whatever is left of the original three years.

Thirdly, purchasers are required to sign an undertaking to pay the subsequent costs. In practice, I suspect, budget holders will be required to make the "cost efficiency" savings our purchasers have been inflicting on us for the past three years, whereby we continue to provide the same level of service for less.

Business managers would be well advised to look carefully at the next tranche (presumably funded by the unspent money resulting from the first scheme) before committing their services to something they may not be able to afford. This apparent concession to professional women trying to combine careers and domestic commitments does not stand up well to closer scrutiny.

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Cutaneous T cell lymphomas

EDITOR,—We were disappointed by the slightly negative emphasis of Paul A Bunn Jr's editorial on cutaneous T cell lymphomas.¹ Understanding of the whole range of cutaneous T cell lymphomas and their management has progressed considerably in recent years, and it is now clear that there are many variants of primary cutaneous T cell lymphoma with differences in clinical behaviour and prognosis.

We disagree with Bunn's comment that "systematic dissemination is an early feature of all types of lymphomas." In the experience of our skin tumour unit many cases of unequivocal mycosis fungoides have a benign course, and only the minority rapidly progress to systemic disease. Most patients can be maintained on photochemotherapy (treatment with psoralens and ultraviolet A) for long periods and do not need topical nitrogen mustard. The challenge is to try to determine which of the patients who present with early stage disease are likely to have an unfavourable prognosis.

We applaud Bunn's desire for increased numbers of controlled clinical trials. The European Organisation for Research and Treatment of Cancer's Cutaneous Lymphoma Project Group, of which there are histopathological and clinical sections, has been active in the past few years. A register of cutaneous lymphomas has been set up, and data from over 20 European centres are being accumulated long term. Every clinician who contributes cases has access to the computerised data

from other centres. The group is already carrying out clinical trials in mycosis fungoides, an example being a study of whether alfa-2a interferon can prolong remission that has been induced by other modalities such as psoralens and ultraviolet A. In our unit most patients with mycosis fungoides of patch and plaque stage find that their symptoms are well controlled with a combination of photochemotherapy and orthovoltage radiotherapy to individual thick cutaneous lesions.

Finally, we were disappointed that Bunn did not mention photopheresis. Since the original paper reporting encouraging results in a multicentre study was published² there has been wide experience in Europe with this technique. Although the results from many centres are not as good as those originally reported, clearly photopheresis has a useful role in the management of some forms of cutaneous T cell lymphoma, particularly erythrodermic cutaneous T cell lymphoma and the Sézary syndrome.^{3,4} These variants of cutaneous T cell lymphoma can be particularly aggressive, and there is no reliably effective alternative treatment.

The recent founding of the International Society for the Study of Cutaneous Lymphomas, which has a large proportion of members from Europe, should permit important research and carefully controlled clinical trials in this challenging group of disorders.

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Original description of Kaposi's sarcoma

EDITOR,—Kaposi's original description of a new skin tumour, which now bears his name,¹ is remarkably similar to Jonathan Weber's reminiscence.² Kaposi was an internationally respected dermatologist, recognised for his keen eye and careful observations; he is credited with the first description of xeroderma pigmentosum.³ He reported on five patients, all men, from the corners of the Habsburg empire, and also on a Swiss boy.¹ He made no comments about their sexual orientation.

In his paper Kaposi repeatedly emphasised that this new disease was incurable and rapidly lethal. He wrote that: "Die Krankheit führt zum Tode, und zwar innerhalb einer kurzen Frist von 2-3 Jahren . . . Die Krankheit muss nach den vorliegenden Erfahrungen von vornherein nicht nur als unheilbar, sondern auch als lethal gelten." [The disease leads to death and it does so within the short span of two to three years . . . The disease must, according to our existing experiences, be considered a priori not only incurable but also lethal.] Indeed, three of the patients were dead within 12 to 16 months of presentation. On the basis of postmortem findings of characteristic lesions everywhere—not only on the limbs, trunk, and face but also throughout the gastrointestinal tract and in the liver—Kaposi also proposed that