thinning of a joint at first and lipping of its margins later. Thinning of an interlaminar joint is wellnigh impossible to demonstrate, and lipping, except in the upper cervical region, is rare.

Generalized osteoarthritis is often associated with spinal osteoporosis. In a lateral radiograph of a normal spine the vertebral bodies appear white and the spinous processes grey. In spinal osteoporosis decalcification affects first the vertebral bodies, which then appear grey and of the same photographic density as the spinous processes. This appears to be the case in the radiograph of the lumbar spine published by Drs. Kellgren and Moore. In osteoporosis, too, there is usually some lordosis. As a result, the size of the spaces between the spinous processes is diminished; hence the appearance of "kissing" spinous processes. By contrast with the narrow spaces between them, the spinous processes appear to be enlarged.

In conclusion, I would submit that generalized osteoarthritis is a disease occurring especially in females over the age of 40 and affecting especially the terminal and later the proximal interphalangeal joints, the carpo-metacarpal and the metacarpo-phalangeal joints of the thumbs, the knees and hips, and the metatarso-phalangeal joints of the great toes. The interlaminar joints are often affected pathologically, but clinically and radiologically they seldom seem to be affected except in the upper cervical region. Generalized osteoarthritis is often accompanied by acroparaesthesia and by spinal osteoporosis. Backache, when it occurs in association with generalized osteoarthritis, is often relieved by the administration of oestrogens and calcium, and this suggests that it is due to osteoporosis and not to osteoarthritis. The cause of generalized osteoarthritis, acroparaesthesia, and spinal osteoporosis will perhaps be found in the relationship of generalized osteoarthritis to the menopause, the relief of acroparaesthesia by large doses of oestrogens, and the alteration of a negative to a positive calcium balance in osteoporosis by the administration of oestrogens.—I am, etc.,

Mt. Hawthorn, W. Australia. JAMES H. YOUNG.

Tenosynovitis

SIR,—In the treatment of acute and chronic non-specific tenosynovitis there is no mention in the Refresher Course article by Mr. D. Ll. Griffiths (March 22, p. 645) of the routine treatment as carried out in some of our hospitals and clinics. If deep friction as advised by Cyriax (*Rheumatism and Soft Tissue Injuries*, J. Cyriax, 1947) is undertaken in these cases, all other forms of therapy can be dispensed with, to the greater satisfaction of the patient and the doctor. I now tell my patients in general practice what to do and how to do it, advising them to get a relation to perform the deep friction.—I am, etc.,

Ryde, I.W. T. HAMBLY.

Family Planning

SIR,—It is unlikely that anyone will find fault with this memorandum (March 15, p. 595), which, so far as it goes, is a perfectly satisfactory document. On the question of women seeking advice, we are told that they are those who on medical grounds have been advised to avoid pregnancy, and secondly that there is a group of women who wish to plan their family with intervals between the birth of the children. Now it seems to me that nowhere in this memorandum is it suggested that the post-natal clinic would be the place to carry out this practice. The obstetrician, with his notes in front of him, can see if the patient has had hypertension, cardiac disease, renal disease, etc. He will know if it is advisable for this woman to have more children or not, and he is the person to fit the patient then and there with some contraceptive appliance and to see that she is instructed in its use. Similarly with the patients who have had two or three children in rapid succession and who look tired and anaemic, etc.

It is always somewhat surprising to me to have to set up special clinics for contraceptive advice when clinics exist but are not being used.—I am, etc.,

London, S.E.3. KEITH VARTAN.

Familial Erythema Nodosum

SIR,—The account given by Mr. John Fry (March 8, p. 529) of erythema nodosum affecting three members of a family emphasizes the danger of open tuberculosis in the home to a young family. In an article on the aetiology of erythema nodosum (*Brit. J. Derm. Syph.*, 1936, **48**, 123) I recorded a similar occurrence of five cases of erythema nodosum in a family of eight children. The cases were admitted to hospital within a week of each other. A month previously one of the family, aged 18 years, had a haemoptysis and a widespread infiltration of one upper lobe. One child, aged 6 years, with erythema nodosum showed an opacity in the lung and enlarged hilar glands and subsequently developed tuberculosis of the lung. Another child, aged 16 years, also had enlarged hilar glands and two months later developed a small opacity in the lung with increase in the size of the glands.

It is vital to regard erythema nodosum in children as a manifestation of early tuberculous infection unless proved otherwise. These children should be kept under close observation for a period of a year.—I am, etc.,

London, W.1. L. FORMAN.

Intra-articular Streptomycin

SIR,—I was interested to see the article by Dr. R. T. Ahern and Mr. G. P. Arden (March 1, p. 466). My own work on intra-articular penicillin has been followed by a study of the intra-articular use of streptomycin. After injections of 1 g., streptomycin may be recoverable from the joint for at least a week, and after five or six injections has been found to persist for a much longer period, often over six weeks. Local assay is possible only by joint washing, since effusions tend to dry up rapidly after the first few injections. If injections are given into joints at weekly intervals it is probably necessary to use streptomycin intramuscularly as well.

Ahern and Arden have followed up their cases for a "fairly short" period (average 20.4 months). To a student of tuberculosis, any conclusions drawn from such a short period of observation would obviously be worthless. I would like to issue a word of warning. Two of my cases followed up for over three years have suffered reactivation with serious bone involvement, although at two years they were apparently doing well and gaining mobile joints. I am glad to see that the authors use the methods of conservative treatment in association with streptomycin. There are, however, dangerous experiments being carried out in other centres where immobilization and general treatment are being neglected. Streptomycin may enable us to shorten our period of treatment, but should be used only as an adjunct to the well-tried methods that our experience has taught us to adopt in the past.—I am, etc.,

Exeter. G. BLUNDELL JONES.

Tooth in Tonsil

SIR,—Foreign bodies embedded in the tonsil are sufficiently rare to warrant recording. I have just seen a 16-year-old girl who was referred to me because of the presence of something hard in the tonsil. This had caused no discomfort, but the patient had noticed something unusual about the right tonsil when she was looking at her throat in the mirror. On examination, a greyish mass was seen at the site of the opening of the crypta magna of the right tonsil. This was hard and brittle to the touch. The mass was removed and found to be a rough concretion about ⅜ by ½ by ⅜ in. (1 by 1.3 by 1 cm.), in which was embedded a primary incisor tooth. Neither the patient nor her mother could remember any incident in which a primary tooth could have been lost.—I am, etc.,

Liverpool G. A. MOULDEN.