—unless, of course, one is to fly to the blood bank and demand blood at once, thus increasing the risk of incompatibility. Dr. Barnard's fears seem to be based mainly on work *in vitro*. I agree that when dextran is mixed with blood in the test-tube many peculiar things happen: but if dextran is mixed with the blood remaining in an exsanguinated patient the patient gets better.

I have never done "dextran compatibility tests" and I do not intend to start until it is shown that they would serve a useful purpose; nor do I propose to allow Dr. Barnard's largely theoretical fears to overwhelm my practical experience, which is that patients who have had a sudden severe haemorrhage can usually be revived by dextran infusion, and that in such circumstances dextran is safer than plasma or whole blood.—I am, etc.,

London, N.W.10. GEORGE DISCOMBE.

"Status Lymphaticus"

SIR,—In his article on "Status Lymphaticus" (*Journal*, January 16, p. 149) Dr. H. B. Dodwell, presumably in support of his views, quotes from Boyd's *Textbook of Pathology*[1] the author's statement that "there is no proof that the thymus gland has anything to do with stoppage of the heart." A few lines above this Boyd writes: "There is no doubt that the diagnosis of status lymphaticus or enlarged thymus has been much misused at coroners' inquests, but on the other hand there does appear to be some relationship between lowered constitutional resistance to certain otherwise trivial injuries and a condition of lymphatic hyperplasia. I may quote the following case from the medico-legal practice of my colleague Dr. Erb, which is surely sufficient proof that the concept of death from status lymphaticus is not a pure myth. One of a group of children who were playing on the road was struck down by a motor car and injured. He did not die, but a little lad watching the accident from an adjoining lawn fell dead. At post mortem the child was found to have an enlarged thymus, a thin-walled hypoplastic aorta, and marked hyperplasia of the lymphoid tissue throughout the body."

I submit that if the above illustrates the way in which Dr. Dodwell has made use of the subject-matter reviewed then his researches on the subject of status lymphaticus, which appear to be entirely literary, must be regarded with misgiving.—I am, etc.,

Alloa. W. B. LAING.

REFERENCE

[1] *Textbook of Pathology*, 1947, 5th ed., London.

SIR,—May I reply to the letters criticizing my article on the above subject (*Journal*, January 16, p. 149) which have appeared in the *Journal*? Dr. H. Ucko (*Journal*, February 13, p. 398) would appear to be discussing an entirely different pathological condition; no report of any case of status lymphaticus that I have ever read has described a patient who, prior to unexpected sudden death, displayed anatomical anomalies, recurrent asthma, lymphocytosis, and evidence of the breaking down of the nuclei of lymphocytes. Had this syndrome been associated in this country with sudden death surely a few cases among the two hundred odd deaths per annum would have been described.

Dr. C. Langton Hewer (*Journal*, January 30, p. 274) raises two points of objection to my views—the late Sir Bernard Spilsbury's expressed opinions, and my denial of Dr. Kemp's case records. With regard to Sir Bernard's view, there is no supporting published evidence, the Medical Research Council's Committee found no association between enlarged thymus glands and enlarged lymphatic glands, the only writers to publish a series of narrowed aortae in unexpected deaths found no enlargement of the thymus gland, and I have failed to find any collection of cases of fatty infiltration of the myocardium in sudden death in the young. As to Dr. Hewer's view that it is incredible that Sir Bernard could have pursued a chimera for so many years, surely it is equally incredible that the twelve distinguished members of the Medical Research Council's Committee should have been thoroughly misled after such painstaking collecting and weighing of evidence?

Turning to Dr. Hewer's second point, I certainly owe Dr. Kemp an apology for stating that he did not cite any cases; he did not do so in the article originally quoted by Dr. Hewer but did cite five cases in his article (which I overlooked) in the *Canadian Medical Association Journal* for 1933 and which, together with two other cases, were reported again in *Elementary Anaesthesia*.[1] I cannot agree with Dr. Hewer in regarding this article as an excellent account, since only a bare majority of the cases have the weights of the thymus glands recorded and all the deaths are capable of another explanation—thus, of the two tonsillectomies, that with the really large thymus gland was found after death to have some blood in the lower trachea, and that with the slightly enlarged thymus some venous congestion of the lungs. Of the five non-operative cases, in only two is the weight of the thymus gland stated; both infants found dead showed cardiac petechiae and the other three cases had been ill for from fifteen hours to two days, one of them having a "chest full of rales" shortly before death.

Finally, in his historical account of status lymphaticus Dr. Kemp, in dealing with the article published in Vienna in 1889 from which Osler took his account,[2] states that Dr. Paltauf had "access to a vast quantity of clinical pathological material and from his wide experience advanced the view . . ."; Dr. Kemp is obviously confusing the author with his elder brother, since the author Arnold Paltauf died in his thirty-third year, four years after the article was published, while it was his elder brother Richard Paltauf who subsequently became in 1898 professor of pathology in Vienna, dying in 1924.—I am, etc.,

London, N.7. H. B. DODWELL.

REFERENCES

[1] *Elementary Anaesthesia*, 1948, Baillière, Tindall and Cox, London.
[2] *Principles and Practice of Medicine*, 1898, 3rd ed., London.

SIR,—The cycles of the old, and some of the new, arguments for and against "status lymphaticus" have been moving again in your correspondence. The observations of Dr. H. Ucko (*Journal*, February 13, p. 398) are not only interesting but seem to relate reasonably thymic hyperplasia with adrenal, or pituitary adrenocortical, deficiency in a lack of resistance to stress.

In gross morbid anatomical study of cases of "status lymphaticus" 25 years ago I noticed that a common finding was peculiarly small adrenals. I am now therefore quite interested in Dr. Ucko's final observation that the hypothesis (adrenocortical deficiency) could easily be verified by investigations into the adrenal cortical reserve of cases with suspected status thymo-lymphaticus. Perhaps some specially skilled team will take up this well-worth-while study.—I am, etc.,

Bristol. A. V. NEALE.

Cortisone and Manipulation of Knee-joint

SIR,—With all due deference to the distinguished members of the Medical Research Council subcommittee, I would like to make a few comments on their recent report (*Journal*, January 30, p. 233) concerning the effect of cortisone as an adjuvant to manipulation in rheumatoid arthritis. No one to-day would use systemic cortisone in preference to topical hydrocortisone to cover the manipulation required to straighten a knee-joint fixed in flexion. It is presumed that when these therapeutic trials were initiated hydrocortisone was either not readily available or its advantages in this situation were not recognized; in either event, it would be interesting to observe the result of further studies, similarly controlled, using intra-articular hydrocortisone.

It is noted that in all cases in this series the contralateral knee was also affected, though less severely than the one selected for manipulation; however, there was no significant difference between the cortisone-treated and codeine-treated groups, the contralateral knee in each group showing some slight improvement. To anyone not entirely familiar with the indications for cortisone therapy, these results might