treated in this way. Surface abscesses were also drained when aspiration failed to clear them.

We would like to emphasize these points so as to spare any disappointment to our colleagues in the tropics when they are faced, as they will be, with such situations.—We are, etc.,

St. Ola,
Orkney Isles

PETER KONSTAM

Shotley Bridge Hospital,
Shotley Bridge, Co. Durham

ARY BLESOVSKY

¹ Konstam, P. G., and Blesovsky, A., *British Journal of Surgery*, 1962, 50, 26.

SIR,—Your leading article on this subject (4 December, p. 613) was no doubt justified by the recent reports you quoted. There was, however, one outstanding flaw in your review which was to my mind almost criminally negligent. You did not draw attention to the fact that it was in the cases treated in an ambulant manner that paraplegia developed during treatment. I feel that you should draw attention to this and that any one treating tuberculosis of the spine in the ambulant manner for the first time should confine his experiment to patients with the disease located below the termination of the dura and particularly not in the dangerous vertebrae, dorsal 4-8.—I am, etc.,

RANDLE LUNT

Boylestone, Derbyshire

** Mr. Lunt has done well to draw attention to spinal cord involvement in tuberculosis of the spine. Because of limitation of space the leading article to which he refers dealt almost solely with healing of the vertebral disease. However, Mr. Lunt, as a consultant in orthopaedic tuberculosis, will certainly have studied the four reports referred to, even though he has drawn conclusions diametrically opposed to the evidence that they showed.

Of 268 followed-up patients treated as ambulant outpatients, three who had been free from central nervous signs on admission to the trials developed paraparesis. None became unable to walk. Two recovered completely on ambulant chemotherapy alone and the third after an operation which hindsight suggests might have been unnecessary. Mr. Lunt will recollect that the leading article did not advise ambulant chemotherapy as the sole method of treatment in circumstances in which radical surgery is safe. When he has demonstrated, not merely implied or asserted, that any other method of treatment produces a lower incidence of paraplegia his charge of "almost criminal" negligence in recommending ambulant treatment in places where surgical facilities are scarce will call for an answer. On the evidence of the Medical Research Council's reports it does not do so at present.—Ed., *B.M.J.*

Cyclophosphamide in Treatment of Nephrotic Syndrome

SIR,—We would like to comment on the excellent article by Professor J. S. Cameron and others (5 October, p. 7). They reported sustained remission after cyclophosphamide treatment in 20 out of 58 children

with corticosteroid-sensitive but relapsing nephrotic syndrome and "minimal-change" lesions on renal biopsy.

We recently reported¹ the results of short-term cyclophosphamide therapy in 13 adults and four children presenting with the nephrotic syndrome or persistent proteinuria, normal renal excretory function, and either mild but definite glomerular lesions (14 patients) or no glomerular abnormalities on light microscopy (3 patients). Sustained remission of proteinuria for 5-22 months (mean 12.7 months) was obtained in 11 of the 17 patients and clinical improvement seen in four other patients. The onset of remission was usually prompt (within three months of starting treatment in nine patients). The response was independent of the duration of disease and histological diagnosis—60-75% of patients with focal proliferative glomerulonephritis, diffuse proliferative glomerulonephritis, and mesangiocapillary glomerulonephritis obtaining complete remission. Two patients conceived normal children after cyclophosphamide treatment. In only one patient, aged 14, was amenorrhoea seen seven months after therapy.

We suggest that cyclophosphamide given for a short period has a definite role in patients with glomerular lesions other than minimal change and that short-term therapy may avoid the reported toxicity to gonadal function.—We are, etc.,

L. S. IBELS
A. A. PALMER
J. F. MAHONY
J. H. STEWART

Kanematsu Memorial Institute,
Sydney Hospital,
Sydney, Australia

¹ Ibels, L. S., et al., in *Drugs and the Kidney*, ed. K. D. G. Edwards. *Progress in Biochemical Pharmacology*, vol. 9, Basel, Karger, 1974.

Fish Tank Granuloma

SIR,—A woman aged 46 cut her hand cleaning a fish tank. After 12 months a small unhealed lesion remained over the head of the fourth metacarpal. No foreign body was found on exploration. Some weeks later the back of her hand and wrist became swollen. At operation a chronic thickened synovium of the extensor tendon was excised. No bacteriological examination was made, but sections of a substantial portion of the thickened synovial tissue showed a granulomatous reaction with small numbers of giant cells but no caseation or necrosis. No acid-fast bacilli were found. Urine, E.S.R., and chest radiograph were all normal. After the biopsy a comparative skin test was carried out using five units of tuberculin (P.P.D.) and an equivalent dose of *Mycobacterium marinum* antigen. Induration 20 mm in diameter resulted from the latter but less than 6 mm from the P.P.D.

Myc. marinum lives in water and is an opportunist pathogen of aquatic animals, including man in the role of swimmer or keeper of pet fish. Risks from it in the latter hobby have been noted.^{1,2} The organism grows very poorly at 37°C, and presumably for this reason human infections are always cutaneous. They present in two main ways: (1) as indolent localized but sometimes extensive lesions of the skin, first papular and then nodular, which may become verrucous or may develop pustules or liquefying granulomata; (2) a sporotrichoid-like infec-

tion initially seen at the site of an injury but followed by the lymphatic spread of skin lesions, which may be nodules or abscesses and from the hand may reach to the axilla.

The present case is of interest because a rather trivial lesion was activated by surgical exploration and the extension of inflammation resulted in tenosynovitis, a complication which appears not to have been previously recorded and which represents a deeper incursion into the tissues than is usual. Histology of the synovium suggested the possibility of a *Myco. marinum* infection and prompted the skin test, which strongly supported the hypothesis. Unfortunately the connexion of indolent skin lesions with aquaria is still not generally known. An initial bacteriological examination and skin test in this case would have led to effective treatment and saved two operations. Perhaps recognition would be helpful by encouraging the memorable name "fish tank granuloma," which has been suggested for the condition.—We are, etc.,

R. L. HAY
O. R. MCCARTHY

Medway Hospital,
Gillingham

J. MARKS

Tuberculosis Reference Laboratory,
Cardiff

¹ *British Medical Journal*, 1970, 2, 438.

² Barrow, G. I., and Hewitt, M., *British Medical Journal*, 1971, 2, 505.

Complication of Austin Moore Prosthesis

SIR,—I read with interest the letter of Mr. O. N. Vyas and Mr. A. K. Varshneya (14 December, p. 658), and I am surprised to hear that insertion of the Austin Moore prosthesis is performed in some centres under x-ray control. Surely this is unnecessary as this procedure is virtually performed under direct vision.

This point, therefore, leads to a comment on the purpose of their letter—namely, the insertion of a probe into the femur. If the femoral shaft is carefully reamed out the alignment of the reamer is readily checked and thus will ensure that it passes along the line of the femur. Similarly, the shaft of the femur below the trochanter may be palpated while reaming and when the prosthesis is being inserted. The problem of lateral protrusion of the stem is thus easily avoided. I therefore feel that this additional step seems unnecessary in an operation that has been performed on countless occasions in different parts of the world.—I am, etc.,

M. I. B. BESSER

Lewisham Hospital,
London S.E.13

Mithramycin for Hypercalcaemia Associated with Myeloma and other Malignancies

SIR,—In his review of myelomatosis Dr. J. S. Malpas (30 November, p. 520) recommends that neutral phosphate be used to treat associated hypercalcaemia when dietary restriction, fluids, and prednisone prove ineffective. Oral phosphate is, however, impractical if the hypercalcaemic patient is nauseated or vomiting and intravenous phosphate infusion carries the risk of ectopic calcification, which may prove fatal.¹ We