contribute aptitudes which they do not possess, hence there is exchange.

Christ lived and He showed us how to turn our longings to success: we must think of others not of ourselves. It has never been refuted that He rose from the dead, and His spirit is with us if we want to accept it.—I am, etc.,

MARY D. SMITH

Glasgow

Infantile Hodgkin's Disease: Remission after Measles

SIR,—The remission of Hodgkin's disease in children after measles is a rare event.[1 2] I should like to report a cure seen at the Paediatric Clinic (Professor S. Bessa), University Hospital, Coimbra.

A 23-month-old caucasian male was seen for the first time in April 1970 with a large mass in the neck due to hypertrophy of the left cervical lymph nodes (see fig.). The mass had first been noticed in November 1969. The child had no fever or pruritus, the chest *x*-ray film was normal, the E.S.R. was 9 mm in the first hour, and the haemogram was normal with no eosinophilia. An intradermal skin test to *Candida albicans* antigen 1 : 100 (Bencard) was negative. A diagnosis of predominantly lymphocytic Hodgkin's disease was made on the histopathological findings of lymph node biopsy (Professor R. Trincao).

Before radiotherapy could be started the child developed measles. Much to our surprise the large cervical mass vanished without further therapy. The chest *x*-ray picture remained normal but the haemogram showed pronounced leucopenia (3,400/mm³). It was decided not to start radiotherapy, and the child remained symptom free for six months. New intradermal tests for Candida were done 2-5 months after the measles episode, and this time they were positive. The immunoglobulins remained normal.

In November 1970 the child's mother noticed he had erythematonstash soon after he had drunk some wine. It covered the face and the area of the neck corresponding to the site of the lymph node biopsy, where enlarged lymph nodes were again palpable (fig.). The haemogram, chest *x*-ray film examination, and Candida skin test were repeated. There was pronounced oesinophilia (11%), the chest *x*-ray film remained normal, and the response to Candida was again negative. Another biopsy showed Hodgkin's disease of mixed cellularity. In view of this relapse irradiation with cobalt-60 was started, and after a total dose of 3,000 rad at the rate of 300 rad every other day (Portuguese Institute of Ocology, Coimbra) the child re-entered a remission period which has lasted for 18 months.—I am, etc.,

H. CARMONA MOTA

Department of Paediatrics,
University of Coimbra,
Portugal

1 Hernandez, S. A., *Archives Cubanos de Cancerologia*, 1949, 8, 26.
2 Zygiert, Z., *Lancet*, 1971, 1, 593.

Research Investigations in Adults

SIR,—With reference to the tape-recorded discussion on this subject (28 April, p. 220) there must be few who would dispute the necessity and value of ethical committees in all hospitals, especially where there is a research interest, but their work must extend further than the walls of a committee room where the members deliberate on the moral and scientific aspects of any project.

As a ward sister in the clinical research centre at Northwick Park I was very aware of conflict experienced by those concerned with the day-to-day care of patients involved in research. The question of informed consent is indeed difficult. I always felt it my responsibility to be sure that any patient understood fully what was happening to him, whether or not it was research, and that he knew he had the right to refuse without any repercussions. Even though most consultants are good at explanations, there are still many patients who are afraid of them and feel happier asking questions of a nurse or junior doctor whom they see every day. In fact this pays dividends, as once the patient feels involved in his own investigation or treatment he is more co-operative and everything runs more smoothly. On several occasions I was asked, "Is this the guinea-pig hospital?" and it is only by being absolutely honest with patients and their relatives that the community's trust in its hospital will be maintained, especially when routine procedures become more complex and less comprehensible.

This draws to light the dual position in which the nurse (and also to a large extent the junior hospital doctor) in a research team finds herself. On the one hand she feels it her duty to protect the patient against the enthusiasms of investigators, and on the other she is part of a team striving to achieve a particular goal, and this can sometimes present difficulties. If she is too much on the side of the patient she may be pressurized by the medical staff and if she is inclined the other way she (quite rightly) has to justify the investigations to the junior nurses.

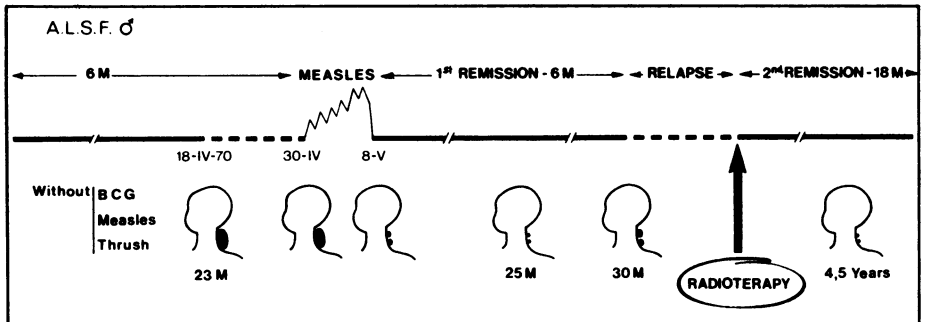
A third difficulty, and possibly the most disturbing, is that it can be very difficult to distinguish between clinical research and beneficial investigation. I trained as a nurse, not a scientist; my knowledge of the sciences and technology is basic, and therefore explanations and understanding of some projects can be difficult. (Indeed, can all doctors understand one another's work?) In this situation an investigator could "pull the wool over the eyes" of the ward sister or she might, wrongly, think this is happening. If her trust and co-operation are to be maintained it is vital that there is someone to whom she can turn for unbiased advice.

Lastly, never let it be said that any procedure is trivial; even a 24-hour timed urine collection may cause anxiety if it means that a mother has to spend an extra night away from her young children, and I have known the fear of venepuncture the next morning disturb a patient's sleep.

As Dr. M. D. Eilenberg pointed out in the discussion, the best way to ensure ethical control is to establish an "ethical climate." This will not be achieved if the committee is a remote body sitting in an ivory tower. It must make itself aware of the effect of its decisions and be accessible to the opinions of everyone—including the most junior of students and the patients themselves—if there is to be the mutual trust vital for the survival of any institution.—I am, etc.,

JANET E. ANDREWS

Ilford, Essex



SKIN TESTS	CANDIDA	NEGAT		++	++	NEGAT	++
	DNFB					SENSIT	+++ +++
SYSTEMIC SYMPTOMS		ABSENT				ABSENT	ABSENT
ESR (1st hour)		9mm					10mm
CHEST X-RAY		N	N			N	N
WBC		20,300	3,400			28,200	11,200
LYMPH %		59				24	22
NEUTROPH %		26	10			61	72
EOSIN %		5				11	0
PATHOLOGY		LIMPHOCYTE PREDOMINANCE				MIXED CELLULARITY	

Treatment of S.L.E Nephritis

SIR,—The article on treatment of systemic erythematosus (S.L.E.) nephritis with chlorambucil by Dr. M. L. Snaith and others (28 April, p. 197) provokes comment. In the first place it seems that when faced with steroid intolerance, rather than try alternate-day therapy, high-protein diet, combination with diuretics, and other immunosuppressives such as azathioprine to achieve steroid-sparing effect, they have chosen to change to chlorambucil. This is a nitrogen mustard derivative like cyclophosphamide, which they have shown to produce amenorrhoea, and it is surprising that they claim that it produces less marrow suppression. Such has not been my experience in treating cases of cold agglutinin haemolytic anaemia with this drug.

I find the suggestion that chlorambucil could be superior to cyclophosphamide equally surprising; no theoretical basis for this is given. While not denying that cyclophosphamide therapy has its complications,