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.,

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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.

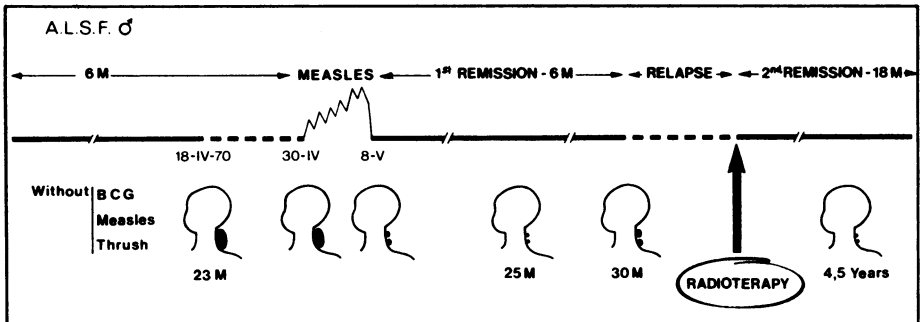
A third difficulty, and possibly the most disturbing, is that it can be very difficult to distinguish between clinical research and beneficial investigation. I trained as a nurse, not a scientist; my knowledge of the sciences and technology is basic, and therefore explanations and understanding of some 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,

it has alone the theoretical advantage of inducing immune tolerance,[1] has a suppressive effect on experimental autoimmune disease,[2] and is more effective than other alkylating agents in suppressing antibody production.[3]

Accepting the fact that patients may be too few for a controlled trial, I feel that patients given treatment of this type should have frequent scientific assessment of the activity of their disease. In the case of S.L.E. one might expect a record of frequent estimations of α_2-globulins, complement components, cryoglobulins, serum DNA, and RNA antibodies, as well as L.E. cells and antinuclear factor.—I am, etc.,

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1 Dukor, P., and Dietrich, F. M., *International Archives of Allergy*, 1968, **34**, 32.
2 Gerebtzoff, A., Lambert, P. H., and Miescher, P. A., *Annual Review of Pharmacology*, 1972, **12**, 287.
3 Lemmell, E., Hurd, E. R., and Ziff, M., *Clinical and Experimental Immunology*, 1971, **8**, 355.

Treatment of Systemic Lupus Erythematosus

SIR,—With reference to the report by Dr. M. L. Snaith and his colleagues (28 April, p. 197) concerning the choice of immunosuppressive drugs in systemic lupus erythematosus, our experience has been that the marrow-depressant effect of azathioprine when used in the treatment of rheumatoid arthritis in a dose of 2·5 mg/kg/day or cyclophosphamide in a dose of 1·5 mg/kg/day has been relatively easily controlled with adequate monitoring of the blood, including platelet counts.

An important difference, however, has been the effect of cyclophosphamide on fertility in the male. We found that six male patients on azathioprine had entirely normal sperm counts. In contrast, of six males on cyclophosphamide, five were found to be azoospermic and one had a count of only 5 million/ml. If chlorambucil produced amenorrhoea in four of six patients in Dr. Snaith's series, it seems likely that its effect on fertility is similar to that of cyclophosphamide.

We would suggest, therefore, that there are strong grounds for first considering azathioprine when an immunosuppressive agent is indicated in young patients with connective tissue disorders.—We are, etc.,

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A. M. BROWNJOHN
JACQUELINE HARRIS
JOHN WOODLAND

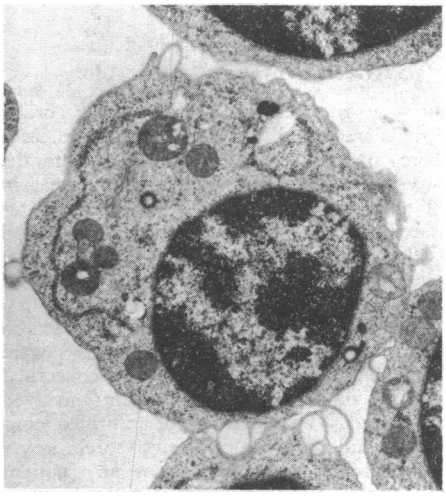
The London Hospital,
London E.1

Surface Particles on Leukaemic Lymphocytes

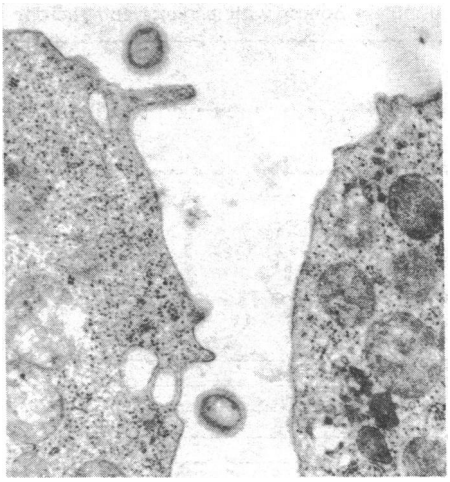
SIR,—In a previous letter (20 January, p. 172) I reported the presence of surface particles on leukaemic lymphocytes from five cases of chronic lymphatic leukaemia and one of acute leukaemia.

After this report had been published a patient aged 41 who was 26 weeks pregnant was diagnosed as having chronic lymphatic leukaemia—a very rare coincidence. Blood was taken from the patient a day after leukaemia was diagnosed. Lymphocytes were separated as described by Hughes and Caspary,[1] the procedure taking about 2½ hours. The patient was admitted again for obstetric reasons at 38 weeks and the baby was born four days later. Blood was taken immediately from the umbilical cord and an hour later from the mother. A third specimen of blood was taken from the mother three weeks later. From all samples of blood lymphocytes were separated and embedded with the same procedure as described in detail elsewhere.[2]

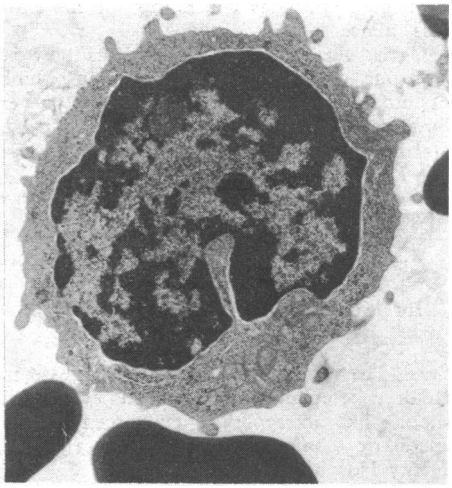
Membrane blebs on the surface of the lymphocytes were a striking feature of the first sample of maternal blood (fig. 1).



Though these blebs were present on the surface of lymphocytes in the second and third samples they did not appear to be as common as in the first. Most of the lymphocytes from the second sample contained granular dense structures similar to those of polymorphs. In all three samples from the mother, besides the blebs, particles were seen budding from the surface of the lymphocytes and a few were free, as described in my previous letter (figs. 1 and 2).



Lymphocytes from the umbilical cord blood appeared quite normal, though they showed pseudopodia; they did not have blebs or particles similar to those in the lymphocytes of the mother (fig. 3).



It has been thought that surface blebs might be artefacts due to the fixation and embedding technique, but the present study clearly indicates the presence of surface blebs and particles in the lymphocytes of the mother with chronic lymphatic leukaemia, as in the other six leukaemic patients studied, while their absence from the lymphocytes from the cord blood and from those of normal subjects does indicate their relationship to the disease. It must be borne in mind that the random sampling variations in the electron microscope may easily give a misleading assessment of the frequency with which a particular structure is encountered, and that this difficulty is increased by the possibility of artefacts even in seemingly "well fixed" material. Although 10 times more lymphocyte blocks were cut from the cord blood sample than from the samples from the mother, there was no evidence that maternal lymphocytes are to be found in the blood of the child.

I would like to thank Dr. F. Clark for his courtesy in allowing access to his patients.
—I am, etc.,

H. K. NARANG

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1 Hughes, D., and Caspary, E. A., *International Archives of Allergy*, 1970, **37**, 506.
2 Narang, H. K. *Journal of Hygiene*, 1973. In press.

FIG. 1—Lymphocytes from 41-year-old leukaemic patient 26 weeks pregnant. Note the surface blebs and particles. x 11,240.
FIG. 2—Lymphocytes from the same patient showing two free virus-like particles. x 19,355.
FIG. 3—Lymphocytes from umbilical cord blood of baby of the same patient. Note normal lymphocyte. x 8,765.

Mute of Malady

SIR,—With reference to your leading article (31 March, p. 755), elucidation of the underlying cause of mutism may be helped by demonstration of thought content. This may confirm a diagnosis of schizophrenic or depressive stupor and can be helpful in the management of elective mutism and some conversion symptoms.

A time-honoured method of achieving this in adults is by amylobarbitone sodium abreaction.[1] Investigators of mute patients, however, are understandably reluctant to administer a powerful central nervous system depressant to patients who may have grave organic brain damage or be suffering from drug effects. Intravenous diazepam has been