in children. It is manifestly unnecessary to emphasise the importance of having these CANCERLINE files available online.

A developing asset

A variety of reasons for needing an online scan may be given by users—remember, these users are medical staff from both Southampton University and the National Health Service, and may be from any part of the Wessex Health Region. A doctor may be writing a paper or chapter and needs articles to read as well as to cite; a research scientist may be reviewing all aspects of intestinal flora; more realistically, a doctor may require to see if the files contain a "match" for a combination of symptoms or complications that are baffling and worrying. Frequently the hoped-for result will be negative; this is particularly so when a drug is being checked for side effects and may lead to the decision to administer a certain drug in the knowledge that no adverse effects have been reported in relation to the condition in question.

As it exists at present, the BLAISE network permits users to log in to the system at their nearest centre or node. Remote centres

exist at London, Birmingham, Manchester, Boston Spa (Yorks), and Edinburgh as well as Harlow, and with the prospect of future developments in telecommunications, costs should be agreeably modified, although this may be offset by a general overall increase in online charges which is being suggested by the systems suppliers.

At the General Hospital branch of Wessex Medical Library an average of five online searches are executed every working day. At the current charge of £30 an hour connect time (that is, for every hour one is connected to the computer), plus extra charges for the number of pages printed offline, updates, supplements for the use of TOXLINE and CHEMLINE, and postage for offsearches, users of the system do not seem in the least inhibited about demanding these expensive searches. Obviously they find them cost-effective. Or, perhaps, there are as many users again who are deterred by the costs, in which case I wonder whether the demand could be met should charges be reduced appreciably.

Reference

- ¹ Welch J. Using *Index Medicus*. Southampton: Dept of Teaching Media, University of Southampton, 1977.

Lesson of the Week

Total knee replacement in unsuspected tuberculosis of the joint

M I B BESSER

Total knee replacement is accepted procedure in treating rheumatoid arthritis and osteoarthritis, but when there is infection in the joint it should not be done. A patient who had an infected knee and had the knee replaced illustrates the hazards, though fortunately what could have been a disaster was eventually a success.

Case report

A 65-year-old man had had pain in his right knee for several years. On three occasions injection of intra-articular steroids had given him some relief. When he was admitted his knee was extremely painful; he had a slight effusion; the joint was in fixed flexion of 20° and flexion was limited to 110°; and movement was painful. He used a stick. X-ray films showed degenerative changes of all the articular surfaces of the knee joint. An Attenu-borough total knee replacement was performed routinely. The synovium was red and hypertrophied. At the time this was thought to be a rheumatoid change. He progressed well. A specimen sent for histology showed that the synovium was infiltrated with tuberculous lesions. Antitubercular treatment was started and routine mobilisation of the knee joint continued. There was never any evidence of inflammation of the knee joint. One year after operation he had no complaints and was pain free.

Frequent intra-articular injections of steroids may induce tuberculous arthritis, which may resemble other arthritic conditions.

The knee joint was cold; there was no effusion; flexion was 0-120°; and x-ray films were normal.

Discussion

The patient showed all the symptoms of a degenerative arthritis of the knee and was treated by total knee replacement. Nevertheless, at operation the synovium showed that in fact he had a tuberculous synovitis. After operation he was given anti-tuberculous therapy and there is now no evidence of infection in that knee. He has made an excellent recovery.

Such a "mistake" is possible, as tuberculous synovitis has been called the great imitator,¹ and the fact that he developed this condition might well be attributed to the steroid injections he had had before he presented on this occasion.²

References

- ¹ Stanish W, Hyndman J, Forsythe M. Skeletal tuberculosis: the great imitator. *J Bone Joint Surg* 1977;59B:511.
- ² Peterson CA. Tuberculous arthritis following intra-articular steroids. *J Bone Joint Surg* 1976;58A:279.

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Department of Orthopaedics "B," Rambam University Hospital, Haifa, Israel

M I B BESSER, FRCS, deputy head