epithelial cells obtained from millipore filter imprints of the conjunctiva in some patients with dry eyes, but did not find these changes in scrapings from these patients.

Perhaps our patient and Marner’s patients with keratitis sicca who had these serpiginous changes really have a form of SLK. On the other hand, perhaps SLK and keratitis sicca have features in common which induce these serpiginous changes.

The cause of this unusual morphology remains obscure as does the cause of SLK. Should these changes be found in other conditions, similarities between such a condition and SLK may help explain the aetiology of SLK.

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AXILLARY OR RECTAL TEMPERATURES IN CHILDREN?

Sir,—The small but real risk of rectal perforation, 1 the comfort of the patient, and the preference of those taking temperatures in children make axillary measurement an attractive alternative to rectal measurement. Correlation of axillary and rectal temperatures by glass thermometry involves waiting 7–10 min for accurate temperature equilibrium in the axilla, but with the electronic thermometer axillary temperature can be determined within a few seconds. Many clinicians feel that the rectal thermometer is an anachronism. One of us (M. D. K.) agreed that the risks of rectal perforation are not greater than the risk of perforation that we have found for children over fourteen months of age. 2 However, electronic thermometer data remain unconvincing. All axillary temperatures need careful interpretation. The risk of rectal perforation can be lowered by more careful temperature reading and by less frequent routine determinations.

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IS HISTIOCYTIC MEDULLARY RETICULOSIS A FATAL FORM OF INFECTIOUS MONONUCLEOSIS?

Sir,—Purtilo 6 has suggested that fatal cases of infectious mononucleosis (IM) may have been misdiagnosed as leukaemia, lymphoma, or histiocytic medullary reticulosis (HMR). As an example, he cited a case of HMR in which the monospot test was positive during the patient’s terminal illness, reported by Merrill and Barrett. 7 In this case, the diagnosis of HMR was based on the necropsy histology and cannot readily be disregarded. There are three other reported cases of necropsy-confirmed HMR in which a positive Paul-Bunnell test had been recorded. 8–10 We have reported 11 a necropsy-confirmed case of HMR in which, like that of Merrill and Barrett, the monospot test was positive. Should all the above-mentioned cases of HMR be re-interpreted as examples of fatal IM? To do this would be equivalent to proposing that the unique histopathology of HMR be included within the spectrum of host responses to Epstein-Barr virus (EBV) infection in man. The cause of HMR is unknown 12 so that this view may be justified, and would be in accordance with suggestions of a role for EBV in the causes of lymphoma, 13 mononucleosis leukaemia, 14 and angioimmunoblastic lymphadenopathy. 15 We have advocated wide use of the monospot test, 16 because of its ready availability, in patients with malaise, pyrexia, lymphadenopathy, hepatosplenomegaly, and progressive pancytopenia; these could be cases of HMR. A positive monospot test would provide an obvious indication for EBV-specific antibody studies to be done.

Eventually, a sufficient number of HMR cases will have been investigated serologically to enable an estimate to be made of how often, if ever, a fatal EBV infection provides the necropsy histology of HMR.

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