

**DOCTORS' PAY**

SIR,—Your editorial, No Cue for Passion (June 13, p. 1269), was a welcome call for sanity in the midst of extremist talk from various quarters—all the more welcome because so many in the profession seem increasingly confused by the rapidly changing situation since the publication of the Review Body's twelfth report.

Your attitude is close to that of the J.H.D.A., whose Executive and Delegate conference feel that the first priority is the re-establishment of satisfactory salary negotiating machinery, in which the J.H.D.A. must play its proper part. This could, of course, include the reappointment of a Review Body with terms of reference similar to that which has recently resigned.

In the meantime, the J.H.D.A., whose attitude has been misrepresented by some, recommends its members to accept their recent salary increase, while it strongly deplors the reference to the P.I.B. of half the award to consultants and general practitioners and feels this should be honoured in full. However, the J.H.D.A. feels that the time for militancy will be when the Government refuses to grant an adequate negotiating machinery; hence it opposes resignations from the N.H.S. and other disruptive tactics for the time being.

Finally, your attitude of caution, and that of the J.H.D.A., have proved to be much wiser than at first we knew, since the change of Government has clearly added new fluidity to the situation. Others may well regret their calls to over-hasty militant action.

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SIR,—There has been no more sophisticated ideal and undertaking than the Health Service, but no social asset more undermined by its intrinsic liabilities. Its present situation, in an emotional field, with added invective from all sides every day, is not in anyone's interest, and apportioning blame to politicians or our plenipotentiaries, is only added fuel to the conflagration; but resignation, even under the greatest provocation, is a resourceless act. The road now must be the shortest one to negotiation, which is the only answer, and never reached by insupportable sanctions or preliminary incriminations.

The strength of the medical profession is unity and the power of the observable justice of a responsibly reasoned case. That there is unanimous dismay in the profession at the present state of affairs there is no doubt, but there is not full unity in response at this time. It is asked, have the profession a special case, a special position? They have such a special position, for the great majority of clinicians are conditioned by years of training to the care of the sick and the surrounding disabilities, no matter what they are doing or wish to do. For most, it has become such a conditioned reflex, performed without thought of financial gain or reasoned obligation, that they do require protection from exploitation. The Health Service has functioned at all only because of uncountable unpaid hours of clinicians' work devoted to administration at all levels. Without this service the structure would undoubtedly have failed and, indeed, many feel that there has been political satisfaction with the title without determination to ensure a fully functional reality. "Paid servants" cannot replace these services, and if these, the greatest assets, are lost, only the liabilities of a health organisation will remain, a skeleton from the past of what greatness could have been achieved.

Everyone's aim must be the rapid resolution of this disagreement and a negotiated settlement of our claims, with a re-established Review Body which is acceptable and

has clear terms of reference. The position at the moment is dynamic, and what is right or wrong today for some is not so tomorrow for all. There is no doubt that our power and strength is in our just claim, and I believe its fulfilment will be achieved by our proper manners and behaviour appropriate to its justice and ourselves. Now is the time for negotiation, not militancy. Everyone must know that much needs to be done apart from the justice of finance, but the floodgates open to aggression and hatred will destroy, not heal, this most necessary humane edifice.

Birmingham 15.

J. M. SMALL.

SIR,—There is really nothing novel about unilateral rejection of an award made by the Review Body. In 1968, the Review Body recommended an increase for the medical-assistant grade. This award was rejected by the B.M.A. They cannot now claim that an award made by an independent body must never be rejected; they set the precedent.

Glasgow W.2.

R. C. R. CONNOR.

### REED-STERNBERG-LIKE CELLS IN LYMPHOCYTIC LYMPHOMA AND CHRONIC LYMPHOCYTIC LEUKÆMIA

SIR,—We have read with interest the reports by Lukes et al.<sup>1</sup> and by Wright<sup>2</sup> on the presence of Reed-Sternberg-like cells in infectious mononucleosis and recurrent Burkitt lymphomas. Lukes et al.<sup>1</sup> emphasised that the Reed-Sternberg cell is probably not pathognomonic of Hodgkin's disease in the absence of the accompanying cellular infiltrates characteristic of one of the histological types of this disease. The findings of Reed-Sternberg-like cells in recurrent Burkitt lymphoma lend support to the view that the Reed-Sternberg-like cell is non-specific. We wish to present further evidence that the Reed-Sternberg-like cell is not by itself specific for Hodgkin's disease.

In the past few years we have observed giant-cells and Reed-Sternberg-like cells—or cells morphologically indistinguishable from Reed-Sternberg cells seen in Hodgkin's disease—in cases of treated malignant lymphoma of the poorly differentiated lymphocytic type (lymphosarcoma). The Reed-Sternberg-like cells were not observed in the pretreatment biopsy specimens. Reed-Sternberg-like cells have also been observed in a splenectomy specimen from a patient with chronic lymphocytic leukæmia. Some of these cells were subsequently noted in the necropsy material.

*Case 1.*—A biopsy was made of a lymph-node from the supraclavicular region of a 45-year-old man with generalised enlargement of lymph-nodes. Histological examination showed a poorly differentiated lymphocytic lymphoma (lymphosarcoma) with a nodular (follicular) histological pattern. The patient was treated with cyclophosphamide, which initially resulted in a decrease in the size of his lymph-nodes. Lymphadenopathy recurred, however, and the patient again received cyclophosphamide and later vinblastine and prednisone. He died 17 months after the disease was diagnosed. At necropsy the lymphoma was found to be widespread, and the histological pattern was no longer nodular but diffuse. An increased number of histiocytic cells was seen among the neoplastic lymphocytes, and Reed-Sternberg-like cells were present.

*Case 2.*—A 49-year-old man was diagnosed as having chronic lymphocytic leukæmia on the basis of generalised lymph-node enlargement, a raised white-blood-cell count of 70,000 per c.mm. with 90% lymphocytes, thrombocytopenia, anæmia, and partial replacement of the bone-marrow by lymphocytes. The white-blood-cell count ranged from a low of 15,000 with 70% lymphocytes to a high of 258,000 with 99% lymphocytes. Three years after the diagnosis was made, splenectomy was carried out because of splenic infarction and subcapsular hæmorrhage. The spleen weighed 1100 g. and was diffusely infiltrated by mature-

1. Lukes, R. J., Tindle, B. H., Parker J. W. *Lancet*, 1969, ii, 1003.
2. Wright, D. H. *ibid*, May 16, 1970, p. 1052.

appearing lymphocytes. Scattered among the lymphocytes were giant-cells including an occasional cell which was morphologically indistinguishable from a Reed-Sternberg cell. Three months after splenectomy, the patient died. He had been treated with radiation, cyclophosphamide, vinblastine, chlorambucil, and prednisone. Occasional giant-cells and Reed-Sternberg-like cells were again found in the widespread lymphoid infiltrates in the necropsy tissues.

The origin of the Reed-Sternberg-like cells in the cases of lymphocytic lymphoma and chronic lymphocytic leukaemia remains obscure. It is conceivable, however, that the Reed-Sternberg-like cells arise from the histiocytic cells scattered throughout the normal lymph-node and usually also seen among the neoplastic cells in lymphomas. These histiocytic cells (which are sometimes more prominent in lymph-nodes, as they are in the bone-marrow, following extensive therapy) may well be altered by the therapy and may give rise to giant-cells and Reed-Sternberg-like cells.

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BERTRAM SCHNITZER.

### CATARACT SURGERY AND INTRAOCULAR IMPLANTS

SIR,—In your review of the latest volume of Duke-Elder<sup>1</sup> (June 6, p. 1210) you say, referring to the results of cataract extraction, that “success can be anticipated in 90–95% of cases if conventional methods are used and intraocular implants are avoided”. May I, Sir, offer a few comments?

1. Having read the relevant section of this excellent production, I cannot find any such statement. No percentage-success figures are given. What the book does say, at the end of a fair and balanced, if somewhat conservative section on intraocular implants, is this: “It can well be argued that while the results of cataract extraction are usually so good and the use of contact lenses so safe and easy (in selected cases) it is perhaps unwise to gamble on further surgical procedures which require considerable specialised technical skill and a healthy eye on which to operate, the results of which in the absence (at present) of long-term observations are somewhat problematical” (p. 291).

2. A clear distinction should be made between the practice recommended by some surgeons—e.g., Binkhorst<sup>2</sup> and Fyodorov<sup>3</sup>—of replacing a cataractous lens by an intraocular implant carrying an aphakic correction *at the same time* (which must, one feels on grounds of common-sense, be associated with a higher rate of complications), and inserting the correcting lens implant as a second-stage procedure, on carefully selected patients *who cannot be helped in any other way*. The outstanding indication would seem to be unilateral traumatic cataract/aphakia in a young child who cannot tolerate a contact lens for sufficiently long periods to prevent development of irreversible amblyopia.

3. There can be no doubt that the functional results of correcting aphakia by an intraocular lens implant are vastly superior to the use of spectacles or contact lenses. The justification for their use hinges (as Duke-Elder rightly says) on long-term observation of implant-containing eyes. Observations on cases followed up since the early 1950s<sup>4,5</sup> suggest very strongly that implantation of artificial lenses can give results comparable to those of straightforward cataract extractions.

The debate will continue; time will provide the answer.

1. Duke-Elder, S. *System of Ophthalmology*; vol. ix. London, 1969.
2. Binkhorst, C. D. *Am. J. Ophthalm.* 1962, **46**, 343.
3. Fyodorov, S. Personal communication.
4. Choyce, D. P. *Proc. R. Soc. Med.* 1970, **63**, no. 3, p. 310.
5. Ridley F. *ibid.* p. 308.

In the interim, I shall continue to correct aphakia—in carefully selected cases—by means of a plastic lens implant inserted as a second-stage procedure.

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Essex.

D. P. CHOYCE.

### HETEROTOPIC CILIATED EPITHELIUM— MÜLLERIAN ORIGIN?

SIR,—Recently one of us (J. V. C.) reported a case in which heterotopic ciliated epithelium was found in a cyst of the lower limb.<sup>1</sup> Since then four similar cases have come to light.

*Case 1*—A 15-year-old girl had a lump on her left thigh for two years. It had not noticeably increased in size but tended to vary in prominence. On examination the lesion on her thigh was found to be an ill-defined cystic swelling, lying subcutaneously 13 cm. distal to the left anterior superior iliac spine. There were no other abnormal swellings, and routine physical examination showed no abnormality. Under local anaesthesia a thin-walled cyst containing clear fluid was easily removed. It was not attached to skin and was easily separated from the deep fascia. No pathogens were cultured from the fluid.

*Case 2*—A 24-year-old woman had noticed a lump on her knee for about two years. It was thought to be a suprapatellar bursa and was excised.

*Case 3*—A woman aged 27 had a swelling on the lateral aspect of her thigh which had been present for several years. During pregnancy the cyst “came up big” and was excised.

*Case 4*—A woman aged 27 complained of a cyst in the lateral aspect of the right buttock. It had been present for many years. At operation it proved to be 5 cm. in diameter, and contained clear fluid.

The histological features in all four cases were identical. The linings of the cysts were formed by columnar epithelium, the cells of which in many cases bore cilia; in between the columnar cells there were many “peg cells” with large nuclei (see accompanying figure). The strong resemblance



Tubal type epithelium from cyst of case 4.  
(H&E, × 700.)

to fallopian-tube epithelium was commented on by the pathologist in all four cases.

The possible origin of this ectopic ciliated epithelium was discussed previously.<sup>1</sup> It was considered that the lesion represented a heterotopia, possibly of ependyma, but the histological resemblance to fallopian-tube epithelium was noted. The cases reported here strengthen the evidence in favour of a müllerian origin. The cysts have all occurred in young or middle-aged women; they have not presented before puberty; and in the case in which pregnancy occurred, there was a rapid increase in size of the cyst.

The manner in which fallopian-tube heterotopias might

1. Clark, J. V. *J. Path.* 1969, **98**, 289.