

both patients had a long course of synovitis which required antiinflammatory drugs to resolve.

These two cases lend support to the hypothesis that calcium pyrophosphate dihydrate crystals previously deposited in the cartilage are released during the acute infection by hydrolytic enzymes that digest cartilage matrix, causing a crystal induced synovitis (2). A similar process may occur with uric acid crystals. Careful synovial fluid analysis late in the course of a septic arthritis by use of polarizing light microscopy may reveal similar cases and thus support this hypothesis.

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Further evidence for plasmapheresis

To the Editor:

In reference to the recent article by Wallace et al on plasmapheresis and lymphoplasmapheresis (1), it is of interest to note that historical support for plasmapheresis and other modalities to remove intravascular blood components has been largely anecdotal, though numerous case reports and testimonials certainly exist in the literature. So impressive have been some of the observed results with one such therapy that Dr. James Johnson, FRS, was compelled to editorialize that it is "so highly useful. . .and one which, in many distressing diseases, contributes our chief and only remedy"(2).

Westfall, in 1949, concluded that it may be useful "in all conditions where blood and lymph stasis exists," and that it clearly will "diminish inflammation, stasis, congestion of blood and lymph, and shorten the period of recovery from disease"(3).

In fact, the first form of "controlled" plasmapheresis, lymphoplasmapheresis, indeed leuko-lymphoerythroplasmapheresis, was documented in the first cen-

tury AD when Themison, founder of the Methodic Sect, wrote of its therapeutic application. Pliny first used it in the rheumatic diseases, finding dramatic responses in cases of gout (4), and Zacutus Lusitanus utilized this procedure successfully in acute arthritis of the hip (4). Numerous reports followed, verifying its effectiveness in a multitude of disorders of the liver, while Petrus Salius advocated its use in treating fever of many origins (4).

But it was Heronymus Mercurialis, attendant physician to Pope Pius IV, who probably had the most keen perception of this modality. Though he used it extensively, he observed that it was not altogether capable of removing the whole of the evil of which the patient might complain, "for the orifice made by the leech is so small," he wrote, "that none but the thinner portions of the blood can escape; the thicker part, from which the evil arises, is still retained" (4).

When a modality is developed which can aphorize that "thicker part," we will find a gratifying end to this business.

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Hypermobility in psoriatic spondylitis

To the Editor:

Ankylosing spondylitis is characterized by fibrous and bony ankylosis of the diarthrodial joints of the spine (1). This unique pathologic process results in limitation of spinal movement which can be assessed by a number of techniques (1,2). One commonly performed office method is the measurement of finger to floor distance with the patient in forward flexion (1).

We report a patient with severe psoriatic spondy-