CLINICAL REVIEW

Haemocytic periodicity and periodic disorders:
Periodic neutropenia, thrombocytopenia, lymphocytosis and anaemia

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Summary
Evidence has accumulated of rhythmic numerical oscillation of each of the blood cells either independently or in combinations.

The cyclic changes originate in the marrow of some normal persons and animals without causing illness, and can be induced experimentally.

In more than 100 reported instances, periodic oscillations of various cells were accompanied by respective episodes of the disorders named in the title. The disorders may be transitory but usually recur throughout life and occasionally are fatal. All resist therapy. Features in common suggest an interrelationship of the haemal disorders and other disparate heritable periodic diseases.

Theoretically, the rhythms are regulated by ubiquitous, inherent, intracellular bioclocks controlled hypothalamically or neurohumorally in relation to a feedback mechanism. Reactions to long cycles are of greater clinical importance than disturbances arising from the circadian rhythm.

Introduction
After the establishment of periodic (cyclic) neutropenia as an entity in 1949 (Reimann & De Berardinis, 1949) nearly fifty cases were added to the forty-two cited in 1963 (Reimann, 1963). Because the trouble originates in the marrow, the term periodic myelodysplasia was proposed. The broad term applies if the numbers of more than one kind of haemocyte oscillate synchronously or independently as they often do. When neutrophils, platelets, monocytes, lymphocytes and erythrocytes alone oscillate, specific designation is appropriate. By including periodic disorders related to the numeric fluctuation of various haemocytes, the total number of reported cases involving the blood exceeds 100. Many unrecognized ones, no doubt, exist.

Periodic haemocytic changes are either primary or are associated with mensis, lymphomas and immuno-suppressive therapy. In both circumstances, the involvement is either overt or clinically inapparent except for the numeric cellular oscillation. Periodicity escapes detection unless cells are counted at short intervals in patients, 'in healthy genetic relatives or others. Serial counts have disclosed periodicity in some patients regarded as cases of continuous, congenital or hereditary neutropenia (Morley, Carew & Baikie, 1967).

Periodic neutropenia is heritable. Probably thrombocytopenia, lymphocytosis and anaemia also are genetically transmissible. The disorders are not always benign. Concurrent infection or bleeding occasionally is fatal. Therapy generally is ineffectual; the symptoms alone are meliorated, cellular cycles usually persist. This review stresses the periodicity of various haemocytes, their interrelated disorders and frequent heritability as described in published cases and personally observed ones. Articles cited in references recount detailed clinical features.

Periodic neutropenia
Heredity
Morley's studies, particularly his opportunity to study five afflicted families, provided much information. Twenty members had had overt disease, usually since infancy. Neutrophils also fluctuated rhythmically in several symptomless members. Some of them had continuous neutropenia with cycles of further depression. The tempo ranged from 15 to 35 days, averaging 20. Synchronous monocytosis and fever occurred often. Anaemia, eosinophilia and thrombocytopenia concurred episodically in three relatives. An autosomal dominant trait of high penetrance and variable manifestations characterized the afflicted families (Morley et al., 1967).

Table 1 portrays thirty-seven primary cases accruing after forty-two previously recorded ones and includes a few I omitted in 1963. Table 2 shows ten cases regarded as secondary neutropenia, making a total of eighty-nine in all. Of the seventy-nine primary ones, forty-two were in females, thirty-seven
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<table>
<thead>
<tr>
<th>Author</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Age at onset (years)</th>
<th>Periodicity (days)</th>
<th>Monocytosis</th>
<th>Lymphocytosis</th>
<th>Thrombocytopenia</th>
<th>Eosinophilia</th>
<th>Familial</th>
<th>Unusual features</th>
</tr>
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<tbody>
<tr>
<td>Lorre &amp; Denys (1960)</td>
<td>F</td>
<td>8</td>
<td>3/12</td>
<td>23</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td>Rapid ESR</td>
</tr>
<tr>
<td>Toro et al. (1960)</td>
<td>M</td>
<td>2</td>
<td>4/12</td>
<td>19 (21 days after cortisone)</td>
<td>+</td>
<td></td>
<td>Thrombocytosis</td>
<td></td>
<td></td>
<td>Sialorrhea, diarrhoea, seizures</td>
</tr>
<tr>
<td>Bray (1960)</td>
<td>F</td>
<td>9</td>
<td>?</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td>Serious infections, steroids ineffective</td>
</tr>
<tr>
<td>Gorlin &amp; Chaudry (1960)</td>
<td>F</td>
<td>8</td>
<td>4</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td>Prednisone meliorated symptoms only</td>
</tr>
<tr>
<td>Malooly (by letter)</td>
<td>M</td>
<td>54</td>
<td>33</td>
<td>28</td>
<td>Monoeytopenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prednisone meliorated symptoms only. Spontaneous remission 1 year fever 40° C</td>
</tr>
<tr>
<td>Alestig (1961)</td>
<td>F</td>
<td>58</td>
<td>54</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Splenectomy and steroids ineffective. Fever 39 °C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fever 38 °C</td>
</tr>
<tr>
<td>Telsey et al. (1962)</td>
<td>F</td>
<td>14</td>
<td>4/12</td>
<td>±21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Splenectomy, prednisone relieved symptoms only</td>
</tr>
<tr>
<td>Videbaek (1962)</td>
<td>M</td>
<td>29</td>
<td>2</td>
<td>21</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
<td>Pulm. abscess</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2</td>
<td>10/12</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hypergammaglobulinaemia</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>18</td>
<td>1</td>
<td>21; later 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Five episodes of pancreatitis</td>
</tr>
<tr>
<td>Wade &amp; Stafford (1963)</td>
<td>M</td>
<td>38</td>
<td>32</td>
<td>21–28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Abdominalgia, arthralgia</td>
</tr>
<tr>
<td>Coulf, Morel &amp; Thomet (1963)</td>
<td>M</td>
<td>6</td>
<td>1</td>
<td>±21</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smith (1964)</td>
<td>M</td>
<td>20</td>
<td>6</td>
<td>14–20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Journal of the American Medical Association (1965)</td>
<td>M</td>
<td>22</td>
<td>16</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simonsen (1966)</td>
<td>F</td>
<td>21</td>
<td>17</td>
<td>±21</td>
<td></td>
<td>Lymphocytopenia</td>
<td></td>
<td></td>
<td></td>
<td>Abdominalgia, arthralgia</td>
</tr>
<tr>
<td>Morley (1967)</td>
<td>7M</td>
<td>Usually childhood</td>
<td>15–35</td>
<td>Often</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7 familial</td>
<td>Periodic arthralgia in three</td>
</tr>
<tr>
<td>Twenty cases</td>
<td>13F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Died, peritonitis</td>
</tr>
<tr>
<td>Feliti (by letter)</td>
<td>F</td>
<td>6</td>
<td>?</td>
<td>?</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td>Stethalgia, abdominalgia, arthralgia, erythema, xerostomia, diaphoresis, diarrhoea, oedema, somnolence, pallor</td>
</tr>
<tr>
<td>Waldron-Shah (by letter)</td>
<td>F</td>
<td>35</td>
<td>8</td>
<td>21</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>Doubtful in several relatives</td>
</tr>
</tbody>
</table>

in males. They began in infancy in twenty-seven and after age 60 in three. Periodicity generally ranged from 14 to 28 days, mostly 20 or 21. Monocytosis or monocytopenia, lymphocytosis or lymphocytopenia, eosinophilia and thrombocytopenia or thrombocytosis characterized some instances. The recorded numbers depended upon whether cells were counted during episodes or in the intervals. Published reports do not always specify the timing. Serious infections occasionally ensued and seven ended fatally. Familial involvement was evident in eleven instances. In several groups, symptomless relatives were neutropenic or had recurrent oral ulcers without detected rhythm. Pregnancy suppressed, worsened or had no effect on episodes. Corticosteroids meliorated the symptoms in a few, but had slight or no effect on the cellular cycles. Splenectomy seldom was justified. As found in common with other disparate periodic disorders, synchronous fever, sialorrhea, xerostomia, exanthems, arthrosis, abdominalgia and diarrhoea occasionally occurred.

Similar to human disease, six grey Collie dogs had heritable periodic neutropenia. Three had concurrent gingival and dermal ulcers, arthralgia and
fever. Neutropenic episodes recurred every 8–13 days averaging 10 with compensatory monocytosis (Lund, Padgett & Ott, 1967).

**Complement anomaly in periodic neutropenia**

Study of my patient E.C. disclosed the inhibitor of Cl esterase reduced from a normal 5-6 units to 3-6 u and 4 u in two respective episodes, and to 4 u in an interval. His whole serum complement activity during the two episodes measured 34 u and 58 u, and in the symptomless interval 44 u (normal 62 ± 19 u) (Reimann, Coppola & Villegas, 1970). Splenectomy failed to help the patient. Testosterone mitigated the symptoms for a time by preventing extreme neutropenia. It induced concurrent monocytosis, and lymphocytosis and increased the granulocytic reserve as demonstrated by the pyrogen stimulation test (Brodsky, Reimann & Dennis, 1965).

**Asymptomatic and secondary periodic neutropenia**

Morley demonstrated symptomless neutropenia at intervals of 14–23 days in eight of eleven normal men from unaffected families. Similar oscillation accompanied menses in two normal women (Morley, 1966). The behavior indicates the existence of an underlying inherent biorhythm and a feedback mechanism affecting the formation of cells. This action in genetically susceptible persons provokes disease (Reimann, 1948). In one of my patients with periodic polyserositis (Case 1, Reimann, 1948), periods of symptomless neutropenia, monocytosis and lymphocytosis occasionally recurred separately from episodes of her disease.

After the deliberate impairment of immunity, Alexander demonstrated fluctuation of antibacterial activity of neutrophils in cycles usually of 14–24 days in patients and monthly in dogs. The activity was independent of the number of neutrophils. Injury and immunosuppressive therapy adversely affected phagocytosis but did not abolish the basic cycle. As in periodic neutropenia, infection occasionally concurred (Alexander, Dionigi & Meakins, 1971). Morley & Stohlman using cyclophosphamide reduced the number of neutrophils in dogs and lowered neutropenia every 11–17 days (Morley & Stohlman, 1970). A hypothetic feedback control was discussed in detail (Morley, 1970).

Patients with polycythaemia or leukaemia and secondary periodic neutropenia listed in Table 2 all were adults. The rhythm of neutropenia ranged from 30 to 120 days. Its amplitude was extended to that length by the gravity of the underlying diseases or by therapy thereof. Thrombocytopenia concurred in four. Episodes of neutropenia affected agammaglobulinemic children (Telsey, et al., 1962).

**Neutropenia and pancreatic disturbance**

Neutropenia and pancreatic dysfunction affected a child at 21-day intervals (Colebatch et al., 1965). In six other patients, a 'new' entity, in one instance familial, consisted of pancreatic insufficiency, anaemia, neutropenia and occasional thrombocytopenia and purpura. The tabulated data suggest unnoticed recurrent episodes of neutropenia (Shwachman et al., 1964). Bodian also commented on the combination of congenital pancreatic hypoplasia, neutropenia and thrombocytopenia (Bodian, Sheldon & Lightwood, 1964). Fluctuation of the three factors appears in the tables of two of his patients, but cell counts were too widely spaced to detect regular periodicity. Elsewhere I described periodic pancreatosis without attention to neutrophilic changes (Reimann, 1962).

**Periodicity during haemal diseases**

In a polycythemic patient, the number of neutrophils fluctuated every 15 days, the platelets every 27 days, both within the normal range. A reticulocyte cycle of another patient lasted 17 days (Morley, 1969a). As noted by Morley and others, periodic neutropenia occasionally accompanies lymphomas (Morley, Baikie & Galton, 1967) (Table 2). In

<table>
<thead>
<tr>
<th>Disease</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Age at onset</th>
<th>Periodycity (days)</th>
<th>Monocytosis</th>
<th>Thrombocytopenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morley (1969a)</td>
<td>M</td>
<td>68</td>
<td>8</td>
<td>15</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Morley, Baikie &amp; Galton (1967)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polycythemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myelogenous leukaemia</td>
<td>F</td>
<td>42</td>
<td>7</td>
<td>50–55</td>
<td>+</td>
<td>27-day cycles +</td>
</tr>
<tr>
<td>Myelogenous leukaemia</td>
<td>M</td>
<td>45</td>
<td>7</td>
<td>30–35</td>
<td>+</td>
<td>Modified by therapy</td>
</tr>
<tr>
<td>Leukaemia</td>
<td>F</td>
<td>60</td>
<td>7</td>
<td>30</td>
<td>+</td>
<td>Modified by therapy</td>
</tr>
<tr>
<td>Leukaemia</td>
<td>M</td>
<td>37</td>
<td>7</td>
<td>100–120</td>
<td>+</td>
<td>Modified by therapy</td>
</tr>
<tr>
<td>Leukemia 5 patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myelogenous leukaemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kennedy (1970)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polycythemia</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Kennedy's five patients with myelogenous leukaemia treated with hydroxyurea, leucocytes and platelets fluctuated in 30-50-day cycles (Kennedy, 1970). Rhythm may be obscured by therapy or by the gravity of the primary disease. On the other hand, either therapy or the disease induces oscillation.

**Secondary lymphocytosis**

Lymphocytosis occasionally accompanies normal mensis (Minot, 1936). During lymphocytic leukaemia in a patient, spells of fever, polyuria and facial oedema appeared at 5-10 day intervals. Four months of observation disclosed a lymphocyte-lymphoblast number of about 280,000 which diminished to normal during episodes. The 2% of segmented cells diminished slightly in unison. An attack of herpes zoster temporarily lengthened the rhythm to 15 and 17 days. On one occasion, withdrawal of spinal fluid promptly increased the number of lymphocytes and averted an expected febrile episode. The event suggested central neural or neurohumoral regulation (Stacher & Bohnel, 1958). The idea was based on the experimental demonstration of prompt leucocytosis after mechanical disturbance of the hypotalamic area. Although governed centrally, the effect presumably is mediated humorally on the marrow (Rosenow, 1951).

**Periodic thrombocytopenia**

Since Demmer's report, at least six primary cases have been described (Demmer, 1920). In one instance, a man had episodes of bleeding for 42 years. His platelets diminished monthly to fewer than 50,000/mm³ after reduction of megakaryocytes in the marrow. The numbers of leucocytes and erythrocytes remained normal. Prednisone was ineffective (Engstrom, Lundquist & Soderstrom, 1966). A man, aged 37, had five episodes of thrombocytopenia and bleeding, each one worse until death from cerebral haemorrhage. Episodes came at predicted 21-day intervals. Platelet counts ranged from 0 to 500,000/mm³. Splenectomy and prednisone had failed to help (Wasastjerna, 1967).

Table 3 lists the six patients. The disorder began in middle age. Periodicity ranged from 21 to 39 days. One patient had haemolytic anaemia. One died during an episode. Splenectomy and corticosteroid therapy had no effect.

**Asymptomatic and secondary periodic thrombocytopenia**

Morley discovered a 21-35-day rhythmic oscillation in the number of platelets in normal persons. In occasional susceptible persons like these, bleeding may occur regardless of the degree of thrombocytopenia (Morley, 1969b). Rhythm may be overlooked unless serial counts are made. If these are made on patients with essential thrombocytopenic purpura, rhythmic fluctuation of platelets may become evident in some of them. Correct diagnosis obviates splenectomy which is ineffective for periodic thrombocytopenia.

Thrombocytopenia and purpura also occur in rhythm with mensis (Pohle, 1939). In a woman aged 46, episodes of epistaxis, menorrhagia and purpura recurred every 28 days for 8 years. Episodes usually coincided with mensis and also happened in the mid-period. Platelets varied in number from 10,000 to 300,000. The marrow contained nonfunctioning megakaryocytes fluctuating in rhythm. Normal hormonal amounts remained constant. Because episodes recurred regularly after oophorectomy (Skoog, Lawrence & Adams, 1957), prior relation to mensis may have been coincidental. In another woman, thrombocytopenic purpura happened at every other menstrual flow (Pepper, Liebowitz &

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**Table 3. Periodic thrombocytopenia**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age (years)</th>
<th>Age at onset</th>
<th>Periodicity (days)</th>
<th>Symptoms</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Demmer (1920)</td>
<td>M</td>
<td>61</td>
<td>55</td>
<td>28</td>
<td>Purpura</td>
</tr>
<tr>
<td>Skoog et al. (1957)</td>
<td>F</td>
<td>46</td>
<td>38</td>
<td>28</td>
<td>Epistaxis, menorrhagia, purpura, mucosal lesions</td>
</tr>
<tr>
<td>Dameshek (by letter)</td>
<td>F</td>
<td>42</td>
<td></td>
<td>27</td>
<td>Episodes of haemolytic anaemia, thrombocytopenic purpura</td>
</tr>
<tr>
<td>Wasastjerna (1967)</td>
<td>M</td>
<td>37</td>
<td>33</td>
<td>21</td>
<td>Severe bleeding</td>
</tr>
<tr>
<td>Engstrom et al. (1966)</td>
<td>M</td>
<td>61</td>
<td>59</td>
<td>39</td>
<td>Purpura</td>
</tr>
<tr>
<td>Bernard &amp; Caen</td>
<td>M</td>
<td>54</td>
<td>17</td>
<td>Monthly</td>
<td>Buccal ulcers, subcutaneous haemorrhages</td>
</tr>
<tr>
<td>Candura (1960)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fourteen cases related to mensis</td>
</tr>
</tbody>
</table>

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**Clinical review**

Irregular synchronous lymphocytosis. Death from nephritis With and between mensis. Persisted after oophorectomy Had prior splenectomy for haemolytic anaemia Died in predicted episode from cerebral haemorrhage. Splenectomy and steroids no help ‘Absolutely regular sequence’ Corticosteroid and splenectomy, no effect
Lindsay, 1956). In the published case record, lower platelet counts appear without comment at about 20-
day intervals suggesting a *circa* 21-day periodicity. 
Candura described two cases related to menis and 
cited reports of at least twelve others chiefly in 
Italian and German journals (Candura, 1960). 
These are regarded here as secondary but if included 
in Table 3 would make a total number exceeding 
twenty. More cases, no doubt, will be diagnosed 
when serial counts are made.

Regardless of known platelet participation, bleed-
ing and purpura can be induced periodically in 
religious stigmatists presumably by wilful excite-
ment of the autonomic neurovascular system (Agle & 

**Periodic erythrocytic oscillation**

A 7-year-old boy had ‘congenital hypoplastic 
anæmia and periodic erythrocytopenia’ since 
infancy. At first, episodes came at 2-3-month 
intervals, later about twice yearly. The marrow 
during episodes showed erythroid aplasia. The 
child was well between episodes and developed 
normally otherwise. An infant brother died from 
anæmia (Gordon & Varadi, 1962).

A man who died at age 21 from Hodgkin’s disease 
had had numerous episodes of anaemia with in-
creased sedimentation-rate, lymphocytopenia and 
fever. Two-week-long episodes alternated with 
about 3 weeks of relative good health. Five episodes 
were observed during 5 months in a hospital. 
Because of brisk erythropoiesis in the marrow, his 
physicians regarded the periodic anaemia as of 
haemolytic origin (Ranløv & Videbaek, 1963).

Ashby observed 8–16-day cycles of haematopoesis 
in animals and changes in human erythrocyte 
numbers every 14 days (Ashby, 1948). In Morley’s 
polycythemic patient, independent reticulocyte, 
neutrophil and platelet cycles indicated that normal 
homeostatic controls still were functional (Morley 
1969a). A 14-day oscillatory rhythm of reticulocytes 
appeared in dogs. Bleeding and transfusion shifted 
the oscillatory phases (Morley & Stohlman, 1969).

**Discussion**

In the past 20 years, clinical interest in life-long 
recurrent disorders in otherwise healthy persons has 
increased. Many examples have been delineated and 
added to those described previously. They are in-
cluded in a proposed group of disparate noso-
logically related entities. Common to all are herit-
ability, precise or irregular periodicity, over-lapping 
features, menstrual suppression of episodes, resis-
tance to therapy and similar serum-complementary 
defects (Reimann, 1963).

Considering the interrelation of periodic dis-
orders, the case described to me as one of possible 
periodic neutropenia by Waldron-Shah (Table 1) is 
pertinent. The patient has constant leucopenia with 
periods of neutropenia every 21 days ‘predictable to 
the day’. Other leucocytes increase reciprocally. 
During episodes, the usual oral ulcers appear. But in 
addition, there occur fever, severe abdominalgia and 
stetalgia, arthralgia of elbows and knees, and 
oedema of the eyelids, face, palate and hands. These 
features respectively characterize periodic poly-
serositis, periodic arthrosis and periodic oedema. 
Myalgia, sialorrhea, xerostomia, erythema, somno-
lenence, blurred vision, diaphoresis, tachypnea, vomit-
ing and diarrhoea common to all periodic disorders 
also concur at times in the episodes as autonomic 
reactions. An electroencephalogram was normal. 
Because none of the symptoms predominate con-
sistently, a basic diagnosis of periodic neutropenia 
with composite symptoms is appropriate.

It may be recalled that a patient with periodic 
polyserositis (Case 1, Reimann, 1948), cited above 
had occasional separate periods of neutropenia. As 
indicated in Table 1, Simonsen’s neutropenic 
patient had abdominalgia and arthralgia. Some 
family members of Morley’s group had arthralgia, 
and Lorre’s patient had synchronous sialorrhea, 
diarrhoea and seizures. Periodic neutropenia with 
pancreatic disturbance was mentioned above. 
Systemic disturbance is obvious.

Regarding periodic haemal disorders, several 
entities have emerged. According to the tables, 
primary periodic haemal disorders begin at any 
time of life, occasionally are familial, have over-lapping 
features, resist therapy and occasionally are 
fatal. Evidence of similar periodicity emerges during 
unrelated diseases. Periodicity can also be induced 
experimentally in man and animals. Various haemal 
cells oscillate in number independently or in com-
binations. When independent, specific names may be 
applied; for combinations, the term myelodysplasia 
seems apropos. Synchronous increases in numbers of 
certain cells may be compensatory or specific.

The immediate site of disturbance is in the marrow. 
Why the oscillatory rhythm varies in days, weeks or 
months, often precisely, in different patients and for 
different cells is unknown. Occasional temporal 
association with menis and may indicate either hor-
monal incitement or the synchronous effects of two 
separate biorhythms. Morley’s discovery of similar 
haemocytic cycles in asymptomatic members of 
afflicted families, in normal persons, and in animals 
indicates the ubiquity of the rhythm. Exaggera-
tion of oscillation or oscillation in susceptible persons 
evokes periodic disease.

Alexander demonstrated depressed antibacterial 
action of neutrophils in the usual 14–24-day rhythm 
in normal persons. At the nadir of action, infection 
ocurred in one person. Infections also occurred at
the time in burned patients and in others treated with immunosuppressive drugs. The behavior may be one variable factor favoring unexpected recurrent infections. Long biorhythms as principles of life and reactions to them are of much more clinical importance than disturbances incident to the circadian rhythm.

Concerning the ultimate cause, no demonstrable inborn-error of metabolism or endocrinal influence participates. The circadian rhythm, extraneous geo-physical or cosmic influences have no bearing. Whether a complement disturbance observed in the single case of periodic neutropenia is a characteristic and relevant to the cause cannot be said without further evidence.

Theoretically, an inherent biorhythm excites the hypothalamic area, the effects of which are mediated neurally. Pertinent to the blood, Richter postulated the existence of local bioclocks or Zeitgebers in cells of the marrow (Richter, 1960). An action-phase in the stem cells of each of the haematopoetic components may synchronize independently to cause neutropenia, lymphocytopenia, thrombocytopenia, reticulocytopenia or anaemia, or these in various combinations. The bearing of the theories on the feed-back proposal (Morley, 1970) is conjectural. Does feedback control the rhythm or the reverse? Morley, King-Smith & Stohlman (1970) discussed the matter of haemal periodicity in detail concluding that 'if many systems do show the same principles of control as does haemopoiesis, many periodic diseases may arise in similar fashion'.

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