- 2 Reynolds JEF. Methotrexate. In: Reynolds JEF, ed. *Martindale - The extra pharmacopoeia*. London: Royal Pharmaceutical Society of Great Britain, 1996; pp 584-8.
- 3 Tracy TS, Worster T, Bradley JD, Greena PK, Brater DC. Methotrexate disposition following concomitant administration of ketoprofen, piroxicam and flurbiprofen in patients with rheumatoid arthritis. *Br J Clin Pharmacol* 1994; 37:453-6.
- 4 Mason P. Fish oils. In: Mason P, ed. *Handbook of dietary supplements*. Oxford: Blackwell Science Ltd, 1995; pp 73-8.
- 5 Harvey SC, Withrow CD. Cardiovascular drugs. In: Gennaro AR, ed. *Remington's Pharmaceutical sciences*. Pennsylvania: Mack Publishing Company, 1990; pp 858-9.

Thyrototoxicosis and antithyroid drugs

Sir,

In their recent self-assessment case on thyrotoxicosis and antithyroid drugs, Monakier and Shilo¹ stated in the learning box that once agranulocytosis is diagnosed, antithyroid drugs should be stopped and treatment with granulocyte colony-stimulating factors (G-CSFs) initiated, in addition to isolation and antibiotic administration. They did not mention the importance of the duration of the neutropenia in deciding to starting therapy with G-CSF. In 1996 a panel convened by the American Society of Clinical Oncology concluded that G-CSF or GM-CSF is unnecessary in patients with neutropenia of short duration (less than a week), but that it may benefit patients with prolonged neutropenia.² Thus, it was probably unnecessary to treat their patient with G-CSF.

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- 1 Monakier D, Shilo S. Thyrotoxicosis and antithyroid drugs. *Postgrad Med J* 1997;73:335-6.
- 2 American Society of Clinical Oncology. Update of recommendations for the use of hematopoietic colony-stimulating factors: evidence based clinical practice guidelines. *J Clin Oncol* 1996; 14:1957-60.

This letter was forwarded to the authors who responded as follows:

Sir,

The American Society of Clinical Oncology paper you mention deals with the use of haematopoietic CSF following chemotherapy and does not deal with other drug-induced neutropenia. It states: "... Existing clinical data suggest that starting G-CSF or GM-CSF between 24 and 72 hours subsequent to chemotherapy may provide optimal neutrophil recovery". (p 1959, para 10). The recommendation is to start CSF even before the appearance of agranulocytosis. Our recommendation, in a case of agranulocytosis induced by antithyroid medications, is to start CSF when agranulocytosis appears, in order to try and avoid fever and infections and to reduce infection complications.

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Sarcoidosis-lymphoma syndrome in a woman with acromegaly

Sir,

We read the article by Romero *et al* on sarcoidosis-lymphoma syndrome¹ with great interest. We would like to report a case of a woman with acromegaly in whom non-Hodgkin's lymphoma was diagnosed 6 years after sarcoidosis.

In 1979, a 38-year-old woman was admitted with complaints of irregular fever and cervical lymphadenopathy. She had a history of active acromegaly which had been treated by local pituitary ⁶⁰Co irradiation (3340 cGy in 20 fractions) two years earlier. At presentation she was in a good clinical condition. Physical examination revealed bilateral, movable cervical and supraclavicular enlarged lymph nodes without hepatosplenomegaly. Chest X-ray was normal. Lymphography showed retroperitoneal and bilateral inguinal lymphadenopathy. Full blood counts were normal; the erythrocyte sedimentation rate was 35 mm/h. After histological examination of two cervical lymph nodes, a diagnosis of sarcoidosis was established. She was put on 45 mg of prednisolone daily. After symptoms subsided, steroid therapy was continued for one year.

She remained asymptomatic for a follow-up period of 5 years. In 1986 she was again admitted to hospital with fever, weight loss, goitre and cervical lymphadenopathy. Her symptoms did not subside on 6 months ambulatory treatment with steroids. Other clinical examination findings were hilar enlargement, revealed on chest X-ray, and lymphatic infiltration of bone marrow (up to 20%). Histological examination of the cervical node demonstrated centroblastic lymphoma. The patient received six courses of CVP chemotherapy (cyclophosphamide, vincristin and prednisolone). A reduction of symptoms, including a reduction of the enlarged lymph nodes and goitre, were noted. The patient remains asymptomatic.

Brincker, in his description of so-called sarcoidosis-lymphoma syndrome² pointed to three typical features: sarcoidosis precedes lymphoma by several years, the patients are on average 10 years older than other patients with sarcoidosis, and an association with Hodgkin's lymphoma is more frequent. Our patient met two of these three criteria. She was in her forties when she developed sarcoidosis. She had received steroid treatment and developed lymphoma 6 years after the diagnosis of sarcoidosis.

The immunologic abnormalities in our patient could have been initiated by radiotherapy. This might have provoked the development of sarcoidosis. Consequently an increased mitotic activity and dysregulation of lymphocytes observed in sarcoidosis,^{3,4} as well as steroid therapy, contributed to the development of lymphoma. We believe that our case supports the theory of non-random association between sarcoidosis and lymphoma and

the existence of sarcoidosis-lymphoma syndrome.

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- 1 Romero J, Ramon y Cajal S, Vargas JA, *et al*. Association of sarcoidosis, low-grade B-lymphoma and epidermoid carcinoma. *Postgrad Med J* 1997;73:580-4.
- 2 Brincker H. The sarcoidosis-lymphoma syndrome. *Br J Cancer* 1986;54:467-73.
- 3 Danielle RP, Dauber JH, Rossmann MD. Immunologic abnormalities in sarcoidosis. *Ann Intern Med* 1980;92:406-11.
- 4 Linnenberg HS, Medici TC, Rhynet K. Das 'Sarkoidosis-Lymphoma-Syndrom'—Eine Lymphozyten Fehlregulation? *Pneumologie* 1992;46:229-35.

Understanding scientific papers

Sir,

We would like to offer an addendum to the articles published in recent years in various journals^{1,2} on how to read medical literature. This addendum, a translation of some of the phrases commonly used in scientific and clinical articles, has been gleaned from various sources and we have made some modifications of our own. We hope that readers will find it both instructive and amusing.

- It has long been known that... = We haven't bothered to look up the relevant literature or the original reference.
- While it has not been possible to provide definite answers to these questions... = The experiment did not work out, but we figured we could at least get a publication out of it.
- Typical results are shown... = Only the positive results are shown.
- It is suggested/believed... = We think.
- It is generally suggested/believed... = A couple of other guys think so too.
- It is clear that much additional work will be required before a complete analysis of the results... = We don't understand what happened.
- Unfortunately, a quantitative theory to account for the results has not yet been formulated... = No one else understands it either.
- Correct within an order of magnitude = Wrong.
- It is clear... = It is not clear.
- It is obvious... = We think that is the way it should be, but we cannot explain why.

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- 1 Greenhalgh T. How to read a paper: Getting your bearings (deciding what the paper is about). *BMJ* 1997;315:243-6.
- 2 Guyatt GH, Rennie D. User's guides to the medical literature. *JAMA* 1993;270:2096-7.