needing early diagnosis. Since all women at risk may be identified by their prenatal history screening for presymptomatic carcinoma is possible. We suggest that the best methods are visualising the vagina and cervix, cytology of both vaginal aspirate and cervical scrape, iodine staining, and colposcopy with biopsy of suspicious areas. It is imperative that all physicians treating young women should be aware of these disease processes if the maximum therapeutic benefit is to be achieved.

We thank Dr W Cowan for his assistance, and Mr G Wilkinson for the histological sections; also Miss Margaret Taylor for typing the script.

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SHORT REPORTS

Poncet's disease: para-infective tuberculous polyarthropathy

In 1897 Poncet[1] introduced the term tuberculous rheumatism, meaning joint disease in patients with tuberculosis not due to tuberculous invasion of the joints—a para-infective arthropathy. The condition has rarely been referred to in British reports[2–4] and is not mentioned in most current textbooks of medicine. We therefore report a child whom we believe suffered from this disease.

Case report

A 5-year-old boy, who had been born in this hospital of Pakistani parents, presented with a three-week history of swelling of both knees, which had begun to ache on the day before his hospital admission. No other symptoms were complained of or admitted to on direct questioning. He had returned from Pakistan with his family four weeks previously after a six-month stay, during which he had been generally unwell with some vomiting, but the cause was unknown. He had no other medical history. He had been vaccinated with BCG in 1976, when his mother had been treated for tuberculosis. His father had died from a myocardial infarction in the same year. He had one brother aged 12 years, who was well.

On admission he was afebrile. Findings were as follows: scattered papules and pustules over the anterior surfaces of the thighs, and submandibular lymph node enlargement on the right; effusion into both knee joints, which were slightly warm and tender; and pain on movement of the left elbow, and swollen and slightly painful ankles. There was no other abnormality apart from a convergent squint of long standing. The results of investigations were as follows: Hb 9·0 g/dl; WBC $14{\cdot}8 \times 10^9$/l; ESR 56 mm in first hour; blood urea and electrolyte concentrations normal; throat swab culture sterile; no pyuria in three early morning specimens; tests for serum rheumatoid factor, antinuclear factor, and Widal titres were all negative, and the ASO titre was 100 IU/ml; routine viral antibody tests no significant titres. In three gastric washings *Mycobacterium tuberculosis* was not identified by microscopy or culture; blood culture was sterile; a chest *x*-ray film showed right hilar enlargement, with streaky shadowing of the right upper lobe; *x*-ray films of knees were normal; and a Mantoux test 1 in 1000 was strongly positive with 15-mm induration.

Primary pulmonary tuberculosis was diagnosed and treatment was initiated with rifampicin, 450 mg daily; isoniazid, 125 mg daily; ethambutol, 400 mg daily; and pyridoxine, 10 mg daily. He improved generally and the rash on his thighs resolved, but the arthritis remained static after two weeks. A course of prednisolone, 60 mg/day, was then begun and the dosage gradually reduced as the joint symptoms subsided over the next four weeks. Two months after starting antituberculous treatment he had only slight residual soft tissue swelling at the knees and his other joints were normal. The knees too had returned to normal after three months. The changes on the chest *x*-ray film resolved slowly on treatment.

Discussion

This child had a polyarthropathy associated with convincing evidence of primary pulmonary tuberculosis. The simultaneous swelling of five joints coincident with the primary complex virtually excludes direct tuberculous infection of the joints. Seronegative rheumatoid arthritis cannot be totally excluded but we believe that it is more likely that the joint features were a manifestation of tuberculous allergy. The rash on the thighs appeared typical of papulonecrotic tuberculid[5] and resolved with antituberculous chemotherapy, giving further evidence of tuberculous allergy. The possibility of tuberculosis should be considered whenever a patient has a polyarthropathy of obscure cause.

We thank Dr B Taylor for introducing us to the earlier reports on Poncet's disease.

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Tetanus after rubber-band ligation of haemorrhoids

Haemorrhoidectomy is usually regarded as a safe operation. Slack[1] stated that no preoperative bowel sterilisation with antibiotics was necessary; all that was required was an enema followed by a rectal washout. Among complications he listed "infection" as an occasional abscess under a redundant skin fold. This case report shows that tetanus can be a complication of operations on the rectum.

Case report

A 33-year-old housewife was admitted to hospital because of a two-day history of difficulty in opening her mouth and in swallowing, neck pain, neck and abdominal muscle stiffness, and excessive sweating. Rubber-band ligation of internal haemorrhoids had been performed nine days previously (seven days before symptoms began). She had had no other injury, and had not been immunised against tetanus. On admission she had clinical tetanus. She had a particularly severe spasm of the jaw on trying to remove her dentures. She was treated with penicillin, tetanus immunoglobulin, and originally with intravenous diazepam. The symptoms were not controlled, so endotracheal intubation was performed followed by paralysis, intermittent positive-pressure respiration, and tracheostomy. Progress was complicated by an unstable blood pressure and a lower-lobe pneumonia, but the relaxants could be discontinued after 25 days and progress thereafter was uneventful.

Comment

The source of clinical tetanus may be difficult to determine. In our experience 10% of patients have no detectable wound. Spores of