to establish a possible relationship between these two diseases.

Finally, though we did not find the same high prevalence of cheiroarthropathy in NIDD as did Fitzcharles *et al.*,[1] we do agree that there is an association between microvascular derangement and diabetic cheiroarthropathy which is independent of glycaemic control.

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**References**

1 Fitzcharles M A, Duby S, Waddel R W, Banks E, Karsh J. Limitation of joint mobility (cheiroarthropathy) in adult non-insulin-dependent diabetic patients. *Ann Rheum Dis* 1984; **43:** 251–7.
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# Rupture of the spleen in rheumatoid arthritis

SIR, Haskard *et al.* reported, in the *Annals*[1] two patients with rheumatoid arthritis, in whom spontaneous rupture of the spleen developed. Two similar cases were subsequently reported.[2] The following case was seen in April 1980 and is reported in order to substantiate the relationship between rheumatoid arthritis and spontaneous rupture of the spleen.

The patient was a 56-year-old white female. In the winter of 1978 she developed pain and stiffness of her knees, neck, and shoulders, which lasted several months. She was then well until the winter of 1980, when she developed soreness and stiffness in the small joints of her hands, wrists, knees, ankles, and the small joints of her feet, which was particularly severe in the morning. She did not have fever, chills, night sweats, sicca symptoms, or Raynaud's disease. She had a 12-year history of insulin-dependent diabetes.

Physical examination at that time disclosed an ill, white female. Her spleen was not palpable. There was tender diffuse swelling of the right second and fourth proximal interphalangeal joints. There was marked synovial thickening of all the metacarpophalangeal joints of the left hand. Both wrists were tender and painful on full flexion. Both knees contained small effusions. The ankles were tender. Her packed cell volume was 36%, leucocyte count $6{\cdot}8\times10^9$/l, platelet count $397\times10^9$/l, erythrocyte sedimentation rate 50 mm/h, rheumatoid factor positive 1:320. Antinuclear antibody was positive 1:80 with a homogeneous pattern.

On 23 April 1980 she developed 'indigestion'. She had not experienced abdominal trauma. At that time her packed cell volume was 28% and leucocyte count $6{\cdot}4\times10^9$/l. The next day she developed diffuse abdominal pain and rectal bleeding. Her packed cell volume was 18%. Sigmoidoscopy showed friable, bleeding rectal mucousa. Above 4–5 cm, the colonic mucousa was normal. Gastrographin upper gastrointestinal series showed displacement of the stomach by a mass in the left upper quadrant.

She underwent emergency laparotomy. At the time of laparotomy it was found that her abdomen was distended with fluid and blood and that there were blood clots in the left upper quadrant of the abdomen. The spleen was actively bleeding and she underwent splenectomy. Microscopic examination of the spleen failed to show fibrinoid necrosis or rheumatoid nodule formation. She then made an uneventful recovery. One month later she underwent repeat colonoscopy, which demonstrated mild erythema of the rectum and no other abnormalities. Repeat colonoscopy in October 1981 was normal.

This additional case supports the hypothesis that spontaneous rupture of the spleen can occur as a complication of rheumatoid arthritis. Awareness by physicians of this possibility in a patient with rheumatoid arthritis with acute abdominal pain would be of great importance in facilitating prompt diagnosis and surgical treatment.

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# Note

## Basic course in rheumatology

A one day meeting will be held at Guy's Hospital on 15 March 1985. It is designed principally for junior staff not yet committed to the specialty, but doctors preparing for MRCP or in the early stages of specialty training may also find it useful. Details from Dr T Gibson, Department of Rheumatology, Guy's Hospital, London, SE1 9RT.