for three days. On admission his temperature was 38·5°C. There were no other abnormal findings except for hæmoglobin 11·5 g/dl; white cell count $17·0 \times 10^9$/l with neutrophilia; high erythrocyte sedimentation-rate (131 mm in first hour); weakly positive antinuclear factor (titre 1/40). Lupus erythematosus cell preparation and rheumatoid factor tests were negative and urine, skin, and blood cultures were sterile. An intense predominantly polymorphonuclear dermal infiltrate was seen on histological examination of affected skin. Sweet's syndrome was diagnosed.

The patient responded well to treatment with 60 mg prednisolone daily for one week and remained symptomless during a four-month follow-up period on a maintenance dose of 15–20 mg prednisolone daily, any reduction causing an immediate relapse. Because of persistent mild anæmia and leucocytosis, and the gradual appearance of abnormal immature cells in the peripheral blood, a bone-marrow examination was done which revealed gross granulocytic hyperplasia compatible with a myeloproliferative disorder. Chromosome analysis was normal, but the leucocyte alkaline phosphatase score was low. The patient's general condition suddenly deteriorated in September, 1977, and he had hepatosplenomegaly, a hæmoglobin of 9·1 g/dl, white cell count of $40·5 \times 10^9$/l, and features of acute myeloid leukæmia on repeat bone-marrow examination. Remission was achieved in early 1978 following treatment with blood transfusions and quadruple chemotherapy, but the patient relapsed six months later and died in March, 1979.

Sweet's syndrome shows a variable clinical picture, as fever is not always present and skin lesions may be solitary or profuse. However, they are all characteristically raised, red, and painful, usually heal without scarring, and have a prediliction for the face, neck, and limbs. Spontaneous remission may occur within a few months, or crops of lesions may continue to appear over many years. Malaise, arthralgia, and eye signs (conjunctivitis and episcleritis) are sometimes present. There are over one hundred documented patients, approximately 80% of whom are female,[8] and although a preceding minor illness is common the ætiology remains unknown. It is important to consider this condition in the differential diagnosis of cellulitis which fails to respond to antibiotics (especially a solitary lesion on the face), atypical erythema multiforme, acute lupus erythematosus, early pyoderma gangrenosum, vasculitis, panniculitis, and erythema nodosum.

We wish to bring Sweet's syndrome to the attention of doctors who are not dermatologists, because it is probably much commoner than is realised, and to reinforce the association with leukæmia described in earlier reports.

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CRYOANALGESIA AND DAY-CASE HERNIORRAPHY

SIR,—In an attempt to reduce the waiting list for herniorraphies in the Oxford hospitals, some fit patients with non-recurrent inguinal hernias were admitted as day-cases for herniorraphy under regional anæsthesia, their time in hospital being approximately 6 h. Initially, the patients were given six pethidine (50 mg) tablets and twenty 'Distalgesic' tablets, to be taken as necessary, for postoperative analgesia. There was general patient acceptance of the technique as an alternative to a long delay before inpatient admission.

Despite the oral analgesia, the patients experienced varying amounts of discomfort, and found difficulty in walking during the first few days. We decided to use cryoanalgesia[1] of the ileoinguinal nerve, under direct vision, to reduce the postoperative pain. Eight patients had an obvious nerve at operation, and a segment of this was frozen for two periods of one minute. These patients had excellent postoperative analgesia, and only required a mean of five distalgesic tablets. There appeared to be blockade of the pain from the muscle and deep tissues, and they were mobile in one or two days. This analgesia did not adversely affect wound healing. Skin sensation was intact, and there was slight soreness from the incision. This enabled early recognition of inflammation or hæmatoma, and prevented the patients from traumatising the wound.

We are engaged at present in a clinical trial to evaluate fully this use of cryoanalgesia, to assess the proportion of patients in whom this technique is practical, and look for any long-term complications. We are also comparing this technique with oral analgesia or long-duration local anæsthesia. We believe that cryoanalgesia may be a useful adjunct for day-case herniorraphies to minimise postoperative patient discomfort.

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MICROENCAPSULATED MITOMYCIN-C THERAPY IN RENAL-CELL CARCINOMA

SIR,—We have found that mitomycin C (MC) microencapsulated with ethylcellulose is released in a gradual and sustained way in vitro and in vivo.[1,2] Microcapsules of mean diameter 224 μm can be readily infused by catheter into an artery and, through embolisation and prolonged drug action,[3,4] have a potential therapeutic effect. We have now treated two patients with MC microcapsules.

In a 66-year-old man with chronic pyelonephritis, carcinoma of the right kidney with fracture of the left femur due to bone metastasis to the hip joint was diagnosed. On March 28, 1978, 15 mg of MC microcapsules and 'Spongel' (solidified gelatin) were infused into the right renal artery, resulting in a persistent occlusion of the tumour vessels for more than 4 months. ^{60}Co irradiation did not relieve the severe pain at the hip joint. Then 20 mg of microcapsules was infused into the left internal iliac and deep femoral arteries on May 17, June 27, and July 11. The pain decreased within 2 weeks of the first infusion but at the end of July, pyelonephritis progressively deteriorated with corresponding leucocytosis and raised serum creatinine and the patient died on Aug. 8. Necropsy revealed an extensive necrosis in the right kidney tumour and degenerative changes in the bone lesion. Metastasis in the lung and the left kidney with chronic pyelonephritis was also identified.

Carcinoma of the right kidney with an extensive invasion of the inferior vena cava was diagnosed in a 58-year-old man. The tumour was supplied from duplicated renal arteries; 20 mg of MC microcapsules and spongel was infused into the lower artery on Oct. 31, 1978, and 10 mg was infused into the upper one on Dec. 4, 1978, and Jan. 9, 1979. In March, computerised tomography and angiography disclosed a striking reduction of tumour size with little invasion of the vena cava.

8. Sweet RD, Acute febrile neutrophilic dermatosis—1978. *Br J Dermat* 1979; **100:** 93–99.
1. Lloyd JW, Barnard JDW, Glynn CJ. Cryoanalgesia: a new approach to pain relief. *Lancet* 1976; ii: 932–34.

1. Kato T, Nemoto R. Preparation and properties of microencapsulated mitomycin C. *IRCS Med Sci* 1978; **6:** 311.
2. Kato T, Nemoto R. Microencapsulation of mitomycin C for intra-arterial infusion. *Proc Japan Acad* 1978; **54B:** 413–17.
3. Kato T, Nemoto R, Kumagai I, Nishimoto T, Mori H. Studies on microencapsulated anticancer drugs. 2. Intra-arterial infusion of microencapsulated mitomycin C into the dog kidney. *J Japan Soc Cancer Ther* 1979; **14:** 157–63.
4. Kato T, Nemoto R, Mori H, Kumagai I. Sustained-release properties of microencapsulated mitomycin C with ethyl-cellulose infused into the renal artery of the dog. *Cancer* (in press).