colleagues' studies then premorbid data may exist which could help clinicians to understand their disorders better. I therefore propose a voluntary data donors scheme, analogous to the organ-donor scheme currently operating in the UK and other countries. Such a scheme could be promoted on the internet and in the biomedical literature. Participants would carry a card summarising what data are held on them by which institution. In the event of a brain disorder, their doctors could use the card to contact the institution and request the data. As our understanding of brain function in health and disease improves, the need for accurate premorbid and postmorbid comparisons will become more urgent, highlighting potential benefits of the scheme—especially if participation could be extended to a wider range of participants in experiments once the scheme were operational.

Of course, there are issues of data ownership, and confidentiality, both academic and medical. However, in the basic scheme proposed above, data would only be requested by doctors responsible for treating a patient, so given the will to do so, it should be possible to overcome difficulties with medical confidentiality. As for ownership and academic confidentiality, these tend to have a shorter effective time-span than medical confidentiality, because the findings on the data are rapidly placed in the public domain (by contrast, brain illness or damage may take years to become apparent). In addition, data useful to the clinician are often not central to the findings of the publications which use them, but are required as background—eg, psychometric assessments.

In an ideal world, participating researchers, and other participants, would volunteer to undergo a standardised test battery. The resultant data would be archived either on a specialist internet site or by participating institutions, in a database format with appropriate data protection built in. As a first step, a data donors scheme could, if sufficiently well-supported, help to provide at least some clinicians with a more accurate view of the premorbid function of their patients. That can only be beneficial for the long-term understanding and treatment of brain disorders.

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1 Wechsler D. Wechsler adult intelligence scales (revised). San Antonio: Psychological Corp, Harcourt Brace, Jovanovich, 1981.

Allergy to latex

Sir—Philippa Goulden and colleagues (Jan 22, p 315)[1] report that a bone-marrow harvest from a volunteer, unrelated donor was cancelled on the day of the procedure, because the anaesthetist judged that the donor, a woman with a known allergy to latex, would undergo an unjustified risk from general anaesthesia. Cancelling a harvest procedure at that late stage, when the patient has already received high-dose chemoradiotherapy and has a high probability of dying because of the missed transplant, should happen only as a consequence of unpredictable and catastrophic events. The circumstances of the case described do not seem to fall into such a category, because allergy to latex was noted at the time of the medical assessment of the donor, when she was judged fit to donate the marrow. We guess this very unfortunate episode has more to do with the role of the anaesthetist in assessing potential marrow donors.

In the routine marrow harvests for volunteer transplants that we do, a senior anaesthetist is part, together with the haematologist and the transfusionist, of the team that sees the donor at the medical examination, about 3 weeks before harvest. If the same anaesthetist is not the one taking care of the donor on the day of harvest, as often happens, somebody else from the same institution will do so, with no risk of different opinions relative to what has been already decided. We have done more than 20 harvests for volunteer, unrelated donor transplants in the past few years, and never had any trouble of this kind. The recommendation that an anaesthetist sees the donor at the time of the medical examination is in the guidelines of our donor registry,[2] and should perhaps be included in all guidelines regarding the issue of unrelated donors. Complying to such recommendations should avoid the repetition of a case such as that reported by Goulden and colleagues.

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1 Goulden P, Gravett P, Goldman J. An unfortunate case of allergy to latex. *Lancet* 2000; **355:** 315–16.

2 Standard di Funzionamento del Registro Italiano donatori di Midoll, Osseo. Rome: Annali Istituto Superiore di Sanità; **35:** 1999; 55–125.

Philoctetes' foot

Sir—Walter Grassi and his colleagues (Dec 18/25, p 2156)[1] take the view of a "western" rheumatologist that acute recurrent pain and redness in philoctetes' foot must be due to gout. They ignore at least five essential points in the case history. The first is fever: "as it [the pain] passes ... it is only then that my fever leaves me". Recurrent joint pain and fever might suggest familial Mediterranean fever. Even more important are the travel history to Asia Minor, the serpent bite which triggered the condition, and the recurrent bloody discharge and its association with the pain ("the dark blood still oozes from the *deep* [my emphasis] vein, I think there is still more pain to come." Finally there is the ostracisation, because his foot presented a hideous sight.

I think that Philoctetes had mycetoma (Madura foot). This chronic condition is more common in Asia than in southern Europe. The fungus is inoculated through a wound—snakes and thorns both produce sharp pain followed by inflammation. The condition is characterised by unsightly swelling of the foot which becomes covered with the mouths and scars of deep sinuses that intermittently discharge viscous material which may be mixed with altered blood. The foot becomes warm and painful before each episode of discharge, and there may be fever at this time. Philoctetes' case illustrates nicely the need to take a careful travel history, and to pay attention to all the patient's complaints.

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1 Grassi W, Farina A, Cervini C. The foot of Philoctetes. *Lancet* 1999; **354:** 2156–57.

DEPARTMENT OF ERROR

Clinical presentation and outcome of Pneumocystis carinii *pneumonia in Malawian children*—In this Article by S M Graham and colleagues (Jan 29, p 369), the heading for the last group in table 4 on page 371 should be, "Outcome for children younger than 6 months".

Psychological response and survival in breast cancer—In this Correspondence letter by M Tashiro and colleagues (Jan 29, p 405), the last two lines of the figure legend should be "in patients who had had chemotherapy (C); and patients with remaining tumours (D)."

A novel method for predicting the long-term outcome of women with very small (T1a, T1b) breast cancers: a prospective study—In this Article by L Tabár and colleagues (Feb 5, p 429), Peter B Dean was involved in the writing of the paper, statistical analysis, interpretation of results, and design of the study.