

## References

1. Anonymous. Cancer of the cervix: death by incompetence. *Lancet* 1985; **2**: 363-364.
2. Chisholm DK, Haran D. Cases of invasive cervical cancer in the north west in spite of screening. *Br J Fam Plann* 1984; **10**: 3-8.
3. Chamberlain J. Failures of the cervical cytology screening programme. *Br Med J* 1984; **289**: 853-854.
4. Hughes HE. The appropriate use of diagnostic services. The effective use of cytology services. *Health Trends* 1985; **17**: 3.
5. McIlwaine GM. The cervical cytology service in Greater Glasgow Health Board. *Primary care circular*, Feb 1986.

## Acute febrile mucocutaneous lymph node syndrome (Kawasaki disease)

Sir,

We would like to report the following case. A two-year-old girl was referred to the dermatology clinic after presenting with a seven-day history of sore throat, fever and a skin rash. A five-day course of cloxacillin had had no effect on the pyrexia. Examination showed an irritable, ill child with a pyrexia of 39°C and there was a blotchy erythematous rash on her trunk and legs, with areas of desquamation. Her fingertips were red with peeling back of the skin towards the base of the fingers. There was left cervical lymphadenopathy and conjunctival injection. Examination revealed no other abnormalities. The diagnosis was not clear at this stage and she was admitted to hospital for further evaluation.

Over the next few days she remained highly pyrexial despite penicillin V therapy. Extensive crusting and ulceration of the tongue and lips developed which necessitated feeding via a naso-gastric tube. Significant haematological findings included neutrophil leucocytosis, thrombocytosis and raised erythrocyte sedimentation rate (ESR). Both electrocardiogram and chest radiograph were within normal limits. Cultures from multiple sites revealed no pathogens; blood and urine cultures were sterile and serological tests were negative. At this stage a diagnosis of Kawasaki disease was made. Detailed questioning of the mother about events prior to the onset of symptoms revealed that the house had been extensively 'spring-cleaned' during the preceding week.

Soluble aspirin was commenced and there was a dramatic clinical response. The pyrexia resolved within 24 hours and the

mouth ulceration healed within four days. The skin rash and desquamation had cleared within a fortnight. The soluble aspirin was stopped after four weeks, the platelet count and ESR having settled to within normal limits. At this time also, a distinct transverse furrow was noticed on all the fingernails (Beau's lines). At follow-up over a two-year period she has remained well apart from developing allergic rhinitis, eczema and mild asthma.

Our patient presented with a perplexing clinical picture which did not really correspond with any of the common febrile illnesses. However, it did fit with all of the established principal features of Kawasaki disease<sup>1,2</sup> which are fever, conjunctivitis, mouth ulceration, inflammation of palms and soles, exanthemata and cervical lymphadenopathy. Kawasaki disease is most common in children between six months and four years of age. It occurs most commonly in the late winter and spring. Cardiac involvement occurs in 20% of patients with Kawasaki disease, with ensuing fatality in 1-2%. Fortunately there was no evidence of cardiac involvement in this patient. Another feature is thrombocytosis which may increase the risk of thrombosis. The most useful treatment is aspirin which has several beneficial effects. Corticosteroids appear to be contraindicated.

The cause of Kawasaki disease remains unknown. Clustering of cases has suggested a common infectious agent though none has been consistently isolated. Immunological tests during the acute phase of the illness have indicated exposure to the house dust mite which suggests that the disease may be due to a hypersensitivity to the mite itself or to some organism carried by the mite.<sup>3</sup> Our patient would probably have been exposed to high concentrations of house dust mite during the 'spring-cleaning' of her house just before the onset of her illness and so this could have been the precipitating event.

We present this case to make this disease more widely known among general practitioners since they spend a significant amount of their time in dealing with febrile illness in young children. The differential diagnosis includes scarlet fever, staphylococcal scalded skin syndrome (toxic epidermal necrolysis), Stevens-Johnson syndrome and Reiter's syndrome. Because of the potentially fatal outcome of Kawasaki disease, early recognition and prompt treatment are essential.

GERARD J.J. MURPHY  
RAYMOND A. FULTON

Altnagelvin Hospital  
Londonderry BT47 1JB

## References

1. Kawasaki T, Kosaki F, Okawa S, *et al.* A new infantile acute febrile mucocutaneous lymph node syndrome (MLNS) prevailing in Japan. *Pediatrics* 1974; **54**: 271-276.
2. Price J. Kawasaki syndrome. *Br Med J* 1984; **288**: 262-263.
3. Fujimoto T, Kato H, Ichiose E, *et al.* Immune complex and mite antigen in Kawasaki disease. *Lancet* 1982; **2**: 980-981.

## The treatable canary

Sir,

The efficacy of doctors' management and treatment of patients depends on another part of their job — the reaching of a diagnosis. The importance of making a correct diagnosis is never more obvious than when an incorrect one has been made or an important one has been missed. The least that a patient expects of their doctor is that he or she will know what, if anything is wrong with them. Doctors are not omniscient, yet along with their other tasks they are required to find a cause for a multitude of complaints and queries. How best can they do this, correctly, consistently and promptly?

Underpinning the teaching and practice of making the diagnosis are the almost absurd-sounding maxims that 'common things occur most commonly'; and that 'the bird on the wire is more likely to be a sparrow than a canary'. But there is no absurdity here. These maxims, though imperfect, are valuable devices bringing a logical sequence out of the multiplicity and even chaos of symptomatology. For each symptom and sign, a huge list of possible causative diseases may be compiled. It is impossible to try and exclude by thorough investigations each and every disease until the correct one is alighted upon. Over-investigation is costly, meddlesome and does a disservice to the patient. The matching of symptoms and signs to the frequency of occurrence of each disease — its commonness — usually leads speedily to a correct diagnosis.

Thus, most patients with headaches do not need computerized tomography scans. Their headaches are understandable using simple means and have a common, benign cause. Most children with a fever and red pharynx need neither a blood test nor a bone marrow examination. Their upper respiratory infection is common, benign and self-limiting. The problem is that brain tumours and leukaemia do occur, and provided they are diagnosed at a sufficiently early stage they can be treatable and curable. Yet they are often missed until it is too late. Review of the history in these cases may reveal their con-