THE JOURNAL OF INVESTIGATIVE DERMATOLOGY, 63: 298, 1974

Vol. 63, No. 3
Printed in U.S.A.

LETTER TO THE EDITOR

We are pleased to receive Letters to the Editor on appropriate subjects. These Letters should be submitted in typewritten form, double-spaced, and not to exceed 2½ pages. When appropriate, we will solicit comments from the original authors. All Letters to the Editor are subject to editing and possible abridgment.

To the Editor:

Your reviewer of our *Primer on Lupus Erythematosus* obviously read everything but the cover of our little booklet. His sharp eyes detected the obvious inexplicable oversight regarding the sedimentation rate. And, we did not make it clear that we recommend steroids only for *severe* systemic LE. For these corrections, we are grateful.

On the other hand, the reviewer seems to ignore the title itself. This booklet was intended to be a Primer, not a textbook. We are flattered by his criticism that we offer "too much for the patient"—we didn't believe that was possible. In fact, after disbursing 13,000 copies of the first two editions, we have received no complaints regarding too much information, nor of anyone being "frightened by photographs of lupus lesions."

The *Primer* was not written for the doctor who practices medicine in sophisticated institutions. We eliminated, for example, references to complement, anti-DNA, and renal biopsies—though we use them ourselves. The *Primer* was for the physician who does not have these procedures available to him—hence, the emphasis on studies available in most smaller hospitals.

The quantitative eosinophil test is not "inappropriate" as the reviewer claims. Perhaps we should have explained more in detail that it is useful in many ways, particularly in following the course of a patient with severe systemic lupus erythematosus, i.e., in the pretreatment stage, the eosinophils are usually found to be zero. Then after response to steroidal therapy, it uncommonly goes to 30–60 per cu mm (which makes it a variety of a therapeutic paradox). It is of particular value during a febrile state that may occur two to three weeks after steroids were started, and the question of an LE flare versus a drug fever can be settled with the eosinophil count. If it is 300–600 per cu mm, it is probably a drug fever; if 0, LE flare. Thanks to your reviewer, we will enlarge on this simple procedure in the next edition—it is hardly "inappropriate" if one knows its value.

Five thousand copies of this second edition were printed in November 1973. We are fresh out and have ordered another 5,000 copies. One does not like to use numerical testimonials as a protective barrier, but we believe that the booklet is doing the job we expected of it, namely, serving as a Primer.

John R. Haserick, M.D.
Pinehurst, North Carolina
and
Robert E. Kellum, M.D.
Seattle, Washington