LETTERS TO THE EDITOR

THE AUTHOR'S REPLY

The extension of hepatic tissue into the left quarter of the abdomen, on posterior view, occurs in perhaps one-third of the cases we have seen. This has been referred to as "hepatic-walk" and might be more common when the spleen is removed. The point made by Dr. Ryo is well taken. Hepatic tissue crossing into the left upper quadrant must be distinguished from the spleen with a defect. We have used the following aids:

1. Multiple angulated views are often helpful (and in the case we reported, the defect was confirmed on several views). Incidentally, we had other studies on the patient showing the progressive change in the lesion.
2. When the liver extends into the left, a continuous band of tissue can often be seen (although "thinned" by attenuation from the vertebral column).
3. A change of position can be helpful in making the decision, as suggested by Dr. Ryo.
4. Finally, "spleen-specific" scanning agents can be used to resolve uncertainties.

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RADIONUCLIDE SYNOVECTOMY WITH $^{32}$P-CHROMIC PHOSPHATE

The paper of Martin A. Winston, et al (J Nucl Med 14: 886–889, 1973) is very interesting in proposing a new radiocolloid for radiation synovectomy. Surgical synovectomy is a procedure extensively used in rheumatoid arthritic patients for alleviation of pain. Some of these patients and others with pathologic traumatic arthritis have chronic effusion and for this latter group radiation synovectomies have been conducted since 1963 by Ansell (1) and Makin (2–6).

As is well known, in rheumatic and osteoarthritic patients, external x-ray radiation was widely used many years ago by radiotherapists for alleviation of pain in the involved joints and in some places it is still used.

In the extensive population under treatment for rheumatoid diseases there is a place for the procedure reported by Winston, et al as shown by the following case.

NE, a 73-year-old white woman, was admitted in August 1972 for exacerbation of rheumatoid arthritis. She complained of pains and difficulty in bending her right knee, which prevented her from walking. Corticosteroids, indomethaine, and acetyl-salicylic acid were withdrawn because of gastric complications. Her right knee was hot, active, but without effusion, and the patient refused a proposed surgical synovectomy. Accordingly, we administered radioactive colloidal gold. The patient received 10 mCi $^{198}$Au intra-articularly. Makin proposed a minimum dose of 8 mCi to absorb effusion, which we chose for these treatments. As reported by Winston, et al there was a flare-up without increase in pain in

![FIG. 1](A) Anterior view of right knee following intra-articular administration of $^{198}$Au-colloid. (B) Lateral view.