

Our patient had concomitant, culture-proven infections with two genospecies of *B burgdorferi* sensu lato, *B garinii* and *B afzelii*. PCR-based evidence of simultaneous infection by two or even three genospecies of *B burgdorferi* sensu lato has been reported.³ We have found several local ticks harbouring more than one genospecies of *B burgdorferi* sensu lato (unpublished). It is possible that double infections with borreliae are not very rare, and could be transmitted even by the bite of a single tick. It has been suggested that the three European genospecies, *B burgdorferi* sensu stricto, *B garinii*, and *B afzelii*, have different organotropisms.⁵ *B garinii* has been proposed as the main causative agent of Lyme neuroborreliosis.³ It is impossible to say which one of the genospecies in our case was responsible for the clinical disease, or whether both were responsible. CSF and blood may give positive PCR results only transiently or intermittently. The reason for this might be the minimal amounts of spirochaetes and their degradation products occurring sporadically in the CSF and blood. It is also possible that spirochaetes are shed to the circulation only intermittently from their hiding places. Both possibilities stress the importance of repeated testing. The first symptom of infection in our patient was persistent myalgia. Transient photophobia, occurring 2 months before definitive diagnosis, was obviously an ocular manifestation of Lyme borreliosis. It is remarkable that the patient, with marked pleocytosis in the CSF, had no meningeal signs or headache. Without the transient bilateral facial palsy 1 year after onset of the infection, the patient's central-nervous-system infection would have remained unrecognised and progressed towards more serious sequelae. On the basis of this case, we advocate analysing the CSF of patients even when symptoms are mild.

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Pruritus

SIR—Yamada says (May 20, p 1314) “now pruritis is not hard to describe”; perhaps then the next step is knowing how to spell it, especially since the epidemic of this specific monolectic dyslexia seems to be spreading from the letters columns into the Articles (May 13, p 1198). *The Lancet* is not alone in this difficulty. Medline from 1966 to May, 1995, reports 4645 cases of pruritus (69 in *The Lancet*), compared with 174 cases of pruritis (none in *The Lancet*). The prevalence of the *-itis* mutation across time (figure) suggests a sudden and virulent outbreak in about 1975, with

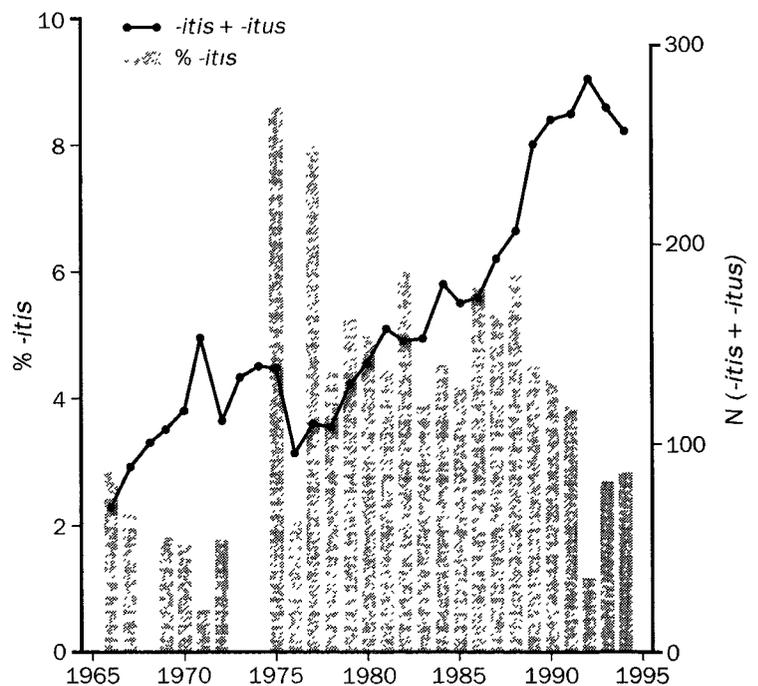


Figure: Prevalence of the *-itis* variant of pruritus (shaded bars) as a percentage of all occurrences of the *-itis* and *-itus* forms (solid line) in Medline, 1966–94

a subsequent decline, possibly attributable to prophylaxis through spell-checking software. The error perhaps results either from a frontal-lobe-type defect of overinclusion or perseveration from other occurrences of the common *-itis* suffix, or from a false etymology that itching must result from inflammation, *-itis* (presumably of the *prur-*, whatever that may be). Pruritus comes instead from the Latin *prurire*, to itch, and finds itself in the rather dubious company of coitus, crepitus, detritus, fremitus, introitus, situs, tinnitus, and vomitus.

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SIR—Taniguchi (April 1, p 870) along with Yamada (May 20, p 1314), and their colleagues, are justly concerned about how to describe, not to mention spell, pruritus. Since pruritus is one of the most misspelled words in medicine,¹ *The Lancet* can probably be forgiven for using pruritis (sic) in the title to Yamada's letter, and the authors must certainly be forgiven since the word (癢), so far as I can tell, is unambiguous in this regard. On the basis of W V Quine's proposition that, “faced with two terms for the same thing, one tends to cast about for a distinction”, I have argued that semantic distinctions between itch and pruritus should be cast aside.² At least in English, the words should be used interchangeably, which would give us one less word to misspell, and, perhaps, one less thing to scratch our heads about.³

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CORRECTION

Is proximal demarcation of ulcerative colitis determined by territory of the inferior mesenteric artery?—In this paper by M I Hamilton et al (18 March 1995), contrary to the figure legends, all figures referred to different patients.