Dimensional ratings may be more reliable than categorical ones, but most general practitioners will be able to recognize the R and S groupings in somatizers, the former anxious to change their environment, and the latter themselves.

When it comes to interventions it may be that, as in psychotherapy, doctor/patient factors are as important as the type of therapy used. If a somatizing tendency is a relatively fixed part of personality, people with R(S) and S(S) should select their primary care physicians with care. Perhaps their first and most important task is whether to choose a ‘splitter’ or a ‘lumper’.

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REFERENCES
1 Tyrer P. New approaches to the diagnosis of psychopathy and personality disorder. J R Soc Med 2004;97:371–4
2 Ernst E, White AR. The BBC survey of complementary medicine use in the UK. Complement Ther Med 2000;8:32–6
3 Beutler LE, Machado PP, Neufelt SA. Therapist variables. In: Bergin AR, Garfield SL, eds. Handbook of Psychotherapy and Behaviour Change. New York: Wiley, 2004

Kikuchi’s disease
In their case report of a patient with Kikuchi’s disease Dr Chung and colleagues (July 2004 J RSM) refer to reported associations with systemic lupus erythematosus, Hashimoto’s thyroiditis and infection with toxoplasmosis, Yersinia enterocolitica and herpesvirus 6. Kikuchi’s disease has also been associated with four other autoimmune diseases—polymyositis, mixed connective tissue disease, adult and juvenile onset Still’s disease and the antiphospholipid syndrome. In addition cases have been linked with breast cancer, dyspepsia and parvovirus B19 and herpesvirus 8.

As Chung et al. state, a viral aetiology has been suggested but never satisfactorily proven. Given the variety of disease associations, it is possible that Kikuchi’s disease represents an unusual response of histiocytes and T-cells to a range of local or systemic immune stimuli, including both foreign and self antigens.

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REFERENCES
1 Chung TT, Chowdhury N, Piper K, Chowdhury TA. Pyrexia and lymphadenopathy in a south Asian woman. J R Soc Med 2004;97:336–8
2 Wilkinson CE, Nichol F. Kikuchi-Fujimoto disease associated with polymyositis. Rheumatol 2000;39:1302–4
3 Aqel NM, Amr SS, Najjar MM, Henry K. Kikuchi’s lymphadenitis developing in a patient with mixed connective tissue disease and Hashimoto’s thyroiditis. Br J Rheumatol 1997;36:1236–8
4 Ohta A, Matsumoto M, Ohta T, et al. Still’s disease associated with necrotizing lymphadenitis (Kikuchi’s disease): reports of 3 cases. J Rheumatol 1998;15:981–3
5 Papaionannou G, Spletas M, Kalousi V, Pavlitou-Tsiontsi A. Histiocytic necrotizing lymphadenitis (Kikuchi-Fujimoto disease) associated with antiphospholipid syndrome: case report and literature review. Ann Haematol 2002;81:732
6 Aqel NM, Al-Sewan M, Collier DS. Kikuchi’s disease in axillary lymph nodes draining breast carcinoma. Histopathology 2000;36:280–1
7 Radhi JM, Shinndier L, McFadden A. Kikuchi’s lymphadenitis and carcinoma of the stomach. J Clin Pathol 1997;50:530–1
8 Yen A, Fearnehough P, Raimer SS, Hudson SD. EBV-associated Kikuchi’s histiocytic necrotizing lymphadenitis with cutaneous manifestations. J Am Acad Dermatol 1997;36:342–6
9 Yufu Y, Matsumoto M, Miyamura T, Nishimura J, Nawata H, Oshima K. Parvovirus B 19-associated haemophagocytic syndrome with lymphadenopathy resembling histiocytic necrotising lymphadenitis (Kikuchi’s disease). Br J Haematol 1996;92:686–71
10 Huh J, Kang GH, Gong G, Kim SS, Ro JY, Kim CW. Kaposi’s sarcoma-associated herpesvirus in Kikuchi’s disease. Hum Pathol 1998;29:1091–6

The death of Napoleon
It was with fascination that I read the paper ‘Channelling the Emperor: what really killed Napoleon?’ (August 2004 J RSM), but I must emphasize that despite its title it is only concerned with the immediate cause of Napoleon’s death. As indicated in my 1996 paper on Napoleon’s health, the Emperor first complained of nausea and upper abdominal discomfort after food in July 1820. The dyspepsia worsened to give loss of appetite, constant nausea, frequent vomiting, upper abdominal pain and constipation. There were periods of remission but the pain and vomiting became increasingly insistent. He lost weight and by the end of January 1821 could only manage fluid nourishment, finally taking to his bed on 17 March. On 27 April he vomited blood and his condition deteriorated with further bleeding and lapses into unconsciousness before death on 5 May.

At necropsy in front of sixteen observers including seven British doctors, of whom five signed the official report, the external surface of the stomach appeared healthy. On opening, however, it contained altered blood and almost its entire lining was cancerous: a scirrhous cancer had converted the stomach into a leather-bottle stomach with spread to the adjacent lymph nodes and with a perforation that had become sealed off. There was a family history of gastric carcinoma, and Napoleon realized he was dying of the same disease as his father and grandfather, remarking on 15 April, ‘I know the truth and I am resigned’.

Clinically the cause of death was clearly gastric carcinoma, but on the publication of my paper in 1996, I...