Letters

Heberden’s nodes and osteoarthrosis of the hip

SIR, I have read the interesting report by McGoldrick and O’Brien studying the relation between the various patterns of osteoarthritis (OA) of the hip and Heberden’s nodes.1 Their paper also challenges our earlier report, which found no significant association between osteoarthrosis of the weight-bearing joints (hips and knees) and Heberden’s nodes in a controlled study.2

My main criticism of the McGoldrick and O’Brien paper is that they do not compare like with like. The prevalence and severity of the nodes in their axillary, superomedial, and profusion groups combined (representing primary OA) is indeed higher than in the congenital dislocation of the hip, dysplasia, and superolateral groups combined (representing secondary OA). On the other hand, the combined female to male ratio is 32/18 among the probands in the first three groups and 15/22 among the probands in the last three groups. As is also pointed out by the authors this represents a clear difference in favour of women in the groups representing primary OA.

It is universally acknowledged that Heberden’s nodes by themselves are more common among women, regardless of the presence of OA in other joints. Thus it would have been better if the authors had analysed their data by considering the prevalence of the nodes among the two genders separately in order to eliminate the sex bias.

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References

Osteomalacia and coeliac disease presenting as isolated dactylitis

SIR, We read with interest the case report ‘Osteomalacia and coeliac disease presenting as isolated dactylitis’ by Jawad et al.1 We believe that the dactylitis was related to secondary parathyroid overactivity rather than a primary manifestation of osteomalacia.

We have a patient, an Asian vegetarian woman aged 46 years, who presented with pain and swelling in her right index and middle fingers. An x-ray examination was suggestive of a dactylitis. Her investigations excluded tuberculosis, sarcoidosis, sickle cell disease, syphilis, and inflammatory arthritis.

Serum calcium was low (2.06 mmol/l), phosphate normal (0.95 mmol/l), alkaline phosphatase raised (212 IU/l), and serum vitamin D very low (3 nmol/l). Parathyroid hormone was 1.5 ng/l (normal up to 0.5). She was treated with 3000 U calciferol daily. Three months later her dactylitis had

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