purchasers might consider “buying” inadequately evaluated therapies, on the same basis that physiotherapy was derailed for accepting electrotherapy by “... giving credence to unscientific hype”1. Caveat emptor.

I fully endorse the author’s call for more research into the efficacy of physiotherapy, and already many of the obstacles that impeded physiotherapy research are being addressed. In a recent letter in the British Journal of Rheumatology2 I explained that through the creation of university departments, the expertise and career structure exists to enable us to advance research in physiotherapy. We are now successfully competing for funding to critically evaluate our treatments, so that we can deliver the most effective treatment to our patients with the optimal use of resources.

MICHAEL V HURLEY
Physiotherapy Group
King’s College
London
United Kingdom


AUTHOR’S REPLY: I am delighted that Dr Hurley agrees with me that much physiotherapy requires proper evaluation. This does not, however, imply repeating experiments indefinitely until the answer to the researcher wishes has been obtained. One well-conducted piece of research may well be all that is necessary to answer a question, and at the very least it requires an equally scientific reply rather than prejudice hidden behind words such as “measured judgments”.

Had Dr Hurley read my editorial carefully he would have realised that I nowhere advocated the use of massage. He must accept, though, that massage and other complementary therapies are already high on the list of purchasers’ wishes. A recent survey by the National Association of Health Authorities and Trusts showed that 65% of District Health Authorities and 70% of Family Health Services Authorities favoured purchasing such therapies as part of their NHS provision.1 Probably many of them act only by a placebo effect, but few are likely to be purchased purely as advocate, as Dr Hurley does for physiotherapy, the use of complex pieces of electrical equipment such as lasers as placebos.

IAN HASLOCK
Department of Rheumatology
South Cleveland Hospital
Marton Road
Middlebrough
Cleveland TS4 3BW

Distinction between initiation and progression of the osteoarthritis process

I read with positive interest but negative feelings the article by Cumming et al.1 Their conclusion that ‘arthritis’ of the hip should be included in the list of factors that protect against hip fracture is in line with our previous observation on the inverse relationship between osteoarthritis and osteoporosis,2 and in particular with the recent epidemiological evidence revealed in the MEDOS Study.3 The MEDOS study is also based on self-reported osteoarthritis in a large series of controls and hip fracture cases. In both studies the inverse relationship between osteoarthritis and osteoporosis is independent of body weight, which supports the hypothesis that there is a direct causal relationship between osteoporosis and osteoarthritis.

A disturbing element in the paper by Cumming and Klineberg is the confusing terminology used throughout the paper. The term ‘arthritis’ is used interchangeably with ‘osteoarthritis’. We do not agree that this interchangeable terminology should be used in an international rheumatology journal. The term arthritis is so bound to many other forms of arthritis, in particular rheumatoid arthritis, gout and pelvispondyloitis, that this will inevitably lead to confusion in later citations. Although the term osteoarthritis is also not the best one, this term is now well accepted as an alternative to osteoarthritis. According to our opinion and to many others, such as, Radin,3 clear distinction should be made between initiation of the osteoarthritis process and progression. That secondary inflammation might be involved in the progression of osteoarthrosis is well accepted, but whether inflammation is the primary trigger of osteoarthritis is doubtful. A number of studies on the initiation of the osteoarthrosis process support the possibility that the increased bone density reduces the mechanical ability of subchondral bone to deform under impact loads with resulting damage to the articular cartilage and osteoarthritis.4 5

J DEQUEKER
R DEQUEKER
Arthritis and Metabolic Bone Disease Research Unit
K U Leuven, U Z Pellenberg
B-3112 Pellenberg, Belgium

AUTHORS’ REPLY: We regret that the use of the terms ‘arthritis’ and ‘osteoarthritis’ appear to have been used interchangeably in our recent paper. We can assure Drs Dequeker and Westhoven that we gave careful thought to the use of these two terms. We tried to use the term ‘osteoarthritis’ whenever possible (particularly in the Introduction and Discussion sections of our paper). However, our data were based on self-reported joint symptoms; we did not ask subjects about osteoarthritis specifically. Thus we tried to use the term ‘arthritis’ whenever we were referring to the data from our study (particularly in the Results section and in the tables). We thought it would be misleading to readers if, for example, we wrote about ‘self-reported osteoarthrosis of the hip’.

ROBERT G CUMMING
ROBIN J KLINEBERG
Department of Public Health, A27
University of Sydney
NSW 2006
Australia
Authors' reply

Robert G Cumming and Robin J Klineberg

doi: 10.1136/ard.53.5.356-c

Updated information and services can be found at:
http://ard.bmj.com/content/53/5/356.3.citation

*These include:*

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/