4) How are your articular symptoms? (joint swelling, spine stiffness, tendinitis).
5) Did you modify your NSAID regime? (maintenance, underdose, reduced/discontinued).
6) Do you consider that the effect of the diet justifies continuing it?

When at least 4/6 variables were improved or positive, and none deteriorated the therapeutic effect was considered as good, and when 2/6 were improved and none deteriorated, as moderate. The compliance to the diet (poor, questionable or good) was assessed from the questions to the patient.

The subgroup results at six weeks (table) showed a relatively good compliance to the diet (18/25). When patients were questioned about its benefit, 13/25 reported good efficacy (no precise symptom was more sensitive), and 4/24 a moderate improvement, among the good responders, 8/13 could discontinue their NSAID therapy. Conversely, despite good compliance, no patients with RA improved at six weeks or continued NSAID, and they all decided to discontinue the trial.

When follow up of the 17 SA responders was carried out, 12/15 were still satisfied and kept up the diet at three months, 10/10 at six months and at nine months. Over the next follow up is now over two years; six patients are still observing the diet and remain free from any other therapy; interestingly, none reported discomfort or frustration with the diet even over the longest duration.

No association between response and variables such as sex, age, axial versus peripheral involvement, enthesisopathies, sacroiliitis, HLA-B27, intestinal, genito- or cutaneous symptoms, duration of disease could be demonstrated. According to some patients, psoriatic lesions remained unchanged but the number of such patients was too low.

In summary, this study indicated that more than half of the patients with SA felt a subjective improvement of their symptoms with a diet without milk products; they felt better, pain was decreased, morning stiffness improved, joint and spine symptoms got better, NSAID consumption was reduced and a large number of patients agreed to continue the diet for a longer period. So far, postulation and its heterogeneity in the subgroup of responders could not be further characterised.

Benefit to the patients appeared within six weeks and most of the responders decided to keep up with the diet for months or years. Interestingly, three patients reported a transient relapse of their complaints within a few days when there was a relapse in the diet and one patient on the diet was free of recurrent episodes of uveitis for over two years. Yet before interpreting these data, one should be aware of the numerous biases: small, heterogenous and not randomised, subjective evaluation of efficacy, diet without excluding all milk products, no control diet, subjective measures of outcome and compliance, and in addition the course of SA which can be spontaneously favourable.

A placebo effect is present in this study; yet a high proportion of SA responders – in contrast to RA patients – continued the trial for a relatively long period of time and in the six-weeks follow-up, analysis, NSAID and salazopyrine/methotrexate could be discontinued in respectively 8/10 and 3/3 patients. The reasons for possible benefit from the diet remains unknown. Digestion is capable of producing a hypersensitivity reaction and certain associations between connective tissue diseases and food (ingredients) have been proposed.1 Approximately one third of SA patients "believe" that certain foods can increase morning stiffness, pain and swelling.2 A diet free of dairy products could modify the content of the intestinal flora and consequently reduce the proliferation of pathogenic bacteria. Some gram negative bacterial fragments could persist despite the ultra high temperature processing of milk.

Alternatively, a chronic intestinal allergy to milk products could contribute to the gut permeability alterations in SA.

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Matters arising

However, the significance of our findings is heightened by the close matching of our rheumatoid alone (RA) and rheumatoid and bronchiectasis (RABR) groups and we suspect that Kelly and Gardiner's groups were not so matched. Clearly the point concerning the relative frequency of Sjögrens syndrome in RA and RABR will not be settled until it has been examined with more rigour and sufficient numbers of subjects. Secondly, there are clinical, genetic and serological differences which make primary and secondary Sjögrens distinct entities, and if bronchiectasis is associated with secondary Sjögrens syndrome, it does not necessarily follow that a similar relationship will be found with primary Sjögrens syndrome.

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The relationship between rheumatoid arthritis and bronchiectasis.

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