differences, even if some changes were present in both groups. We agree that conventional radiograph pictures of zygapophyseal joints are difficult to read. Histological analysis of several or many samples at different stages of disease evolution is needed to reconstruct the ‘natural’ history of chronic diseases with unknown etiology.

Professor Dihlmann and Dr Hering are quite correct when they state that these experts cannot expect their opinion to be shared all over the world. We did not aim to elevate ourselves to the rank of judges, deciding which ideas are correct and which people should be condemned for theirs. Instead we tried to alleviate part of the confusion that has arisen from improper coinage or use of terms. Many people do not understand the real meaning of some words of everyday medical jargon. We first established a methodology in order to avoid arbitrary selection of terms that we would like or dislike. Five rules were adopted and the first one was to respect the etymological sense of the terms.

Many acquired conditions are characterised by hyperostosis: for example vertebral ankylosing hyperostosis, florosis, and Paget’s disease, to name but three. Therefore, the term ‘acquired hyperostosis syndrome’ applies strictly sensu a wide variety of conditions and is not the best one to replace the 40 that exist to name sternocostoclavicular hyperostosis, recurrent focal osteomyelitis, etc. SAPHO as an acronym just means that the authors, in common with Dihlmann, wanted to group several conditions. Are we yet certain that the pathological basis of acne related locomotor changes is the same as that of the other hyperostoses? There is also the lumpers-splitters controversy: we support that similar diseases be grouped in the same section of a textbook, but should they be named by one term?

Acronyms are often no more than a society game or a good mnemotechnic device. The game, however, should be fair. DISH contains a pleonasm (skeletal hyperostosis); the original and the English spelling of the Lesbo poetess is Sappho; in French dictionaries, Sappho is the main entry, but Sapho is accepted too.

Concerning parasyndesmophytes, we defined them according to their morphological character. We could have added a comment that they are more frequent in psoriasis and Reiter’s syndrome; they do occur in uncomplicated ankylosing spondylitis. The psoriatic paravertebral ossifications differ from parasyndesmophytes in that they are unconnected to the vertebral bodies. Of course, that term applies as well to other paravertebral bone formations. This is why in the glossary it is followed by the qualification ‘(in psoriasis)’.

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3 Khan M A, ed. Ankylosing spondylitis and related spondyloarthopathies. In: Spino-
7 Auffermann J M. Bandscheibenbeteiligung der Wirbelstiere beim chronischen Gelenk-

Destructive large joint arthritis

I was interested to read the article on destructive large joint arthritis by Regan and colleagues. In the differential diagnosis they have not included the destructive arthropathy sometimes seen in chondrocalcinosis artilcularis as a result of calcium pyrophosphate crystal deposition. The two patients described by Regan and colleagues had neuropathic joint destruction, but no mention is made as to whether crystals were sought in the biopsy specimen of patient 1 or if the shoulder effusion of patient 2 was aspirated and examined for crystals.

Calcium pyrophosphate deposition in large joints may be found without radiological chondrocalcinosis, particularly when joint destruction has taken place, and calcium pyrophosphate crystal deposition has also been described in neuropathic joints, albeit in four patients with late latent syphilis.

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AUTHORS’ REPLY: We thank Dr Richard for his comments. We agree that the destructive arthropathy seen in chondrocalcinosis should be included in the differential diagnosis of a rapidly destructive large joint arthritis.

Crystals were not sought in the synovial biopsy specimen or synovial fluid from either patient described.

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Destructive large joint arthritis.

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