MATTERS ARISING

Periarticular bone mineral density at the knee joint

Recently, dual energy x-ray absorptiometry (DXA) was presented by Murphy et al as a new method for assessing periarticular bone mineral density (BMD) at the knee joint.1 Precision errors for BMD measured at the patella and proximal tibia were reported for 14 subjects. The paper highlights the emerging importance of measurement of radiological data and attention to regional density characteristics in bone and joint diseases. Subchondral bone mineral density of the proximal tibia has previously been assessed by dual photon absorptiometry (DPA)—the precursor of DXA. Relations between subchondral BMD of the proximal tibia and age, height, weight, and BMI of the lumbar spine and femoral neck were examined by Bohr and Schaad.2 Petersen et al presented subchondral BMD values for a large number of healthy subjects and for patients with various orthopaedic conditions.3 Bohr and Lund4 and Petersen et al examined changes in BMD at the proximal tibia after meniscectomy.5 Moreover, Petersen et al examined subchondral BMD after meniscectomy and Madsen et al reported data for subchondral BMD measured in several subregions of the proximal tibia in healthy subjects and in subjects with osteoarthritis of the knee.6 Petersen et al studied relations between bone strength assessed by DPA and DXA in the proximal tibia.7 Other related studies could be mentioned. Unfortunately, none of these studies was referred to by Murphy et al.8

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Author’s reply

We appreciate the interest shown in our work by Dr Marsden. We acknowledge that subchondral bone mineral density has previously been assessed by dual photon absorptiometry. However, we do not feel that this is particularly relevant to our paper. The purpose of our study was to develop and validate a method for measurement of periarticular bone mineral density at the knee joint using the technique now recognised as the gold standard for the assessment of bone mineral density—that is, dual energy x-ray absorptiometry (DXA). With the exception of one study,9 the studies referred to by Dr Marsden use only dual photon absorptiometry.

As mentioned by Dr Marsden, Petersen et al measured bone mineral density of small regions of interest within the proximal tibia by DXA and used these measurements to investigate the relation between trabecular bone strength and bone mineral density in the proximal tibia.10 However, it is not clear from this paper how many measurements were taken for calculation of precision values as the paper concentrates on the use of, rather than the validation of, this technique. Furthermore, the DXA measurements were performed only on postmortem sections of tibial bone obtained at necropsy. Finally, unlike our study, which showed how to measure bone density of periarticular bone, the regions of interest selected by Marsden et al did not include the periarticular surface of tibia, but rather were confined to small areas within the subchondral bone. Thus the areas measured consisted primarily of trabecular bone.

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LETTERS TO THE EDITOR

A mnemonic for SLE diagnostic criteria

Like many rheumatological diseases, systemic lupus erythematosus (SLE) is difficult to diagnose owing to the constellation of findings required. I offer a mnemonic that contains the 11 categories used by the American College of Rheumatology, from which four or more must be present to diagnose SLE: A RASH POINTS MD.

Arthritis
Renal disease (proteinuria, cellular casts)
ANA (positive antinuclear antibody)
Serositis (pleurisy or pericarditis)
Haematological disorders (haemolytic anaemia or leucopenia or lymphopenia or thrombocytopenia)
Photosensitivity
Oral ulcers
Immunological disorder (positive LE cell, anti-DNA, anti-Smith, false positive serological test for syphilis)
Neurological disorders (seizures or psychosis, in the absence of other causes)
Malar rash
Discoid rash

Because the malar rash is the most easily recalled finding, this uses the phrases that word and an accompanying message that it "points an MD to a possible diagnosis." Readers may find this useful in teaching students and residents to remember the many elements of this complex condition.

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Can rheumatologists agree on a diagnosis of inflammatory arthritis in an early synovitis clinic?

Irreversible joint damage can occur within months rather than years of the onset of rheumatoid arthritis.1 It is therefore important that these patients are diagnosed and treated as early as possible. To facilitate the early introduction of effective treatment, a rapid referral system is important. Throughout Europe, a number of centres have developed early synovitis clinics (ESCs) for this purpose. However, the diagnosis of early inflammatory arthritis (IA) is often difficult and confusing for the primary care doctor. Dr Marsden1 suggests that the efficiency of ESCs is impaired by inappropriate referrals.2 Is this criticism justified? If general practitioners find it difficult to diagnose early IA, what about hospital specialists? In this short study we posed the question “Can rheumatologists agree on a diagnosis of IA in an ESC?”

Patients were recruited from primary care in the greater Belfast area (population ca 400 000). We randomly selected 24 patients who had been referred to an ESC in a Belfast teaching hospital and invited them to attend for outpatient assessment. Informed written consent was obtained from each patient before they took part in the study. Six hospital rheumatologists (two specialist registrars and four consultants) independently assessed 20 patients referred to an ESC by their primary care doctor. Patients were randomly assigned to each rheumatologist, who was asked to judge whether or not the patient currently had any type of IA. Before the study, the assessing rheumatologists had agreed on a definition of IA. Each assessment was conducted in a maximum of 15 minutes, but patients were not informed of their diagnosis until the final consultation, which included an additional 15 minutes to provide time to arrange a management plan for their problems.


Twenty four patients were invited to participate in the study and 20 consented to take part. Three patients failed to turn up for their outpatient appointment and one patient who did attend declined to take part in the study. There was complete agreement in the assessment of 14/20 patients (70%), 11 (55%) of whom were deemed to have IA (including RA, psoriatic arthritis, and reactive arthritis) and three (15%) who were not. In two cases (10%), only one rheumatologist diagnosed IA. In a further two cases (10%), only two specialists diagnosed IA and in the final two patients (10%), four of the six specialists diagnosed IA. In all cases where there was disagreement, the final assessor shared the majority opinion as to the correct diagnosis. The level of agreement between assessors was calculated using the k statistic, where a value of 1.0 represents total agreement. The overall k value for the six assessors was 0.68. Interestingly, the registrars had a higher level of agreement (k 0.9) than the consultant rheumatologists (k 0.6), though the difference was not statistically significant.

These results show that IA can be a difficult diagnosis to make in the setting of an ESC, even among experienced rheumatologists. Nevertheless, the level of agreement in this study compares favourably with that in other specialties such as radiology and ophthalmology. Given these findings, it is clearly important to keep an open mind about the diagnosis of IA in its early stages, especially where the clinical findings are equivocal. Careful follow up of such patients should be an important part of the work of any ESC.

MATTERS ARISING, LETTERS

Ultrasound guided injection of plantar fasciitis

Kane et al reported four cases of ultrasound guided injection in recalcitrant idiopathic plantar fasciitis.1 We would like to report a different experience using a similar method.

Two patients with a clinical diagnosis of idiopathic plantar fasciitis, unresponsive to an initial palpation guided injection with 10 mg of triamcinolone acetonide, underwent ultrasound examination of the heel. Increased thickness of the plantar fascia near the calcaneal insertion was noted with both plantar fasciae measuring 7.5 mm in depth. Under real time ultrasound guidance, using a medial approach, the tip of a 21 gauge needle was positioned in the centre of the plantar fascia. However, on both occasions, considerable resistance was experienced in attempting to inject triamcinolone and lidocaine mixture into the centre of the plantar fascia. Injection was possible only by withdrawing the needle, under ultrasound guidance, to the edge of the plantar fascia where the injected solution was seen to disperse around the edge of the plantar fascia as shown in figs 1A and B. Both patients responded well to this treatment, being symptom free on review one month later.

Kane et al described injection directly into the substance of the plantar fascia with dispersal of the injection mixture into the substance of the fascia. Our experience suggests that it is difficult to inject into the substance of the plantar fascia. Rather, one may inject at the edge of the plantar fascia with perifascial dispersal of steroid. This still appears to result in satisfactory alleviation of symptoms.

HLA-DRB1 and DQB1 genes in antecentromere antibody positive patients with SSc and primary biliary cirrhosis

The frequency of certain HLA class II alleles has been reported to be high in patients with systemic sclerosis (SSc), especially in the clinical subsets defined by SSc related antinuclear antibodies and ethnicity.1 In antecentromere antibody (ACA) positive SSc, a high frequency of HLA-DQB1*0602 has been reported.1 Moreover, ACA positive patients have been shown to have a high frequency of HLA-DQB1*0601.2 At least one association of ACA with HLA antigens has been reported in SSc-PBC overlap.3 However, no association between ACA and HLA-DRB1 and HLA-DQB1 has been reported in SSC-PBC overlap.

Table 1 Gene frequency of selected HLA-DRB1 alleles in antecentromere antibody (ACA) positive patients

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<tr>
<th>DNA alleles</th>
<th>SSc‡ (%)(n=20)</th>
<th>PBC‡ (%)(n=13)</th>
<th>Healthy control (%)(n=215)</th>
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* p<0.0005, OR=4.4, fP<0.01, OR=3.7, fP<0.005, OR=3.5. 
† p<0.0005

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3 Sackett D L, Haynes RB, Guyatt GH. Clinical epidemiology—a basic science for clinical medicine. London: Little.
The p values were calculated by Fisher's exact test: †p<0.005, ‡p<0.01, §p<0.05.

**SS = Sjögren's syndrome; PBC = primary biliary cirrhosis; AMA = antimitochondrial antibody; SS-A = anti-Ro/SS-A antibody.**

In PBC, no difference in phenotype frequency (the number of patients positive for an allele) of DRB1*0803 was found between ACA positive patients and ACA negative ones (6/13 (46%) vs 5/18 (28%)). Patients with PBC who were ACA positive frequently overlapped SSc compared with ACA negative patients (6/13 (46%) vs 1/18 (6%), p<0.05). On the other hand, DRB1*0803 in PBC showed no difference between overlap and nonoverlap patients with SSc classified by the presence of ACA and DRB1*0803. Phenotype frequency of DRB1*0803 was not different between ACA positive SSc and ACA negative SSc. ACA positive SSc frequently overlapped SS-A positive SSc and PBC with ACA negative SSc. In ACA negative SSc, DRB1*0803 positive patients frequently overlapped SS-A positive SSc, and one of the five patients with DRB1*0803 overlapped SSc. DRB1*0803 may be a candidate allele to determine the susceptibility to SSc and PBC in patients with SSc with no relation to the presence of ACA, and the existence of common candidate alleles in PBC and SS-A may explain the high frequency of overlap of both the diseases. There was no significant difference in skin sclerosis or organ involvement in patients with SSc classified by the presence of DRB1*0803 (data not shown).

Our report describes the variation of HLA class II alleles among ACA positive patients according to their clinical features; high frequency of HLA-DRB1*0101/ DQB1*0501 and DRB1*0803 are restrictively found in SSc and PBC, respectively. Although DRB1*0803 is not related to the production of ACA, this allele may be related to the susceptibility not only to PBC but also to SS-A in patients with SSc.

We thank Dr Takehiko Abe and Dr Akira Kojima, The First Department of Internal Medicine, for their help in collecting blood samples from patients with PBC.

This study was partly supported by grants from Kanazawa Medical Research Foundation (1999) and a Scleroderma Grant for Intractable Disease from the Japanese Ministry of Health and Welfare (1999).

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Table 2 shows clinical analyses in patients with SSc classified by the presence of ACA and DRB1*0803. Phenotype frequency of DRB1*0803 was 43% (3/7) in SSc-PBC overlap and 33% (8/24) in PBC without SSc related features. Table 2 shows clinical analyses in patients with SSc classified by the presence of ACA and DRB1*0803. Phenotype frequency of DRB1*0803 was not different between ACA positive SSc and ACA negative SSc. ACA positive SSc frequently overlapped SS-A positive SSc and PBC compared with ACA negative SSc. In ACA negative SSc, DRB1*0803 positive patients frequently overlapped SS-A positive SSc, and one of the five patients with DRB1*0803 overlapped SSc. DRB1*0803 may be a candidate allele to determine the susceptibility to SSc and PBC in patients with SSc with no relation to the presence of ACA, and the existence of common candidate alleles in PBC and SS-A may explain the high frequency of overlap of both the diseases. There was no significant difference in skin sclerosis or organ involvement in patients with SSc classified by the presence of DRB1*0803 (data not shown).

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Can rheumatologists agree on a diagnosis of inflammatory arthritis in an early synovitis clinic?

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