New issues in tuberculosis

We read with interest the recent article by Kaufmann, who reported new issues in the epidemiology and treatment of tuberculosis. Dr Kaufmann pointed out that tuberculosis remains a significant health threat in the new European Union member states, in contrast with the "old" EU member states, in which the incidence of this disease is decreasing. Accordingly, he reported the incidence for Slovenia as above 20/100,000.

It is important to clarify that the mentioned incidence was last reported in Slovenia in 1999. Since 1995, tuberculosis in Slovenia has been decreasing constantly, reaching an incidence of 17.5/100,000 in 2002. Data also available on website http://www.eurotb.org, accessed 24 February 2005.) The preliminary data of the central registry for tuberculosis in Slovenia have shown a further decrease for 2003, with an incidence of 14.7/100,000 (personal report).

The importance of the omitted information is not only academic. Fictitious higher incidences of tuberculosis misrepresent the risk of this disease in Slovenian patients treated with biological drugs, which could be important in multicentre clinical studies.

Furthermore, we would like to mention that the incidence of tuberculosis in patients treated with biological agents in Slovenia is very low. This treatment is centrally indicated and evaluated. We have confirmed only one case of tuberculosis among 200 patients receiving biological agents (anakinra, infliximab, etanercept).

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Authors' reply

I read with great interest the comments about the decreasing incidence of tuberculosisc rates Slovenia. As is stated correctly, the incidence of tuberculosis in Slovenia is now below 20/100,000. Indeed, fig 1 of our report shows the correct incidence rate and the text stating incidence “above 20/100 000” for Slovenia and Slovakia should read “above 15/100 000”. Data for 2002 provided by the most respected organisation, the World Health Organisation, were used for comparison of tuberculosis incidences in different EU member states.

I am pleased to witness a constant decrease in the incidence of tuberculosis in Slovenia (and other EU member states), which may have reached less than 15/100,000 in 2003.

References


Disparities in health according to socioeconomic status

The viewpoint expressed by Lee and Kavanaugh of great interest, and may even underestimate the potential importance of data concerning socioeconomic status and race in clinical trials. In one study low formal education level was associated significantly with higher joint counts, erythrocyte sedimentation rate, and patient questionnaire responses. In another study, formal education was a more important identifier of poor physical function and high pain scores than age or duration of disease in patients with rheumatoid arthritis, scleroderma, systemic lupus erythematosus, fibromyalgia, and osteoarthritis. In the B-HAT study, education level was as prognostic of outcome over 3 years after a myocardial infarction, whether patients were randomised to a beta blocker, propranolol, or placebo.

Many physicians continue to believe that the primary reason for associations of low socioeconomic status and poor health is limited access to medical care. One explanation is that the classical “biomedical model” suggests that disease outcome and health in general is determined largely, if not entirely, by health professionals, with minimal contribution from patients. That certainly applies by health professionals, with minimal contribution from patients. That certainly applies.

Disparities have widened in people of low socioeconomic status in most of data concerning socioeconomic status and race in clinical trials. In one study low formal education level was associated significantly with higher joint counts, erythrocyte sedimentation rate, and patient questionnaire responses. In another study, formal education was a more important identifier of poor physical function and high pain scores than age or duration of disease in patients with rheumatoid arthritis, scleroderma, systemic lupus erythematosus, fibromyalgia, and osteoarthritis. In the B-HAT study, education level was as prognostic of outcome over 3 years after a myocardial infarction, whether patients were randomised to a beta blocker, propranolol, or placebo.

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Authors’ reply

We agree with the comments of Professor Pincus, and appreciate his interest. His points expand upon and agree with our own, very nicely we believe, and we support his remarks.

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Frozen shoulder

The study by Buchbinder et al suffers from a major drawback to any study dealing with frozen shoulder when the pathophysiology
has passed the acute phase. In their study the mean duration of symptoms was 25.5 weeks in the active group with a standard deviation of 13.3 weeks, the mean therefore being approximately 6 months. This is well over the time course one would expect in the inflammatory phase of frozen shoulder, and therefore it is not surprising that prednisolone provided some benefit. I suspect the benefit provided was related to improvement in myalgia and wellbeing that occurred with the prescription of prednisolone, but which was quickly lost when prednisolone was reduced or stopped.

Although the authors quote a study co-authored by Buchbinder on a standardised protocol for the measurement of shoulder movement,1 we have concerns that the definition of frozen shoulder, as restricted passive movement by <30° in two or more planes measured at the onset of pain with a gravity inclinometer, may not be appropriate, given that frozen shoulder restricts all movements. There may also be other diseases present. In particular, it would be prudent to consider magnetic resonance imaging scans of the shoulder to confirm the diagnosis, or not, of the adhesions within the shoulder capsule, and a rotator cuff tear. Further subtle changes which may not be clinically apparent, such as rotator cuff tears unidentified on ultrasound.

The study, therefore, provides no insight or treatment options for prednisolone in frozen shoulder. Rather, it fails to recruit patients into the classical acute phase of a frozen shoulder within the first several months. Until such treatment is examined in an appropriate clinical trial, this study by Buchbinder provides no further evidence of the usefulness or otherwise of prednisolone in frozen shoulder. The study, not surprisingly, failed to show any long-lasting benefit of prednisolone because the shoulder, by its natural history, had entered the stiff phase.

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References

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Further details can be obtained from: Miss Lisa McClair, ARC Epidemiology Unit, Stopford Building, University of Manchester, Oxford Road, Manchester M13 9PT, UK. Tel: (0) 161 275 5993. Fax: (0) 161 275 5043. Email: Lisa.McClair@manchester.ac.uk

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