PROF. BYWATERS (*Taplow*) The life of this type of presentation is becoming shorter with rapidly advancing knowledge and changing concepts. This is one of the great drawbacks of all these types of pre-recorded teaching. I do not quite see how that can ever be got over.

DR. HOLROYDE The question is a philosophical one. It relates to whether the quality of a lecture such as this is haphazard. The lecturer may be extremely good one week and bad the next week. How much better to have a presentation when the lecturer is on top form, and for this to be available at the end or beginning of term.

Metatarsalgia caused by Derangement of the Second, Third, and Fourth Metatarsal Joints. By J. M. FITTON (*Leeds*)

The syndrome known as metatarsalgia is common, and only in a small proportion of cases is there a recognizable disease entity to explain the complaint of pain. In the majority of cases pain is attributed to reversal of the metatarsal arch, to prominence of a metatarsal head in the sole, or to the indirect effects of a severe hammer toe.

Three types of pathological lesion have been found to occur in the flexor tendon sheaths and in the accessory plantar ligaments of most patients:

- (a) Rupture of the flexor tendon sheaths under the metatarsophalangeal joints;
- (b) Degeneration and rupture of the accessory plantar ligaments;
- (c) Derangement of the 'Sleeve' of the metatarsophalangeal joint.

Rat Adjuvant Arthritis: Modification by Intraperitoneal Injections of Dead Tubercle Bacilli or Tuberculin. By H. L. F. CURREY (*The London Hospital*) To be published in full with the Discussion in a future issue of the *Annals*.

Test of Diagnostic Criteria – Experience in England and Wales. By T. M. CHALMERS, J. DANCHOT, J. H. KELLGREN, D. KING, E. PIKHLAK, K. SIEVERS, ELIZABETH STREVEVS, B. TAIT, and P. H. N. WOOD (*Manchester*)

The information required for the various criteria for rheumatoid arthritis, ankylosing spondylitis, and gout was recorded for 200 consecutive new patients and 213 additional cases of established disease attending the Manchester Royal Infirmary. Patients were classified by the final clinical diagnosis, and the performance of the different sets of criteria was studied in each group of patients.

(a) *Gout* – 39 cases

Rome and New York criteria:

sensitivity 92 per cent.; specificity 99.8 per cent.

(b) *Ankylosing spondylitis* – 62 cases

Clinical criteria used on their own had a sensitivity of only 34 per cent. Iritis and chest expansion of little value.

Sacroiliitis and one clinical feature:

sensitivity 74 per cent.; specificity 99 per cent.

Relative value of sacroiliac radiographs so high that obtaining these x rays must be regarded as a *sine qua non* of any survey for spondylitis.

(c) *Rheumatoid arthritis* – 127 cases

Performance of criteria:

– Active polyarthritis (ARA clinical), probable+definite: sensitivity 90 per cent.; specificity 77 per cent.;

– Inactive RA (Rome), probable+definite:

sensitivity 91 per cent.; specificity 90 per cent.;

– RA (New York), 2+ criteria:

sensitivity 93 per cent.; specificity 82 per cent.

Although many of these sets of criteria seem to be working quite well, certain individual features are of questionable value. Moreover, this test takes no account of one important aspect – recognition of mild or early cases.

Discussion

DR. WRIGHT (*Leeds*) This is a very interesting and important approach. I wonder, however, whether one is starting a little too far along the line, since we do not know the clear definition of each criterion. You will remember that Dr. Macrae from our Group presented to the Society in November a method of measuring back movement, and showed clearly that unless one took age and sex into account then you would miss some cases of significant limitation of back movement, and conversely assume the measurements were significant when they were not. More recently, Dr. John Moll in our Unit has been looking at various methods of measuring chest expansion, and he has shown a very similar age relation. I would really like to ask, therefore, in your spondylitic study what method was used for measurement of limitation of back movement, what method was used for defining limitation of chest expansion, and was age taken into account?

DR. WOOD We tried to produce definitions of methods and of other problems encountered in the survey, and this filled eight pages. Even so there were many points we did not cover. Age has not been taken into account in these analyses. Some years ago we looked at chest expansion in Dr. Lawrence's Watford data, where there was much limitation of expansion. Even if we looked only at younger men in the spondylitic age group, chest expansion was unsatisfactory as a means of differentiating between spondylitics and non-spondylitics.

PROF. KELLGREN (*Manchester*) The sacroiliac x ray is obviously vastly important. It must be remembered that this is in-operative in people under 15 years of age which present a difficult problem. We shall undoubtedly have to work out different criteria for spondylitis under the age of 15.

DR. HILL (*Stoke Mandeville*) I wonder to what extent a follow-up will come into the picture? The problem is that you could never by prolonged follow-up prove that a patient did not have rheumatoid arthritis, but if the diagnosis was in doubt originally you might be able to