Correspondence

Cardiac tamponade in juvenile rheumatoid arthritis

Sir,

I was interested to read the paper by Majeed and Kvasnicka (1978) on cardiac tamponade in a patient with juvenile rheumatoid arthritis. The final comment is that it is difficult to judge the value of local corticosteroid injections after pericardiocentesis, but they quote the paper of Scharf *et al.* (1976) in which the effect of local corticosteroid was dramatic. The authors have overlooked a recent case report (Richards *et al.*, 1976) of an adult with seropositive nodular rheumatoid arthritis whose pericardial effusion cleared promptly following pericardiocentesis and intrapericardial steroids. Immunological data from that patient supported the concept of local production of immune complexes in the pericardial cavity. Might I suggest that if their patient develops another large pericardial effusion, they give in the first instance local corticosteroids after pericardiocentesis rather than systemic corticosteroids?

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References

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- Scharf, J., Levy, J., Benderly, A., and Nahir, M. (1976). Pericardial tamponade in juvenile rheumatoid arthritis. *Arthritis and Rheumatism*, 19, 760-762.

Sir,

We sympathise with Dr Gumpel's confusion (*Annals*, August 1978, p. 389) about the incidence of gastric side effects in different studies. We used FROST (Canada) high-quality film coated granular aspirin but we know of no studies comparing this and other varieties of aspirin. We also note with regret that there is very little evidence to support the use of the known brands which rheumatologists apparently prefer to any old, unspecified, but not so expensive aspirin. This surely emphasises the need for controlled studies. We can only say what happened to patients taking sulindac compared with those taking aspirin in a double-blind trial. The actual incidence of side effects will depend on many factors including the number of times the patient is questioned and the manner of the enquiry.

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