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Book review

Clinics in Rheumatic Diseases: Osteoarthritis. Edited by Leon Sokoloff. Pp. 444. £15.00. Saunders: Eastbourne. 1985.

This is another good volume in a consistently good 'review' journal. Sokoloff as editor has chosen to cover the topic in its widest sense, and his own description of rare endemic forms of osteoarthritis (Kashin-Beck and Mseleni disease) is comprehensive and encourages the search for environmental influences in the multifactorial pathogenesis of the common disorders of local or generalised osteoarthritis.

In a chapter on pathogenesis Dr Cooke treads neatly through the issues of mechanical and inflammatory contributions to the final pathology of joint destruction. Distinguishing metabolic features and the inverse relation between osteoarthritis and osteoporosis are well set out by Dequeker; and Dieppe and Watt make the case for crystals being an 'opportunistic' event in osteoarthritis, yet in certain disease subsets it is felt they do not remain as innocent bystanders.

In contrast, there is good advice on clinical aspects of management from Dr Rudd and the Swansons, although I wonder if the 'grind test' for x ray negative early osteoarthritis of the interphalangeal joints may not be considered an iatrogenic contribution to the pathology by

Dr Cooke. Other issues such as the osteochondrodysplasias and endocrine arthropathies are clearly presented, and Hadler's critique of several decades of epidemiological studies ends on a hopeful note for bigger analyses with clearer outcomes in the future.

Although one might question its inclusion in a volume on osteoarthritis, I personally enjoyed several dips into DISH (diffuse idiopathic skeletal hyperostosis) with Dr Utsinger. This is a common disease, which fortunately has a low morbidity. There are suggestions of a primary metabolic cause which may be elucidated by the study of newer relevant animal models.

As with previous volumes this is a comprehensive review of osteoarthritis which will be of use to most jobbing rheumatologists, and may stimulate newcomers to investigate certain aspects of this common disease. Only regular subscribers might recognise the thinly disguised reissue of a chapter on drug therapy of osteoarthritis which appeared in the August 1984 volume. The authors have, however, been consistent over 12 months.

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Clinical vignette

The 'L4 syndrome' as a cause of obscure knee symptoms

The deep pain referral territory (sclerotome) of the fourth lumbar segment includes the knee and anterior region. Irritative lesions of the fourth lumbar nerve root are often poorly localised to their site of origin, especially in the absence of back symptoms. The patients may complain of obscure and ill defined discomfort in the knees or anterior legs, or of the knees 'giving way' or 'feeling weak' on walking. Elderly patients may even fall. Although the distribution of symptoms often suggests a local cause, examination at the site of symptoms for local anatomical abnormalities of the knees or other lower limb structures is often negative. There may, however, be referred tenderness as well as pain. Any or all of the following physical signs may be present:

- (a) local tenderness in the region of the fourth lumbar spinal segment on firm pressure with the patient lying prone;
- (b) restriction of movement or muscle spasm, or both, at the same spinal level, with increased discomfort in the symptomatic leg on lateral flexion to one or other side.

In addition, on the affected side there may be:

- (c) a positive femoral nerve stretch sign;
- (d) weakness of hip flexors;
- (e) depression of patellar reflex;
- (f) disturbance of light touch or pain sensation in the anterior knee and tibial area;
- (g) tenderness at the insertions of tendons in the popliteal fossa.

The symptoms and signs may be relieved by reducing traction on the femoral nerve roots, as with flexing the hips and knees to about 30 degrees by resting the knees over pillows in the supine position. Conversely, symptoms may be provoked by increased traction on the femoral roots, as when lying prone or supine with hips and knees fully extended. Symptoms may temporarily increase during the recovery phase after this latter posture is relaxed. As prolonged sitting or standing erect may provoke pain, perching stools and the new kneeling chairs offer an ergonomic approach to management.

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preliminary results for ten of them. The amyloid found in annular ligament and perineural region in three cases and in fragments of villi of knee synovial fluid sediment in another seven cases were studied by means of immunohistochemical analysis using the peroxidase-antiperoxidase method, with anti β_2 microglobulin antibodies (Dako), confirming that they contain β_2 microglobulin.

As Ian Rowe points out 'although the biochemical nature of amyloid deposits in osteoarthritic joints has not been characterised, it should be possible to determine whether these or any other age related amyloid deposits contain β_2 microglobulin'.⁷

Until then, and considering all the above mentioned points, we think that there is no basis for considering that we are dealing with the same kind of amyloidosis.

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Note

Symposium on antirheumatic drugs: basis for variability in response

A satellite meeting of the 10th International Pharmacology Meeting, Sydney, Australia will be held on 20-22 August, 1987 at Manly Pacific Hotel, Manly, Sydney, Australia. Details from Professor P Brooks, Department of Rheumatology, Royal North Shore Hospital, St Leonards, Sydney, NSW, Australia 2065.

Correction: Clinical vignette—The 'L4 syndrome' as a cause of obscure knee symptoms

In this vignette by Drs M I D Cawley and J C Robertson (*Ann Rheum Dis* 1986; **45**: 704) we regret that a word was omitted from the first sentence. This should have read 'The deep pain referral territory (sclerotome) of the fourth lumbar segment includes the knee and anterior tibial region.'