LETTERS TO THE EDITOR

Pigmented villonodular synovitis

Sir: In a recent article entitled 'Pigmented villonodular synovitis' (PVNS) Drs Bentley and McAuliffe state that up to date there have been few reports of the use of computed tomographic scanning in PVNS and none of magnetic resonance imaging (MRI).¹

In fact, MRI features in PVNS have been reported previously: firstly, by Dr Spritzer *et al* in 1987,² and then by Dr Weisz *et al* in 1988.³ The second group of authors asserted that MRI was an excellent non-invasive diagnostic aid that completely outlined the extent of the synovitis and correlated well with surgical findings.

We agree with these authors that MRI is an important tool for investigation of the synovial pathology as PVNS. In many countries like Tunisia, however, and even in some European and American hospitals, MRI is not available; thus arthroscopy and computed tomographic scanning remain important in the diagnosis of PVNS.

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- 1 Bentley G, McAuliffe T. Pigmented villonodular synovitis. *Ann Rheum Dis* 1990; 49: 210-1.
- 2 Spritzer CE, Dalinka M K, Kressel H Y. MRI of pigmented intercondylar synovitis: a report of two cases. *Skeletal Radiol* 1987; 16: 316-9.
- 3 Weisz G M, Gal A, Kitchener P N. Magnetic resonance imaging in the diagnosis of aggressive villonodular synovitis. *Clin Orthop* 1988; 236: 303-6.

Dynamic injection of the digital flexor tendon sheaths

Sir: I read with interest Liu and Canoso's technical note in the *Annals*.¹ They describe their modification of local injection of the flexor tendon sheath, which they believe may be more accurate and avoid damage to the underlying tendon.

Generally, in my experience, the major site of inflammation of the tendon sheath is found over the palmar surface of the metacarpal head of the affected digit at a surprisingly superficial level. Adequate skill in entering the sheath can usually be acquired with a modicum of experience. Our technique includes use of a 7/8 inch hypo needle, 25-27 gauge, instilling 0.25 ml of suspension. The skin is sprayed with a skin refrigerant before the injection, thus avoiding the use of a local anaesthetic wheal. If one suspects the needle is in the substance of the tendon the patient is asked to flex the finger gently at the proximal interphalangeal joint with the needle in site. If the needle is within the tendon it will tilt or swing distally. The needle is then slowly withdrawn until flexion no longer causes tilting, the syringe is attached, and the injection given. This simple test to check on the position of the needle has been described by Dixon and Graber.²

Our success rate with this approach has been high. No complications have occurred in many thousand tendon sheath injections, except rare transient postinjection pain, and a single infection that responded promptly to treatment with antibiotic drugs.

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- 2 Dixon A St J, Graber J. *Local injection therapy in rheumatic diseases*. Basle, Switzerland: EULAR, 1981: 66-8.

Cardiac tamponade in juvenile chronic arthritis

Sir: According to Goldenberg *et al*¹ the first description of cardiac tamponade in juvenile chronic arthritis was given by Handforth and Woodbury in 1959.² In fact, I reported the first case of pericardial effusion with tamponade in Still's disease in my thesis on the cardiac complications in juvenile rheumatoid arthritis, published in 1958.³ This case report is mentioned in our article about pericarditis in Still's disease, published in 1962.⁴

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- 1 Goldenberg J, Pessoa A P, Roizenblatt S, *et al*. Cardiac tamponade in juvenile chronic arthritis: report of two cases and review of publications. *Ann Rheum Dis* 1990; 49: 549-53.
- 2 Handforth C P, Woodbury J F L. Cardiovascular manifestations of rheumatoid arthritis. *Can Med Assoc J* 1959; 80: 86-90.
- 3 Hayem F. Complications cardiaques de l'arthrite rhumatoïde juvénile. University of Paris, 1958. (Med thesis).
- 4 Mozziconacci P, Hayem F. La péricardite de la maladie de Still. *Rev Rhum Mal Osteoartic* 1962; 29: 1-11.