

did not require an analgesic, 5 had stopped naproxen and started another analgesic finding prolonged treatment with naproxen ineffective. 28 continued naproxen. At 24 months 26 continued naproxen, 6 being in remission and 4 on other analgesics. At 12 months the 28 patients on naproxen had less pain (at rest  $P < 0.05$ , on movement  $P < 0.001$ ), morning stiffness had decreased ( $P < 0.001$ ), and immobility stiffness had markedly improved ( $P < 0.005$ ) so that many patients can sit indefinitely without becoming stiff.

The first 10 patients to complete 6 months on naproxen took part in a double-blind cross-over trial comprising two consecutive 4-week periods, in one of which each patient took 500 mg naproxen, in the other identical placebo capsules, the order being randomized. 8 patients correctly identified the placebo capsules and were unable to complete the 4-week period because symptoms recurred ( $P = 0.019$ ).

The patients who continue with naproxen are impressed by their improvement, continue in full-time employment, and have been able to increase their leisure activities without discomfort. Improvement in stiffness has been more marked than decrease in pain, and naproxen

appears to be most useful in patients with ankylosing spondylitis where stiffness predominates. No persistent side effects were observed.

**Radiological lesions in coxitis mellitensis.** P. González de Vallado, A. Zea Mendoz, F. Atero Carrasco, J. Gijón Baños, and J. Beltran Gutierrez

466 cases of brucellosis were studied of which 383 (82.2%) showed articular symptoms and signs and 28 (6%) clinical and radiological evidence of hip damage. Of these 28 cases, 24 were men and 4 women, with an average age of 35 years. The hip was affected during the first 3 months of the illness in 20 cases, of which 7 displayed coxitis from the start of the brucellosis.

The most commonly observed symptomatology was the presence of pain in the inguinal region, radiating out through the front part of the thigh as far as the knee, with positive signs in the physical examination in almost all cases. 50% of the patients displayed at the same time brucellar infection in other osteoarticular locations, mainly in the lumbar spine. The diverse radiological patterns observed in this series can be classified according to certain types, the most frequent of which, because of its incidence in cases of short evolution, was the existence of localized areas of osseous demineralization, predominantly in the cotyloid rim.

Analysis of these radiological findings allows us to suggest that in a great number of cases, coxitis mellitensis starts by osteitis in some area close to the joint, although in other cases a capsull-synovial origin cannot be discounted. With appropriate antibiotic treatment and local rest the prognosis of coxitis mellitensis is good.

**Table I** Overall summary

	12-month follow-up	24-month follow-up
In remission and off all drugs	3	6
Naproxen ineffective; other analgesics effective	5	4
Continue naproxen	28	26
Total	36	36

**Table II** Patients remitting

Months on naproxen	Reason for withdrawal	Result of follow-up	Months of follow-up after stopping naproxen
3	In remission	Continued remission	23
7	In remission	Continued remission	17
12	In remission	2 relapses, both controlled by restarting naproxen	15
13	In remission	1 relapse, controlled by restarting naproxen	13
18	In remission	Continued remission	6
18	In remission	Continued remission	6

**Table III** Reasons for withdrawal

Months on naproxen	Reason for withdrawal	Result of treatment with other analgesic	Months of follow-up after stopping naproxen
1	Ineffective	Indomethacin effective	26
6	Ineffective	Indomethacin effective and reduced remission after 11/12	23
10	Ineffective	BTZ effective	17
5	Partially effective	BTZ effective	21
10	Effective 7/12, thereafter ineffective	BTZ, distalgesic, Ketoprofen ineffective, ACTH partially effective	14