Discussion

Although our study confirmed previous observations that PMP given as three 1 g pulses can improve active RA both clinically and biochemically, it showed that this improvement was too short lived to be acceptable to the majority of rheumatoid patients. It should only be considered as an alternative treatment in patients with RA who have already failed to tolerate or respond to alternative, long-term agents. In contrast, PMP proved successful in combination with either SAS or DPA. We have compared our results with those obtained from two earlier studies of groups of 15 patients with active RA. In one of these DPA was given alone with the same dosage regimen as in the present study. In the other study SAS was given at a maintenance dose of 2–3 g/day. These two earlier studies used the same recruitment criteria and methods of assessment, and biochemical data were analysed in the same laboratories as in the present study. DPA alone produced little improvement until 16 weeks after the start of the study, and SAS when given alone showed substantial improvement only after eight weeks. Comparison suggests that the use of PMP in addition to these therapies thus accelerated the response to treatment by at least six weeks. At 24 weeks the overall response to either DPA or SAS was not altered by the addition of PMP.

Various serious side effects have been related to methylprednisolone pulse therapy, including sudden cardiac arrest and acute anaphylaxis. However, we observed no serious adverse effects due to PMP: those we saw could be attributed to either SAS or DPA. The question remains, whether short courses of high-dose oral prednisolone would be as effective as PMP as well as being safer, cheaper, and more convenient to administer. The use of PMP in rheumatoid arthritis stems from its successful use in renal medicine for the treatment of allograft rejection episodes. In a recent study when high-dose methylprednisolone (600 mg/m²) was compared with low-dose oral prednisolone (3 mg/kg) for the treatment of such rejection episodes in children both therapies were equally effective and equally well tolerated.

In conclusion, our study has shown an effective use of PMP in combination with slow-acting anti-rheumatoid drugs in active RA. However, we have yet to show that this combination is superior to a combination of oral steroids and slow-acting anti-rheumatoid drugs and are now testing this alternative.

References


Book review


This book will have a limited readership, but it contains several good chapters, particularly on radiology and computed tomographic scanning. Unfortunately the impression it gives that sacroiliitis is a common manifestation of rheumatoid arthritis spoils the overall validity. The mythology is perpetuated that radiology is essential before manipulative therapy; actually it may give a false sense of security and be used instead of full clinical assessment. I would consider the presence of inflammatory joint disease a contraindication to neck manipulation even with normal x-rays. In the chapter on neck and shoulder pain the section on pain from periaricular lesions of the shoulder is inaccurate and misleading.

M G WRIGHT