weeks. All patients were given intra-articular injections of saline or 1% procaine solution, or both, for control observations, before receiving phenylbutazone.

Of the 11 patients with osteoarthritis who received 34 intra-articular injections, one derived major improvement, seven derived slight to moderate improvement, and three failed to benefit. Of 18 patients with rheumatoid arthritis, given 45 intra-articular injections, seven obtained major benefit, seven slight to moderate improvement, and four failed to respond.

The only adverse effect was transient local discomfort described as a 'burning' sensation that occurred during and after the injection in approximately half of the patients.

Synovial fluid showed a significant decrease in the white blood cell count in five of 10 fluids examined one to two weeks after injection. When synovial fluid was removed shortly after the phenylbutazone injection, however, examination disclosed severe disintegration of the white cells, making a differential count impossible.

To summarise, although intra-articular injections of phenylbutazone may produce a beneficial response, the drug causes local irritation and offers no therapeutic advantage compared with corticosteroids.

Incidentally, if the authors had recommended a strict postinjection rest regimen, the use of this technique might have facilitated a beneficial response, especially in some of their patients reportedly unresponsive to conventional steroid joint injections.[3]

University of Louisville, School of Medicine, Louisville, Kentucky

DAVID H NEUSTADT

References

1 Moens B, Moens C H R. Intra-articular injection of phenylbutazone in gonarthrosis. *Ann Rheum Dis* 1986; **44:** 788.
2 Neustadt D H, Steinbrocker O. Observations on the effects of intra-articular phenylbutazone. *J Lab Clin Med* 1956; **47:** 284–8.
3 Neustadt D H. Intra-articular therapy for rheumatoid synovitis of the knee: effects of the postinjection rest regimen. *Clinical Rheumatology in Practice* 1985; **3:** 65–8.

Systemic lupus erythematosus presenting as polymyalgia rheumatica

SIR, I read with interest your recently published report of systemic lupus erythematosus presenting as polymyalgia rheumatica in the elderly,[1] in which three cases were described.

Three hundred and fifty six cases of polymyalgia rheumatica/giant cell arteritis have been recorded at this hospital since 1968, with long term follow up.

In 1973 a 76 year old Caucasian woman presented with a history of pain and stiffness of the shoulder and hip girdles developing over a four week period. She had also felt feverish and complained of general malaise. She had had a radical mastectomy for carcinoma of the breast two years previously, and had a longstanding ulcer over one shin. She had otherwise been in good health. Investigations showed a haemoglobin of 10·1 g/dl (101 g/l) and a markedly raised erythrocyte sedimentation rate (ESR) of 135 mm/h. Electrolytes, liver function tests, and creatine phosphokinase were all normal, and a temporal artery biopsy was negative. An initial diagnosis of polymyalgia rheumatica was therefore made, and she was started on prednisolone 10 mg daily. There was clinical improvement on this dose with an associated fall of the ESR to 41 mm/h. Autoimmune profile then showed a positive antinuclear antibody titre at 1/40 960 and a positive latex test and deoxyribonucleic acid (DNA) binding. She continued to require between 12·5 mg and 20 mg of prednisolone daily long term and on this dose there was also rapid healing of her leg ulcer.

In view of the markedly raised antinuclear antibodies (ANA) and raised DNA binding the diagnosis was changed to systemic lupus erythematosus (SLE), though she did not develop any other features of the disease; in particular at no time was there evidence of muscle disease. She died in 1976 of a myocardial infarction.

Of 356 cases of polymyalgia rheumatica/giant cell arteritis followed up over an 18 year period, this is our only recorded case of SLE. Weakly positive ANA titres of up to 1/40 have been recorded in a larger number but with normal DNA binding. Although we accept that SLE may have an atypical presentation in the elderly, it is clearly extremely uncommon for it to present with a polymyalgia-like syndrome.

St Peter's District General Hospital, Guildford Road, Chertsey Surrey KT16 0PZ

JANE FOLEY

Reference

1 Hutton C W, Maddison P J. Systemic lupus erythematosus presenting as polymyalgia rheumatica in the elderly. *Ann Rheum Dis* 1986; **45:** 641–4.

Small joint involvement: systematic roentgenographic study in rheumatoid arthritis

SIR, Halla, Fallahi, and Hardin reported in this journal their observations on radiological involvement of small joints in rheumatoid arthritis (RA).[1] They studied 200 consecutively hospitalised patients with definite or classical RA and concluded that radiological asymmetry was usual, unilateral involvement common, and absolute symmetry uncommon. We would like to report our findings in a similar group of patients.

Eighty three consecutive patients with definite or classical RA attending an outpatients clinic were studied. The disease duration was variable, and radiographs of the patients' hands were taken in the standard posteroanterior position.