

Letters

Heberden's nodes and osteoarthritis of the hip

SIR, I have read the interesting report by McGoldrick and O'Brien studying the relation between the various patterns of osteoarthritis (OA) of the hip and Heberden's nodes.¹ Their paper also challenges our earlier report, which found no significant association between osteoarthritis of the weight bearing joints (hips and knees) and Heberden's nodes in a controlled study.²

My main criticism of the McGoldrick and O'Brien paper is that they do not compare like with like. The prevalence and severity of the nodes in their axillary, superomedial, and protrusion groups combined (representing primary OA) is indeed higher than in the congenital dislocation of the hip, dysplasia, and superolateral groups combined (representing secondary OA). On the other hand, the combined female to male ratio is 32/18 among the probands in the first three groups and 15/22 among the probands in the last three groups. As is also pointed out by the authors this represents a clear difference in favour of women in the groups representing primary OA.

It is universally acknowledged that Heberden's nodes by themselves are more common among women, regardless of the presence of OA in other joints. Thus it would have been better if the authors had analysed their data by considering the prevalence of the nodes among the two genders separately in order to eliminate the sex bias.

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References

- 1 McGoldrick F, O'Brien T. Osteoarthritis of the hip and Heberden's nodes. *Ann Rheum Dis* 1989; 48: 53-5.
- 2 Yazici H, Saville P, Salvati E A, Bohne W H O, Wilson P D. Primary osteoarthritis of the knee or hip. *JAMA* 1975; 231: 1256-60.

SIR, I wish to make a number of comments in reply to the question posed by Dr Yazici on our paper entitled 'Osteoarthritis of the hip and Heberden's nodes'.¹ Dr Yazici feels that our population sample is based in favour of women, thereby distorting the data. I would like to make two points.

Our total population was composed of 44 men and 56 women, giving a male/female ratio of 1/1.27. This fits closely with publications throughout the world. Hoaglund *et al* quoted a population of 1/1.29.² Our population sample was a consecutive number of patients attending for total hip replacement, in which no attempted bias was

undertaken, therefore it can be reasonably said that the reflected the population of osteoarthritic patients requiring total hip replacement. If we look at our data allowing for the skew of 1/1.27 there is still a greater number of women showing primary osteoarthritis, with a male/female ratio of 1/1.77, whereas the reverse is the case for secondary arthritis, with a male/female ratio of 1/0.65. Even if we allow for the skew that may well exist in a population sample by virtue of the greater number of women present it is clear that the ratio indicates a greater prevalence of women with primary osteoarthritis.

The second point I wish to make is that if we were to extrapolate and compare an identical population of male and female patients with osteoarthritis, our data then would not reflect that of the population and would be skewed in favour of men. On that basis the ratios would then fall to almost even figures, which is not a reflection of the true picture.

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References

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- 2 Hoaglund F T, Shiba R, Newberg A H, Leung K Y. Diseases of the hip. A comparative study of Japanese Oriental and American white patients. *J Bone Joint Surg [Am]* 1985; 67: 1376-83.
- 3 Yazici H, Saville P, Salvati E A, Bohne W H O, Wilson P D. Primary osteoarthritis of the knee or hip. *JAMA* 1975; 231: 1256-60.

Osteomalacia and coeliac disease presenting as isolated dactylitis

SIR, We read with interest the case report 'Osteomalacia and coeliac disease presenting as isolated dactylitis' by Jawad *et al*.¹ We believe that the dactylitis was related to secondary parathyroid overactivity rather than a primary manifestation of osteomalacia.

We have a patient, an Asian vegetarian woman aged 48 years, who presented with pain and swelling in her right index and middle fingers. An x ray examination was suggestive of a dactylitis. Her investigations excluded tuberculosis, sarcoidosis, sickle cell disease, syphilis, and inflammatory arthritis.

Serum calcium was low (2.06 mmol/l), phosphate normal (0.95 mmol/l), alkaline phosphatase raised (212 IU/l), and serum vitamin D very low (3 nmol/l). Parathyroid hormone was 1.5 ng/l (normal up to 0.5). She was treated with 3000 U calciferol daily. Three months later her dactylitis had