Encore

Osteoporosis and fluoride

The treatment of osteoporosis has been much argued over, and by no means all women can tolerate hormone replacement therapy. What should we give them instead? Many have resorted to fluoride because it increases bone mass, but a recent four year prospective clinical trial showed that although fluoride increases cancellous bone, it decreases cortical bone mineral density and increases skeletal fragility: we should use other methods instead. Perhaps biphosphonates as indicated in the next abstract, or calcitonin? *N Engl J Med* 1990; 322: 802-9.

Osteoporosis again

It seems to be accepted wisdom at the moment that the best treatment for osteoporosis is to use hormone replacement therapy in appropriate patients and at the right age. This, however, has its drawbacks, as does fluoride, so it is with great interest that the recent report of the effectiveness of biphosphonate in this disease is received. So far it seems to be remarkably free from side effects in the dose recommended.

N Engl J Med 1990; 322: 1265-71.

Perhaps more important than all our new drugs?

We are so excited by new research into the causation of disease and therapeutic advances that we sometimes forget that among the most important advances in world health have been improvements in sanitation. The description of a new, cheaply made latrine that is fly proof and needs no water may be much more important than a new wonder drug that cannot be afforded anyway.

Lancet 1990; 335: 633-4.

Bacterial infections and reactive arthritis

A study from Finland showed the presence of salmonella antigens in the joints of patients with a reactive arthritis triggered by a salmonella infection, particularly in one patient who was a chronic carrier. This has implications for other forms of inflammatory arthritis, especially rheumatoid arthritis, and lends further weight to the postulate that infections (not necessarily bacterial) might trigger arthritis.

Lancet 1990; 335: 685-8.

HIV, zidovudine, and myopathy

We are likely to see infection with the human immunodeficiency viruses and their complications more and more within the next few years. It is timely to remind ourselves that treatment is not without problems too. Zidovudine (AZT) may cause a myopathy itself. Fortunately, this responds either to stopping the drug or the use of corticosteroids or even non-steroidal anti-inflammatory drugs.

N Engl J Med 1990; 322: 1098-105.

Vertebral compression fractures, osteoporosis, and ankylosing spondylitis (AS)

Such fractures are much commoner than perhaps we realise in AS, particularly if spinal deformity is severe. Patients with this condition have a greater degree of osteoporosis than we suppose and such a fracture is easily missed. The patient may get increased spinal deformity and pain.

Br Med J 1990; 300: 563-5.

When to stop treatment in polymyalgia rheumatica

Polymyalgia rheumatica responds dramatically and well to corticosteroid treatment, but both patient and doctor want to know when they can stop treatment. That is not so easy. On average, treatment seems to be necessary for from two to

five years and sometimes even longer. Also, patients should be monitored for six months after stopping treatment just in case there is a relapse.

Br Med J 1990; 300: 344-5.

Non-steroidal anti-inflammatory drugs (NSAIDs) and dyspeptic symptoms

NSAIDs are well known to be toxic to the gut and this causes many problems as we all know. What is perhaps less well known is that the symptoms of the development of peptic ulceration and hence possible bleeding may be very slight or even absent. It is wise to take even mild symptoms seriously, therefore, and investigate them quickly and thoroughly.

Br Med J 1990; 300: 368-9.

Bone resorption and mechanical stimulation

Regular physical activity has long been recommended to slow down the development of osteoporosis in humans so it is of interest to note that intermittent compressive force seems to decrease mineral resorption and osteoclast numbers in mouse cartilaginous long bones. This seems to be due to the action of a soluble factor on osteoclast precursor-like cells.

Arthritis Rheum 1990; 33: 66-72

Tryptophan, scleroderma, and eosinophilic fasciitis

The regular swallowing of tryptophan (which can be purchased at a health food store in the United States) may lead to a syndrome resembling scleroderma and eosinophilic fasciitis. The symptoms may include myalgia, and the regular ingestion of this substance, as we have been advised, may be dangerous. Two recent publications warn of this.

N Engl J Med 1990; 322: 874-81, 931.

Should we use disease modifying antirheumatic drugs early?

The consensus from a panel at last year's meeting of the American College of Rheumatology was that the answer is yes, but a letter in *Arthritis and Rheumatism* disagrees. I believe that it is now common practice in the United Kingdom to treat rheumatoid arthritis early and vigorously with so-called disease modifying drugs, but does everyone agree?

Arthritis Rheum 1990; 33: 451.

Backache—Which comes first: degeneration of the intervertebral disc or the facet joints?

Apparently the discs are more likely to degenerate first. A study from Chicago using magnetic resonance imaging and computed tomography in 68 patients with backache showed that degeneration of the intervertebral discs may occur without facet joint degeneration but it is very unusual to see it the other way around.

Spine 1990; 15: 111-3.

Ankylosing spondylitis in the young

This disease may present in young people in several different ways. A 16 year old boy presented to the hospital with a sore throat and what appeared to be thrombophlebitis of the leg. It proved to be rather different when it was investigated, however: he was shown to have juvenile ankylosing spondylitis with a Baker's cyst. Young people with this disease may first come to our attention with a peripheral arthritis and only after careful investigation may the true diagnosis become apparent.

N Engl J Med 1990; 322: 1214-23.

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