Cricothyroid arthritis in a child with familial Mediterranean fever

Sir: We describe for the first time the occurrence of cricothyroid arthritis in a girl who first presented with migratory polyarticular arthritis but eventually developed the classical features of familial Mediterranean fever.

A 9-year-old Palestinian Arab girl was admitted in January 1979 with fever and migratory polyarticular arthritis of the large joints. The heart was normal. The erythrocyte sedimentation rate was 110 mm/h and the antinuclear antibody titre was 400 Todd units. A diagnosis of acute rheumatic fever was made and treatment was started with secondary prophylaxis. During the following six years she had several episodes of arthritis, which were interpreted as recurrence of acute rheumatic fever due to irregular prophylaxis, and occasional fever and abdominal pain.

In January 1985 the girl was admitted with fever and arthritis of both elbows and the right wrist. Her temperature on admission, 37°C, was 400 Todd units. A diagnosis of secondary infection was suggested, and treatment was started with secondary prophylaxis. Following this episode she had several episodes of arthritis, which were interpreted as recurrence of acute rheumatic fever due to irregular prophylaxis, and occasional fever and abdominal pain.

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6 Chondroprotective drugs and osteoarthritis

Sir: I read with interest the leader article by Doherty on 'Chondroprotection on non-steroidal anti-inflammatory drugs' published in Ann Rheum Dis May 1990.

Although I am in general agreement with the views expressed by Dr Doherty, I raised some issues which I consider deserve further comment.

In his article Dr Doherty questions the relevance of certain laboratory derived data on non-steroidal anti-inflammatory drugs (NSAIDs) to their clinical use in osteoarthritis. He considers the standard for assessing these drugs in the long term symptomatic and functional improvement in patients ‘rather than individual biochemical or structural characteristics’. It should be noted, however, that most NSAIDs are also powerful antagonists and may effectively relieve the symptoms of osteoarthritis without necessarily influencing its progression. Pain relief and improvement of joint mobility are thus inadequate criteria for distinguishing between an NSAID acting only as an analgesic and an NSAID which is also positively influencing the underlying osteoarthritic disease. More objective methods of clinical assessment of patient response to drug treatment are therefore required. In this respect, the question of how this matter can be resolved. Such methods are presently under investigation, and promising findings have been reported with biochemical markers of cartilage breakdown and with synovial fluid and serum.6,9,10 x-ray microcalorimetry (Buckland-Wright et al, unpublished data)