LEADER

The impact of our expanding aging population and rheumatology p 3
Our population in the United Kingdom is changing in its demographical mix. We are beginning to see the effects of the various baby booms and the undoubted fact that people are living longer. The incidence of arthritis rises with age and its pattern changes. The size of families is changing. All this is likely to have a great effect on the specialty of rheumatology.

SCIENTIFIC PAPERS

Osteoarthritis (OA)—the clinical syndrome p 8
It is no coincidence that osteoarthritis features prominently in this issue. It is a form of arthritis greatly neglected in the past and yet likely to be of increasing importance in the future to patient and doctor alike. The rheumatology department in Bristol has paid particular attention to this—to its great credit—and its paper sets out to describe the clinical entity in detail.

Magnetic resonance imaging of the knee in OA p 14
Conventional radiography just does not give adequate information on the state of the knee when affected by OA nor does it give much information about the underlying disease process. Magnetic resonance imaging, is much better, not least because it discloses the state of the soft tissues and also some insight into the pathophysiology. It shows, for example, the diversity of the changes and raises some questions about the importance of meniscal changes.

OA in West Africa p 20
The type and prevalence of OA vary, depending upon which ethnic population is studied. This paper from West Africa gives us a timely reminder that the disease we call OA is different in its form there, though the knee, as in the United Kingdom, is commonly affected. The hip much less so. Trauma does not seem to play much of a part, unlike the Bristol experience.

Brucellosis and its osteoarticular complications p 23
Infection certainly seems to have a part to play in the demonology of OA in Spain. One quarter of those affected by brucellosis developed osteoarticular complications, though it was not obvious why they should. Disease of the spine was relatively common and troublesome and was seen particularly in those whose infection was unsuccessfully treated, as others have shown.

Interleukin (IL) 1α and 1β production by peripheral blood monocytes p 27
And now for something different. The secretion of human IL-1α and IL-1β from blood monocytes in connective tissue disease as opposed to its production has been shown in this paper from Japan to show no significant correlation. Those patients with connective tissue disease with the demonstrable presence of nuclear ribonucleoprotein released a significantly greater amount of IL-1 of both forms. The enzyme linked immunosorbert assay (ELISA) technique described is rapid and suitable for general use.

C reactive protein (CRP) and IgG in joint disease p 32
Both were measured in the serum and synovial fluid of patients with various forms of arthritis. The results were somewhat different than expected: in OA the CRP concentrations in synovial fluid were higher than expected. In rheumatoid arthritis (RA) CRP concentration was lower and IgG higher. Seronegative arthritis was different again. C reactive protein seems to have a definite role in RA, and measurement of the CRP:IgG ratio may be helpful in making a differential diagnosis.

Bronchial hyperresponsiveness, methacholine, and primary Sjögren’s syndrome p 36
The prevalence of bronchial hyperresponsiveness as measured by the reaction to inhaled methacholine was seen to be commoner in those with extraglandular symptoms associated with primary Sjögren’s syndrome. Those with glandular symptoms only had much less of a response. The authors conclude from these investigations that those patients with primary Sjögren’s syndrome seem to have definite respiratory disease. This diagnosis should be considered in the differential diagnosis of apparently asthmatic patients, especially those with abnormal lung radiographs.

Stanozolol in primary Raynaud’s phenomenon and systemic sclerosis p 41
A double blind study of stanozolol in primary Raynaud’s disease and in systemic sclerosis using various criteria showed that although patients showed a definite objective improvement during treatment, subjectively this was not so. The dermal changes of sclerosis seemed to improve a little too but not significantly. Anabolic problems caused several withdrawals from treatment, and although stanozolol seems to be indicated for systemic sclerosis because of its microvascular improvement, the same cannot be said for primary Raynaud’s phenomenon.

CASE REPORTS

Raynaud’s phenomenon and cutaneous polyarteritis nodosa p 48
The relation between cutaneous polyarteritis nodosa and the systemic form is not as yet understood, though both are characterised by a vasculitis. Presentation of the cutaneous form with Raynaud’s phenomenon as the first symptom is unusual to say the least. Nevertheless, it is described here in a 45 year old white man. In fact the Raynaud’s manifestations were all that were seen for many years.

Muscle cramps in sarcoidosis p 51
Most patients with sarcoidosis have some evidence of muscular involvement. It may or may not cause symptoms, and the presentation with a palpable nodule causing pain is the least common form in which it is seen. Treatment with rest, diclofenac, and local injections of triamcinolone was effective in the woman described here.

Palmar fasciitis, arthritis, and malignancy p 53
The association of malignant disease with some forms of connective tissue disease has been known for over a quarter
of a century. The occurrence of palmar fasciitis in this context is rare, however, and little recognised. It occurred here in a white woman with an adenocarcinoma of the coelomic epithelium. She was cachectic, pigmented, and had an arthritis as well. There was some response to prednisolone. The development of the palmar fasciitis may precede obvious signs of the underlying malignant condition by some months.

Eosinophilic fasciitis and L-tryptophan  p 55
The development of the eosinophilia-myalgia syndrome after the ingestion of products containing L-tryptophan has recently received wide publicity both in the United States and elsewhere. The possible association of this substance with eosinophilic fasciitis is described in this case report from California. There were some similarities to the toxic oil syndrome seen in Spain. Withdrawal of the compound and treatment with azathioprine was successful in dealing with it.

Rapid Report
Degradation of human cartilage by synovial fluid  p 57
Interleukin 1 and tumour necrosis factor are believed to be responsible for the degradation of human cartilage in RA and OA by stimulating the chondrocytes to produce degrading enzymes. This process is described here in synovial fluids from patients with these two diseases. It worked in living but not killed human cartilage. Serum from normal people did not degrade living cartilage nor did recombinant human cytokines. Cytokines by themselves may not be enough—some synergising elements may be required.

Dispatch
From Scandinavia  p 59
Our second dispatch article by Frank Wollheim continues his description of the rheumatological happenings in Scandinavia. Clearly much is going on there of great interest to rheumatologists generally, both in the laboratory and the wider clinical field. Yersinia infection seems to be less prevalent than once it was, though the role of the Epstein-Barr virus in RA is receiving more attention. Rheumatological education—so important for us all—is rightly being given full emphasis. The specialty is clearly alive and awake in the northern lands.

Now and Then
A theme to discuss  p 61
Trainee specialists often ask whether they should attempt to write a thesis or not, both for their greater good and the furtherance of their careers. Michael Snaith ruminates about the various pitfalls and advantages. To write a thesis for a university degree certainly has a long and honourable history.

Review
RA—its familial nature?  p 62
The observation that RA is familial goes back nearly 200 years. To what extent are there familial characteristics? The evidence for a genetic predisposition to RA seems to be only slight: perhaps only about 2–3% of those with RA in the population have an affected first degree relative. The pros and cons of the argument are discussed here in some detail. See what you think.

Editor