

LETTERS TO THE EDITOR

What is meant by 'rheumatoid'?

The term '*rheumatoid arthritis*' is now established worldwide in the nosography of rheumatic diseases. Its origin can be found in the following statement by the London physician Alfred Baring Garrod, who proposed this term as an alternative to '*rheumatic gout*', which was previously used: 'Although unwilling to add to the number of names, I cannot help expressing a desire that one may be found for the disease under consideration, not implying any necessary relation to gout or rheumatism. Shortly before the first edition of the present work was published, about 1858, I proposed the term *Rheumatoid Arthritis*, by which name I wish to imply an inflammatory affection of the joints, not unlike rheumatism in some of its characters, but differing materially from it in its pathology.¹ As was clearly stated in a comparative table in Garrod's book, *rheumatism* thus referred to the condition that is now known as rheumatic fever. Therefore, *rheumatoid arthritis* was then introduced as a new nosographical term associating two ideas: first, that of a comparison with another nosological entity established in the XVIIth century when Baillou initiated a series of studies that, together with those of Sydenham and Heberden, led to the modern nosography of rheumatic diseases;^{2,4} and second, that of a joint illness.

After more than a century, today the term *rheumatoid arthritis* remains a useful tool, despite some dismemberment as a result of advances in biology, pathology, and medical imaging, and a heterogeneity which had already been noted by Archibald, the son of A B Garrod: 'For this name, which, was introduced by my father, I have naturally a pious respect, but I am fully alive to its shortcomings. It was certainly an advance upon the term "rheumatic gout", which it superseded in the middle of the last century, but this in turn has lost its utility, and might be superseded by a better name if such could meet with general acceptance.'⁵ Archibald Garrod also said that one of the questions 'is whether there be any one specific disease to which the name rheumatoid arthritis may be applied, or whether the condition so called is rather a syndrome'⁵ Nevertheless the persistence of the term illustrates the words of the philosopher John Locke: '...language had yet a farther improvement in the use of general terms, whereby one word was made to mark a multitude of particular existences'⁶

In parallel, it is interesting to note that the term *rheumatoid* had already been proposed in 1826 by the physician Louis-André Gosse of Geneva: 'Although far away as I may be from a pedantic neologism, I was forced nevertheless to create new terms to generalise my ideas; the term *Rheumatoid* (*) seemed to me a convenient term to assemble this group of diseases with which I am dealing, of which the commonest example is Rheumatism'⁷ The asterisked footnote indicated, with Greek characters, 'from rheuma, fluxion and from oidos, similar to.'

In fact, unlike A B Garrod, Gosse used *rheumatism* with the general meaning of algic fluxion not restricted to the joints, a meaning in line with that used by Galen,² which today remains in popular use in parallel with the nosographical nomenclature. He emphasised the relationship of such congestive changes with cold (particularly a rapid passage from warm to cold) and with the nervous system. His 'ideas' concerning *rheumatoid* were thus an extension of the above mechanisms to a large panoply of conditions including practically all those which are painful, congestive, or both. This study is obsolete as regards today's nosology, and was obviously expressed in the words of its day, before knowledge of the aetiological data that were revealed by advances in bacteriology. However, it foretold the modern investigations into the diffuse role of non-specific vascular disturbances and of neurotransmitters in neurogenic inflammation.

While each of these meanings of *rheumatoid* had its own logic, a long term follow through confirms that the term had a useful place in the progress of an already established nosography, though it was abandoned when it served only to extend an already unclear pathogenic concept. Today, at a time when modern biology is providing a plethora of basic information in rheumatology, the origin of the term *rheumatoid arthritis* must not be forgotten. In extensions such as *rheumatoid nodules* or *rheumatoid factor*, the adjective *rheumatoid* is elliptical, as the changes which are thus named cannot be directly explained by the etymology, but are indirectly related to it through a nosological entity.

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- 2 Baillou G de. *Liber de Rheumatismo et pleuritide dorsali*. Thevart M J, ed. Paris, 1736. [Translated into English by Barnard C C.] *Br J Rheum* 1940; 2: 141–62.
- 3 Copeman W S C. *A short history of the gout and the rheumatic diseases*. London: Cambridge University Press, 1964.
- 4 Lagier R. Rheumatism as perceived by some quotations: as seen by the patient and physician. *Rev Rhum* [English edn] 1995; 62: 775–80.
- 5 Garrod A. Discussion on 'the aetiology and treatment of osteo-arthritis and rheumatoid arthritis.' *Proc R Soc Med* 1923; XVII: 1–18.
- 6 Locke J. *An essay concerning human understanding—Book III, ch I*, 1690. Nidditch P H, ed. Oxford: Oxford University Press, 1975.
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Interleukin-6 in clinical relapses of polymyalgia rheumatica and giant cell arteritis

Polymyalgia rheumatica and giant cell arteritis are related diseases associated with increased concentrations of acute phase reactants. Clinical symptoms and acute phase reactants respond promptly to corticosteroid treatment in most patients, and a decision to withdraw prednisone may be recommended after two years of evolution of the disease.¹ This may represent a critical phase for patients with polymyalgia rheumatica, who

are exposed to relapse with threatening symptoms of giant cell arteritis. At present there are no signs or tests that distinguish patients with evolving disease from those in complete recovery. Erythrocyte sedimentation rate (ESR) and C reactive protein (CRP) are used as aids in the management of the disease,^{2,3} but their values remain normal in about 50% of patients with clinical relapses of polymyalgia rheumatica and giant cell arteritis who are receiving treatment.⁴ Furthermore, diagnosis of relapse is frequently based on the clinician's experience in detecting clinical symptoms. Additional tests would be of help in enabling more precise monitoring of patients receiving treatment, and might also make possible a reduction in the duration of steroid treatment.

Interleukin-6 (IL-6) mediates the acute phase response by hepatocytes. Its concentration is increased in patients with polymyalgia rheumatica and giant cell arteritis before corticosteroid treatment,^{5,6} and while this increase is not specific to these disorders, IL-6 could be a biological marker of their disease activity. To determine the value of IL-6 as such a marker in clinical relapses of polymyalgia rheumatica and giant cell arteritis, we studied the variations in IL-6 concentrations, compared with those of acute phase reactants, during the reduction of prednisone dosage in patients with polymyalgia rheumatica and giant cell arteritis.

Twenty patients (15 women, five men: 17 with polymyalgia rheumatica (criteria of Bird *et al*⁷) and three with giant cell arteritis (American College of Rheumatology 1990 criteria⁸)) were followed prospectively. Clinical evaluations were made by a consultant rheumatologist and blood samples were taken before and one month after 50% reduction of the prednisone dose, and at clinical relapse. The latter, defined as the reappearance of typical morning pain and stiffness of the shoulder and pelvic girdles, was identified by a rheumatologist blinded to the results of acute phase reactant and IL-6 assays. When it occurred, and after blood was taken, clinicians took the decision to increase the dose of prednisone to that given before relapse. ESR was measured by the Westergren method; CRP (normal value (NV) < 10 mg/l), orosomucoid (α_1 -acid glycoprotein; NV < 1.2 g/l), and haptoglobin (NV < 4.1 g/l for men, < 2.6 g/l for women) were measured by immunonephelometry; fibrinogen (NV < 5 g/l) was measured by a chromometric method. Plasma samples were stored at -80°C until required for determination of IL-6 concentration by radioimmunoassay (Medgenix).

Statistical analyses for unpaired and paired data were performed using the Mann-Whitney test and the Wilcoxon test, respectively. The level of significance was set at $p < 0.05$.

At entry to the study, all patients were in remission and were receiving a stable dose of prednisone less than 10 mg/day (mean 4.4 (SD 2) mg/day). The mean disease duration was 53.3 months (range 12–170). Nine patients had a clinical relapse within one month after their prednisone dose was tapered. No subsequent evaluation was made, so the occurrence of late relapse could not be determined in this study. The clinical characteristics of patients who did or did not experience clinical relapse were not different (table 1), and there was also no difference in concentrations of IL-6 and acute phase reactants between these two groups before