Of the 14 patients classified by ultrasonography as affected with chondrocalcinosis, 13 presented with CPPD crystals in synovial liquid, whereas 2 of the 29 patients of the control group were positive for CPPD crystals at microscopic analysis (table 1). Therefore, ultrasonography demonstrated a high specificity (equal to 96.4%) and good sensitivity (equal to 86.7%), with a positive predictive value of 92% and a negative predictive value of 93%.

Considering that CPPD crystals could be found in synovial fluid even when characteristic calcifications are not found in joint tissues by traditional radiology,^{5,6} a sensitivity of 86.7% must be an excellent result. The important data of this study is, however, the high specificity of ultrasonography (96%) in identifying CPPD calcifications.

Other studies have been carried out on the utility of ultrasonography in knee chondrocalcinosis,^{7,8} but this is the only study that has used the presence of CPPD crystals in synovial liquid as a gold standard. The objective of this study was to evaluate the capacity of ultrasonography to offer a diagnosis, by identifying CPPD calcifications. For this purpose, microscopic synovial fluid analysis, the most widely used examination for the diagnosis of CPPD crystal deposition disease, was used as the gold standard.

Therefore, ultrasonography, as opposed to traditional radiology (ionizing radiation) and to magnetic resonance imaging (still conflicting data),^{9,10} is the only innocuous examination currently available to the physician that is able to identify CPPD crystal deposits. Considering that CPPD crystal deposition disease frequently has a subclinical course and the patient does not always reach the surgery in an acute stage, it is important for the physician to have a tool at his disposal that permits a diagnosis even in the absence of joint effusion. Moreover, the possibility that ultrasonography can be carried out rapidly during a rheumatology examination places it as a prime tool of diagnostic practice when there is suspected CPPD arthropathy.

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Competing interests: None declared.

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Accepted 16 January 2007

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FORTHCOMING EVENTS

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CORRECTION

doi: 10.1136/ard.2006.058784.corr1

There was an error in table 1 of the article by Micheloud D, Calderón M, Caparros M, D'Cruz D P. Intravenous immunoglobulin therapy in severe lupus myocarditis: good outcome in three patients. *Ann Rheum Dis* 2007;**66**:986–7. The units IU/ml and ug/l should refer to CK and troponin levels, respectively. There should also be an extra line in the table. The corrected table is available on our website at <http://ard.bmj.com/Supplemental>.