work? Are they any more effective than an appropriate placebo? There is accumulating evidence to demonstrate the benefit of foot orthoses in the treatment of lower limb disorders [10] of manipulative techniques in the management of back pain [11] and of the use of caudal epidurals in sciatica [12]. But how do epidurals work [12] and what is the role of sclerosant injections [13, 14]? Should we be incorporating the Alexander technique into the management of back pain? Having more consultants with a recognized hospital-based training in orthopaedic medicine within the National Health Service (NHS) and teaching centres would help to develop the research programmes necessary to address these types of issues.

The employment of orthopaedic physicians as NHS consultants has come about because non-inflammatory, non-surgical soft tissue disorders are not particularly prioritized by either rheumatologists or orthopaedic surgeons. The employment of NHS consultants who have not completed higher specialist training programmes recognized by the Royal College sets a dangerous precedent undermining the concept of post-graduate medical training. However, until we can improve the training in musculo-skeletal medicine within the NHS we have to accept that non-NHS-trained orthopaedic physicians provide a valuable clinical service.

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REFERENCES


CORTICOSTEROIDS IN THE MANAGEMENT OF RHEUMATOID ARTHRITIS

In 1949, Hench [1] described the impressive clinical benefits of Compound E (17-hydroxy-11-dehydrocortisone) in the treatment of rheumatoid arthritis (RA). His study was greeted with enthusiasm by patients and doctors alike at a time when there were few therapeutic options.

For the first time, it seemed, an effective and rapid suppressor of inflammation had been found. Function was restored, albeit temporarily, to severely affected patients; prompting one to remark, 'All I have left is arthritis in miniature'.

However, even in this small study of 14 patients, the symptoms of some individuals remained difficult to control without high doses of corticosteroids, which resulted in significant side-effects; a disorder we now recognize as iatrogenic Cushing's syndrome. Ever since, the place of corticosteroids (oral, i.m. or i.v.) in the management of RA has remained the subject of much interest, discussion and controversy. Are these agents merely useful for short-term symptom relief, do they have 'disease-modifying' properties and does their side-effect profile render them unacceptable in the longer-term management of RA?

One of the first clinical trials was undertaken by the Empire Rheumatism Council in 1957, comparing cortisone and aspirin over 3 yr [2]. Patient function, well-being and sedimentation rate (ESR) improved equally in both groups. Thus, no definite added benefit was obtained using corticosteroids.

Similar results have subsequently been reported in much later trials of pulse treatment with i.v. methylprednisolone combined with second-line drugs [3, 4].