prospective trial would be required to answer this question.

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Health Economics as an Aspect of Health Outcome: Basic Principles and Application in Rheumatoid Arthritis

Sir—We read with interest the recent article on health economics [1]. We are aware that in-patient care accounts for most of the direct medical cost of patients with rheumatoid arthritis, and of the need to demonstrate that elective admission of rheumatology patients to hospital beds can be efficient and effective. To attempt to improve the efficiency of our RA in-patient treatment with pulsed i.v. methylprednisolone, we established a pre-assessment clinic.

The pre-assessment clinic involves review by the rheumatology nurse specialist with a pre-designed questionnaire aimed at screening for infection, peptic ulceration, diverticular disease and uncontrolled heart disease. All patients have blood pressure, acute-phase reactants and mid-stream specimen of urine checked. Sputum culture, electrocardiogram and chest X-ray are performed if necessary. In addition to this, initial physiotherapy assessment occurs.

Patients who are pre-assessed have their results reviewed and further treatment (e.g. antibiotics) or investigations (e.g. gastroscopy) performed prior to admission.

We compared 27 RA patients with active disease who attended the pre-assessment clinic and all 27 RA patients with active disease who were admitted directly from waiting list. The two groups were matched for Steinbrocker functional class. All were treated with i.v. methylprednisolone (2–3 g), bed rest, review of DMARD, physiotherapy and occupational therapy assessment and treatments. The two groups were compared for age, length of stay and major complications (Table I).

We have demonstrated both a statistical and clinically significant reduction in length of stay of RA patients requiring i.v. methylprednisolone by running a pre-assessment clinic. A reduction in length of stay by 4 days produces a reduction in cost of £600 per patient, in our unit. There is an overall decrease in length of stay by 40% which could correspond with a matching increase in patient throughput. We are awaiting the results from follow-up of disease outcome measures. Lambert and Hurst [1] quoted that 50–80% of in-patient costs are attributable to fixed costs over which clinicians have little or no control [2, 3]. Although we cannot alter fixed costs, by running a pre-assessment clinic we can reduce in-patient stay, but still offer the same clinical service, with obvious financial benefit.

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Parvovirus B19 in Rheumatoid Arthritis: Comment on the Article by Kerr et al.

Sir—We were pleased to read an article by Kerr et al. [1] concluding ‘... our findings do not support involvement of B19 in the aetiopathogenesis of RA’. However, we would have been even more pleased had they included in the list of references our work [2], from which several sentences were cited exactly word by word (see, for example, the last sentences in the abstract and discussion).

S. Nikkari, P. Toivanen

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Reply

Sir—Drs Nikkari and Toivanen, having read our paper [1], point out our error in not citing their work on the role of B19 in rheumatoid arthritis [2]. Our paper had been cited as the conclusion was similar to our own.

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| TABLE I |
|------------------|-----------------|-------------------|
|                  | Pre-assessed    | Not pre-assessed  | P (Student's t-test) |
| Number           | 27              | 27                | 0.037               |
| Mean age (yr)    | 60.8            | 67.5              |                     |
| Mean length of stay (days) | 7.2            | 11.9              | 0.0015              |
| Range of length of stay (days) | 3-14           | 4-35              |                     |
| Major complications | 0              | 0                 |                     |