such as limited or diffuse cutaneous systemic sclerosis or systemic lupus erythematosus.

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Time to review the distribution of rheumatology National Training Numbers

Sir, In the survey by Price et al. [1] on behalf of the British Society for Rheumatology Research and Training Committee, East Anglia emerged with the dubious distinction of having the smallest number of rheumatology NTNs (National Training Numbers) of any deaney in the UK and also the highest proportion of training posts occupied by non-NTN holders. The true position was actually bleaker as one of the five NTNs was only temporary. This high occupancy of NTN posts by LAT (Locum Appointment for Training) holders results in an exceptionally high turnover of trainees.

Our efforts to increase our number of rheumatology specialist registrars over the past 5 yr have been singularly unsuccessful, due partly to a freeze on the national quota of NTNs and partly to the understandable reluctance by regions to relinquish any of their trainees, with the consequent inevitable disruption of popular and successful rotations. The situation has scarcely improved following the redrawing of deanery boundaries in April 2001 to create a new Eastern Deanery encompassing East Anglia, Essex and Hertfordshire. This exercise added just two extra rheumatology NTNs, giving a meagre total of six for this large geographical area. Moreover, as the two additional posts both rotate with hospitals in Thames Deanery, there has been no opportunity to satisfy the training aspirations of the rheumatology departments in Ipswich, Peterborough and Stevenage or to upgrade the LAT posts in Bury St Edmonds and Luton.

The present distribution of rheumatology training posts is largely historical. As the provision of rheumatology services has expanded and become more uniform across the UK, it is time that the spread of training provision was changed to reflect this.

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A comparison of the views of rheumatologists, general practitioners and patients on the treatment of osteoarthritis

Sir, Osteoarthritis (OA) is the most common form of joint disease and is an almost universal problem in people aged over 65 yr [1, 2]. Current management remains largely symptomatic [3] and involves a wide variety of options provided by a multitude of health professionals [4]. Given the number of professions involved in treatment and the importance of service provision for the successful management of chronic conditions [5], it is perhaps surprising that there is very