Osteitis deformans’ is clearly an inaccurate description and we believe ‘osteodystrophy deformans’ deserves to be far more widely recognized within the English language medical literature. Nonetheless, we expect ‘Paget’s disease of bone’ will stay with us for many more years.

The authors have declared no conflicts of interest.

B. RHODES, A. S. M. JAWAD
Department of Rheumatology, The Royal London Hospital, Bancroft Road, London E14DG, UK
Accepted 21 September 2004
Correspondence to: A. S. M. Jawad. E-mail: alismjawad1@hotmail.com

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Management of Paget’s disease of bone: reply

We thank Drs Jawad and Crisp for their interest in our review [1] and read their comments with interest.

With regard to the terminology for Paget’s disease of bone/osteitis deformans/osteodystrophy deformans, we think that ‘Paget’s disease of bone’ is as good a name as any, and we use this in preference to others as it is easily understood by health-care professionals and patients alike. We also suggest that when searching Medline for articles, it is useful to use both osteitis deformans and osteodystrophy deformans as search terms. Indeed, we’d recommend also using ‘ostitis deformans’ as it appears that there are many articles that have used this alternative spelling of Sir James Paget’s original name for the disease.

We welcome Dr Crisp’s comments on the use of pamidronate for the treatment of Paget’s disease. The regimen outlined in our paper is that recommended by the manufacturer and outlined in the summary product characteristics for pamidronate as licensed within the UK. We recognize, however, that many other dose regimens of pamidronate have been successfully used in the treatment of Paget’s disease and that as far as one can gather, these appear to be equally effective at suppressing serum alkaline phosphatase values [2–6]. There is no evidence to support the view that one regimen of pamidronate is better than another in terms of clinical response (or cost-effectiveness) since they have never been compared with each other in the context of a randomized controlled trial where clinical response and health economic issues have been addressed. This is relevant to the main point that we wanted to get across in our review, which is that there is little evidence to guide clinicians upon what the most appropriate management strategy is for any antiresorptive agent in Paget’s disease. This is particularly true with regard to the prevention and treatment of complications of the disease such as fracture, pain, deafness and bone deformity. Hopefully, on-going studies such as the PRISM trial (http://www.abdn.ac.uk/hrsa/hta/prism.shtml) will help to answer these questions and contribute to the development of future guidelines that will address the issues of efficient use of NHS time and resources mentioned by Dr Crisp.

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S. H. RALSTON, A. L. LANGSTON
Institute of Medical Sciences and 1Health Services Research Unit, University of Aberdeen, Aberdeen, UK
Accepted 23 September 2004
Correspondence to: S. H. Ralston, Institute of Medical Sciences, Forsterhill, Aberdeen AB25 2ZD, UK. E-mail: s.ralston@abdn.ac.uk

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The treatment of Paget’s disease

Sir, In their recent review of the management of Paget’s disease, Langston and Ralston perpertuate the advice to administer three infusions of pamidronate 60 mg/day i.v. over 6 weeks [1]. This is profligate of limited day-care resources and of course our patients’ time.

A single infusion of pamidronate 90 mg achieves normalization of alkaline phosphatase (ALP) in over 70 per cent of patients by 6 months. If ALP remains elevated after 6 months a second dose of 90 mg can be administered to achieve optimal control of disease activity. Long-term efficacy of the Cambridge protocol is indistinguishable from the conventional one with obvious financial and time economies [2, 3].

The author has declared no conflicts of interest.

A. J. CRISP

Rheumatology Department, Addenbrooke’s NHS Trust, Hills Road, Cambridge, UK
Accepted 23 September 2004
Correspondence to: A. J. Crisp, Rheumatology Department, Box 204, Addenbrooke’s NHS Trust, Hills Road, Cambridge CB2 2QO, UK. E-mail: ajcrisp@addenbrookes.nhs.uk

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