adult SLE patients was noted between the presence or levels of antibodies to hsp90 and the presence or levels of rheumatoid factor.

It is thus clear that the disease-specific occurrence of autoantibodies to hsp90 in adult SLE patients [1] and MRL/lpr mice [2] cannot be accounted for by the presence of RF. In our studies, we did not examine in detail the immune response to human hsp65. It would certainly be of interest, therefore, to examine whether the detection of autoantibodies to this human protein is complicated by the presence of RF. Unfortunately, the study of Lim and Sharif does not bear on the question since they chose to use hsp65 derived from *Mycobacterium leprae* in their study, rather than the human protein which would represent the ultimate target of any autoimmune response.

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Measuring Outcome in Rheumatoid Arthritis—Which Measures are Suitable for Routine Clinical Use?

Sir—

This house believes—none developed so far

Outcome measures have obsessed some of the sharper brains in academic clinical rheumatology for some time. The results of their endeavours have been a disappointment to one and all (or possibly only to me), Rheumatoid arthritis is a serious condition. Unfortunately, patients often deteriorate. The slavish prescription of outcome measures to record this deterioration is counterproductive, as it erroneously gives the impression to our managers that clinical rheumatologists cannot treat RA. We can treat RA very well, but we cannot cure it.

There are probably in excess of 2000 events that make up a rheumatoid patient's total experience. The development of carpal tunnel syndrome, a ruptured Baker's cyst, an extensor tendon rupture, an episode of vasculitis, a deteriorating social relationship; I can treat or help them all, and need to see the patient very regularly to minimize the consequence of this devastating disease. My new patient to follow-up ratio needs to reflect this and favour the latter, and I need help in convincing my managers of this.

Those with an interest in providing us with outcome measures may like to concentrate on what I do very well, rather than worry over what I do less effectively. Dr D. Symmons' editorial [1], 'Measuring outcome in rheumatoid arthritis—which measures are suitable for routine clinical use?', is easily answered—none developed so far.

Let us move forward and start measuring clinical events. Outcome, Dr Symmons reminds us, is defined as something that follows from an action. Clinical rheumatologists need to be very active to cope with the multiple treatable events that beset a rheumatoid patient. Those providing us with outcome measures need to follow suit—who will second this motion?

My case rests.

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