was limited to those older than 65 yr and with more severe symptoms. Radiological stage of osteoarthritis (OA) was found not to influence outcome in this trial. With this knowledge, the subsequent trial was planned to focus on this particular subgroup of knee OA patients, and found only a small difference between hyaluronan and placebo, and no difference between the two different hyaluronan preparations. A subgroup analysis was not performed in this trial due to power limitations.

Comparison of outcome in different trials of OA is complex because of differences in outcome measures, study populations and other causes. While the explanation suggested by Dr Magilavy and colleagues remains a possibility, there may be many other possible reasons for the different outcomes and conclusions of these trials.

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Reactivation of ancient trochanteric tuberculosis
60 years after surgical drainage

SIR, Tuberculous bursitis with associated osteitis of the greater trochanter is a rare cause of lateral hip pain and most cases were diagnosed in the early part of the twentieth century [1]. However, in those countries such as Spain where tuberculosis infection has had a higher incidence in the past, elderly people are susceptible to reactivate an ancient tuberculosis owing to the impairment of their immune system. With the re-emergence of tuberculosis more atypical osteoarticular cases have been reported [2–4]. Nowadays, the latest modalities in diagnosis and the specific antituberculous drug therapies allow us to make an earlier diagnosis and to find a definitive cure. However, it is necessary to keep in mind that tuberculosis is one of the causes of severe hip pain in elderly people.

We describe an 80-yr-old woman who had a surgical drainage of the trochanter area owing to tuberculous osteitis when she was 20. The patient was admitted to our hospital in 1995 complaining of lateral right hip pain, limping gait, tenderness over the greater trochanter and a skin fistula with a white suppurative fluid. Radiographs of the hip showed a partial destruction of the margin of the greater trochanter, lytic foci in the underlying bone and a small focus of calcification in the adjacent soft tissues (Fig. 1). Magnetic resonance imaging showed fluid around the greater trochanter in the subgluteus medium and maximum bursae, revealing the extent of the inflammation within the adjacent marrow and delineating the extent of abscess formation in the gluteal region and subcutaneous tissues (Fig. 2). The bone scan with technetium-99m-labelled leucocytes showed an important uptake of the trochanteric area and tender tissues around it. Blood tests revealed an erythrocyte sedimentation rate of 35 mm/h, C-reactive protein of...
4.5 mg/dl and leucocytes at 10.90 × 10⁹/l (85% neutrophils, 5.4% lymphocytes). A wide excision and curettage of the bone was done and microbiological and pathological studies were performed. No acid-fast bacilli were detected in the sample, but DNA of Mycobacterium tuberculosis was amplified using the polymerase chain reaction (PCR). Löwenstein culture was positive for M. tuberculosis susceptible to first-line antituberculous drugs. Typical granulomas containing caseum were observed in the pathological studies. The patient completed a treatment with rifampicin, isoniazid and pyrazinamide for 2 months followed by 7 months of rifampicin and isoniazid. Six years later the patient is asymptomatic and the range of movement of the hip is normal.

Trochanteric bursitis: Tuberculosis is a rare cause of hip pain. It accounts for 1–2% of all musculoskeletal tuberculosis [3]. There are no cases reported in the recent English medical literature [5, 6] and no reported cases of trochanteric tuberculosis reactivation after surgical drainage have been found.

Trochanteric tuberculosis used to present as a chronic pain and local tenderness over the lateral aspect of the hip that can be intermittent and may be undiagnosed for many years [5]. However, the most frequent causes of trochanteric pain are idiopathic trochanteric bursitis, septic bursitis, osteochondritis and tumours. The use of ultrasound or computed tomography in order to direct aspiration of bursal fluid for culture may be useful in the early diagnosis of tuberculous bursitis. In the absence of cold abscesses, fistula formation or evidence of tuberculosis elsewhere, this condition may be confused with other aetiologies. In the presence of a cutaneous fistula an over-infection could occur and prevent the diagnosis of tuberculosis if specific tests are not requested. Currently, modern tests to detect tuberculosis (genetic detection by means of PCR) allow us to obtain an early diagnosis.

Osteoarticular tuberculosis can reappear in those elderly people who were exposed to tuberculosis in their youth. Therefore, it is necessary to bear this fact in mind when making the differential diagnosis of the cause for hip pain in the elderly.

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F18-FDG-PET as a helpful tool in the diagnosis of giant cell arteritis

Sir, The diagnosis of giant cell arteritis and polymyalgia rheumatica remains a challenge, especially in patients presenting with non-specific symptoms [1]. Angiography and magnetic resonance angiography are standard diagnostic procedures. They may show non-specific lesions that cannot be differentiated from lesions of arteriosclerotic origin [2], and they cannot fully evaluate the extent of disease. Histological examinations are positive in only 70% of patients who also present with temporal artery involvement. All the other diagnostic tools involving clinical symptoms and laboratory parameters are also non-specific. Colour-coded duplex sonography with the typical findings of hypoechogetic intimal wall thickening seems to be one of the best diagnostic tools for this disease entity, although it is limited by the impossibility of scanning all the vascular regions that could potentially be affected, e.g. the thoracic vessels and aorta [3]. 2-¹⁸F-fluoro-2-deoxy-D-glucose (FDG) positron emission tomography (F18-FDG-PET) has shown promise in the diagnosis of vasculitic disorders [4, 5].

In a 6 month period, we saw seven patients (six females and one male) with a mean age of 71.9 yr (range 61–78 yr) for whom colour-coded duplex sonography strongly suggested a diagnosis of giant cell arteritis, which was confirmed by F18-FDG-PET. One of them had undergone subclavian bypass surgery on her left upper extremity three times, twice for bypass graft reocclusion, accompanied by severe shoulder pain and deteriorating general condition. Two further patients presented with sudden onset of severe headache and three with severe pain in the neck and shoulders and worsened general condition. An extensive examination had ruled out other systemic disease, e.g. malignancy. The final patient presented with typical upper extremity claudication accompanied by malaise.

All patients showed differing extents of hypoechogetic hyperplasia of the neointima of the supra-aortic vessels. The two patients presenting with clinical signs of temporal arteritis showed additional involvement of the temporal arteries. Thickening of the neointima was