Comment on: Guidelines for the management of the hot swollen joint in adults

Sir, We are grateful to Dr Coakley and colleagues for producing helpful revised guidelines on the hot swollen joint in adults [1]. Clearly a lot of thought and effort have gone into the preparation of these guidelines. We feel, however, that when this topic is next revised, the guidelines group should consider two further issues.

First, over the past year we have had at least three patients under our care with deep soft tissue infections, including one patient who had cellulitis overlying a wrist joint. We are not aware of any specific guidelines for deep soft tissue infections and the future guidelines group should consider whether to broaden their guidance to include such patients.

Second, we have noted variations in the length of intravenous antibiotic administration and the subsequent length of oral antibiotic therapy amongst both surgeons and physicians. Given this wide variation in practice by doctors for virtually identical patients with septic arthritis, more precise guidance on this aspect of management would be welcome.

We do recognize that there are limited clinical studies to provide an evidence base. We applaud the efforts of the guideline group and suggest that at least open clinical trials relating to these issues are required to help inform future guideline groups.

The authors have declared no conflicts of interest.

C. Welhengama1, A. O. Adebajo2

1 A&E Department, Wycombe General Hospital, High Wycombe, Bucks HP112TT and 2 Consultant Rheumatologist, Rheumatology Department, Barnsley Hospital NHS Foundation Trust, 48-51 Gawber Road, Barnsley S75 2PW

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Correspondence to: C. Welhengama, A&E Department, Wycombe General Hospital, High Wycombe, Bucks HP112TT. E-mail: cwelhengama@gmail.com

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Comment on: Arthritis as presenting manifestation of pure neuritic leprosy—a rheumatologist’s dilemma

Sir, I read with great interest the concise report of the pure neuritic leprosy and arthritis by Haroon et al. [1] in the April issue of Rheumatology. They elegantly described five interesting cases of leprosy, whereby the disease was manifested by neurological and arthritic features in the absence of any of the known associated skin manifestations. Some of their cases did not appear to have lepra reaction. Recently, we diagnosed a case of tuberculoid leprosy in which the clinical features were similar to some of those described by the above colleagues.

The patient was a 51-yr-old male, Bangali driver who is known to have type 2 diabetes mellitus for the last 10 yrs and was on metformin 500 mg twice daily along with diet control. He was referred to our rheumatology clinic in September 2006 as a case of seronegative RA. There was a history of generalized pain and stiffness of 4-month duration involving both the small joints of the hands, wrists, elbows, shoulders and knees. He also described a continuous pricking pain in the extremities. The posterior parts of his feet were also sore. His symptoms began as migratory arthropathy to become fixed polyarticular in the recent months. He was on metformin 500 mg twice daily along with diet control. He was not aware of any arthritis disease. He used diclofenac and other non-steroidal anti-inflammatory drugs, and pain killers during the course of illness but without improvement. There was no history

The authors have declared no conflicts of interest.

G. Coakley, C. Mathews, M. Field1, A. Jones2, G. Kingsley3, D. Walker3, M. Phillips5, C. Bradish6, A. McLachlan7, V. Weston8 on behalf of the British Society for Rheumatology Standards, Guidelines and Audit Working Group

Queen Elizabeth Hospital, Woolwich, London, 1Centre for Rheumatic Diseases, Royal Infirmary, Glasgow, 2City Hospital, Nottingham, 3University Hospital Lewisham, London, 4Freeeman Hospital, Newcastle, 5King’s College Hospital, London, 6Royal Orthopaedic Hospital, Birmingham (representing the British Orthopaedic Association), 7Herethington Group Practice, London and 8University Hospital NHS Trust, Nottingham (representing the British Society for Antimicrobial Chemotherapy)

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Correspondence to: Dr G. Coakley, Consultant Rheumatologist, Queen Elizabeth Hospital, Stadium Road, London, SE18 4QH, UK. E-mail: gerald.coakley@nhs.net


