SIR, A diagnosis of idiopathic inflammatory myositis (IIM) is not be underestimated. The simple message is that thanks to a daily intake of 75 or 150 mg of diclofenac, dependent on the day’s activity, I can maintain an active and productive lifestyle. I know that diclofenac has side-effects. As a trained biologist, I expect all drugs to have side-effects and for the side-effects to vary in severity throughout a population. I also believe that as an adult I am able to make an informed choice and that I am capable of assessing risk based on available information. In other words I feel fully able to discuss a benefit/risk ratio with regards to diclofenac. Without any special knowledge or research I would anticipate that all NSAIDs have similar side-effects. Those that have been withdrawn may have more severe side-effects than those currently available but the same legal arguments apply to all.

Thus, one can anticipate that those living in a world that can suggest drugs are risk free will advance similar arguments against all NSAIDs. The whole family of drugs and the benefits that they bring could be at risk. Binymin and Phillips [1] may find that ‘Doubling the risk of myocardial infarction and stroke to control chronic dull ache and stiffness due to arthritis …’ plays well with accountants and lawyers but to a patient the withdrawal of a valued and successful drug can reduce the patient from a contented, productive individual to a miserable burden on family and friends. It must be regretted that we live in a system where lawyers and accountants determine which drugs are useful, where a doctors professional opinion is little valued and the patient’s voice seldom heard.

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Muscular dystrophy mimicking refractory idiopathic inflammatory myositis: a trio of cases

SIR, A diagnosis of idiopathic inflammatory myositis (IIM) is usually considered when a patient presents with muscle weakness. Histological diagnosis with a muscle biopsy remains the gold standard test for IIM. The most common diagnostic criteria used for IIM are the Bohan and Peter criteria [1]. We report on three patients who presented with an initial diagnosis of polymyositis (PM), which was subsequently revised on repeat muscle biopsy.

Case 1 is a 23-yr-old female presenting with fatigue and proximal muscle weakness. Anti-nuclear antibodies (ANA) were absent and creatinine kinase (CK) level was 11 297 IU/l. A muscle biopsy showed small basophilic muscle fibres infiltrated with macrophages and lymphocytes, necrotic fibres and increased connective tissue. She was treated for PM with steroids and multiple immunosuppressives (azathioprine, methotrexate, cyclophosphame, plasma exchange) for 7 yrs with limited success. A second muscle biopsy again suggested an IIM. The development of calf hypertrophy led to a third muscle biopsy.

The therapeutic effects of maintaining an active lifestyle should not be underestimated.