health professionals, which will be awarded by a UK university and endorsed and supported by arc. This will further the charity’s support of allied health professionals working with patients with musculoskeletal disorders.

We believe that, through these and other ongoing developments, several of the issues raised by Goh et al. are being addressed. Evaluation of several of these initiatives indicates that they are beginning to have a significant impact on the various undergraduate curricula in the UK.

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Undergraduate education in rheumatology: reply

I write on behalf of my co-authors to thank Adebajo et al. for their interest in our article [1] and their extremely helpful comments. The pioneering work of the Arthritis Research Campaign in developing strategies to enhance rheumatology teaching through its education subcommittee is well recognized and acknowledged. It is very reassuring that the zeal to promote educational aims continues, and it is encouraging to note that the range of initiatives outlined by Adebajo et al. are beginning to impact on the rheumatology undergraduate curriculum within the UK.

Whilst in no way trying to detract from the excellent work that has already been done, it is believed that there is room for improvement. Unfortunately, there still exists a perception that the rheumatology curriculum and musculoskeletal teaching take second place to a number of other specialities. This assertion is made on personal observations as well as informal discussion with a number of colleagues. The time devoted to rheumatology teaching within the undergraduate curriculum is generally still an inadequate reflection of the high prevalence of musculoskeletal conditions in the community. A needs analysis based on a questionnaire survey of recently qualified medical graduates in Leicester (Samanta A, Goh L, Cavendish S, Heaney D, unpublished) indicates a lack of confidence in examining the musculoskeletal system, as well as in dealing with rheumatic conditions.

The concept of competency-based assessment is strongly supported. It is suggested that the delivery of undergraduate teaching can be enhanced further through an integrated curriculum, as well as multiprofessional and community-based teaching. The idea of a constructivist approach through spiral learning is highly attractive. This would allow the undergraduate student to move through different experiences throughout the curriculum, and to re-explore and extend previous learning by slotting new knowledge into pre-existing schemata.

The pioneering work and energy of the Arthritis Research Campaign and other organizations in promoting the undergraduate rheumatology curriculum is highly lauded. It is only through continued effort of this kind that a real change can be achieved.

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Timing of DAS28 in infliximab therapy

Sir, Durez et al. [1] argue that the clinical judgement of an experienced rheumatologist might be more useful than clinical trial outcome criteria such as ACR20 or DAS28 when assessing response to infliximab at 22 weeks. They report that 34.2% of patients clinically felt to require an increase in dose nevertheless fulfilled the ACR20 criteria, and that in a sub-group of their study in whom DAS28 was performed, 53% of patients who required a dose increase on clinical grounds fulfilled the DAS28 response criteria. In their opinion, in these patients, an ACR20 or DAS28 response underestimates ongoing disease activity.

It would be equally enlightening to analyse the ‘mirror-image’ data, i.e. how many patients failed the ACR20 or DAS28 response at 22 weeks but were nevertheless felt not to require an increase in dose. An assessment performed at 22 weeks, just prior to the fifth dose of infliximab, is a full 8 weeks since the last administration, when some of the beneficial effects may be wearing off. If a patient has had an excellent clinical response for 6 or 7 weeks, but experiences a deterioration in control over the last 7 days, he or she may ‘fail’ a global assessment tool on the day, but nevertheless be felt generally well enough controlled not to require an increase in dose, or to have the drug withdrawn. In this case, it is the timing of the assessment rather than the efficacy of the drug which is the crucial factor. For example, Sidiroopoulos et al. [2] report a significant improvement in DAS after increasing the frequency of infliximab infusions from 8-weekly to 6-weekly, in a study in which DAS, EULAR and ACR responses were assessed immediately before the next infusion. Although they naturally suggest that the significant improvement in DAS is related to the increasing dose intensity, after the increase the patients were assessed 6 weeks rather than 8 weeks after the previous infusion.

Information from the Durez et al. study on DAS28 failures who were nevertheless felt to be able to continue on their 8-weekly dose might further strengthen the case that the DAS28 8 weeks after the last infusion is not the ideal tool for measurement of infliximab efficacy. A fair assessment of disease activity and apparent response might require an increase in the frequency of the assessment, rather than necessarily an increase in the frequency of the drug.
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Timing of DAS28 in infliximab therapy: reply

We very much appreciate the careful reading by Armstrong and Bruce of our paper on dose adjustment in patients with rheumatoid arthritis not optimally responding to a standard dose of infliximab of 3 mg/kg every 8 weeks [1].

We agree with them that the time-point of measurement is crucial, and we support their interpretation on the results reported in the paper of Sidiropoulos et al. [2]. Of course the instrument for measuring disease activity or response is also crucial. We have already been interested in analysing the ‘mirror-image’ as defined in Armstrong and Bruce’s letter to the Editor.

In a sub-analysis of a non-selected sub-group of 241 patients from our cohort, we analysed differences in response scoring, and these data were presented at the EULAR Stockholm Meeting in 2002 [3]. One hundred and seventy-five of the 241 patients were clinical responders as judged by the expert. Twenty-three of these 175 clinical responders were ACR non-responders but DAS responders, six of the 175 clinical responders were ACR responders but not DAS responders and 25 of the 175 were ACR and DAS28 non-responders. So, 54 of the 175 clinical responders or almost 31% of all patients continued the same dose although they did not fulfil one of the classical response criteria used in clinical trials, or even failed both.

At present we are performing a further in-depth analysis of our data to contribute to a better understanding of which measures to use in daily practice, aiming for treatment optimization.

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