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Faye A. H. Cooles1,2, Graham H. Jackson3, Geetha Menon4 and John D. Isaacs1,2

1Rheumatology Department, Musculoskeletal Research Group, Newcastle University, 2Rheumatology Department, Haematology Department and 4Pathology Department, Newcastle-upon-Tyne NHS Foundation Trust Hospitals, Newcastle-upon-Tyne, UK
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Correspondence to: Faye A. H. Cooles, Rheumatology Department, Musculoskeletal Research Group, Newcastle University, Framlington Place, Newcastle-upon-Tyne NE1 7RU, UK.
E-mail: faye.cooles@ncl.ac.uk

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Comment on: Steroid injection for hip osteoarthritis: efficacy under ultrasound guidance

Sir, We read with interest the paper by Micu et al. [1] reporting benefit of US-guided steroid injection in their cohort of hip OA patients. We agree with the authors that US guidance is preferable to fluoroscopy guidance, not just from the point of view of practicality, cost and safety, but also US enables detection of synovitis/effusion. It has been demonstrated that competence in performing US-guided hip injection can rapidly be achieved by a novice using a flexible training strategy [2], and this may be an additional reason for rheumatologists to prefer US-guided technique rather than fluoroscopy.

The findings of the study are in line with accumulating evidence from recent randomized controlled trials confirming the efficacy of guided steroid injections [3-5]. The authors seem to imply that benefit of steroid injection is limited to those with US evidence of synovitis/effusion only. Indeed, the presence of synovitis/effusion on US was a prerequisite for entry in their study. However, in our randomized controlled trial of CS injection of the hip of 77 patients with advanced OA, even those without synovitis/effusion (mean measurements of bone to capsule distance of >7mm were defined as indicative of synovitis/effusion) responded to steroid injection [6]. However, the duration of response was reduced when compared with those with synovitis. US evidence of synovitis/effusion may help to stratify patients more likely to have a prolonged benefit, but some patients without inflammation may still find the risk/benefit aspect of guided injection attractive and should not be denied this treatment option.

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Ismaël Atchia1,2, David Kane2,3 and Fraser Birrell1,2

1Department of Rheumatology, Northumbria Healthcare NHS Foundation Trust, Newburn, 2Musculoskeletal Research Group, Institute of Cellular Medicine, Newcastle University, Newcastle-upon-Tyne, UK and 3Department of Rheumatology, Adelaide and Meath Hospital, Dublin, Ireland
Accepted 5 January 2011
Correspondence to: Ismaël Atchia, Department of Rheumatology, North Tyneside General Hospital, Rake Lane, North Shields, Tyne and Wear NE29 8NH, UK. E-mail: ish@doctors.org.uk

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Comment on: Steroid injection for hip osteoarthritis: efficacy under ultrasound guidance: reply

Sr, The letter of Atchia et al. [1] raises an important point and we agree with the authors that a certain degree of response to IACS injection could also be obtained in patients without hip synovitis. In fact, only a few studies address the problem of cut-off value between hip synovitis and normal reference values in adult hip [2–5]. The definition, including the numerical values, has proved to be very helpful in clinical practice but does not exclude the presence of a possible focal synovitis, minimal degrees of unilateral synovitis or bilateral involvement of the hips within the normal measurements range. On the other hand, IACS deposition has not only a local anti-inflammatory effect but is accompanied also by a mild systemic CS effect. This may be followed by the reduction of inflammatory cytokine blood levels and reduction of inflammatory parameters like ESR and CRP [6]. In our patients, we had two important selection criteria: the presence of synovitis condition for performing IACS, and exclusion of patients on a hip arthroplasty waiting list [7]. In our opinion, US hip evaluation is mandatory after clinical examination and the presence of synovitis is easily and rapidly confirmed. Moreover, US offers the possibility to guide the needle to aspirate the joint fluid and to deposit CS under visual control [8]. Therefore, IACS must not be delayed to late phases of OA when severe structural damage is present and also other mechanisms generating pain are involved. In our group, after 3 years of follow-up, 13 patients (32.5%) had a single episode of hip synovitis with no relapse or new involvement (data not published). Also in the work of Atchia et al. [9], the only criteria that correlated with CS response was the presence of synovitis. For this reason, we believe that the US approach is a fundamental tool that allows a precise delivery of the CS into the joints contributing significantly to reduction of pain and discomfort in hip OA. The long-term effect and benefits of this procedure are still to be defined.

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Mihaela C. Micu1 and Daniela Fodor2

1Rehabilitation II Department, Division of Rheumatology, Rehabilitation Clinical Hospital and 2Department of Internal Medicine, Clinica Medica II, University of Medicine and Pharmacy ‘Iuliu Hatieganu’, Cluj-Napoca, Romania

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Correspondence to: Mihaela C. Micu, Division of Rheumatology, Rehabilitation Clinical Hospital, Cluj-Napoca 400306, Viilor No. 46-50 str, Romania. E-mail: mcmicu@yahoo.com

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