Rheumatology 2003;42:918
doi:10.1093/rheumatology/keg415, available online at www.rheumatology.oupjournals.org

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Robin returned from the BSR meeting in Manchester, fired up with new ideas and ready to tell you about the poster reporting miocardiophaty enolic as a non relacionated complication of Sjögren's syndrome, but found that delightfully Hispanic misspelling trumped by one from the Department of Health, which had sent (with commendable promptness) a CD of performance data Robin had requested. It was addressed to the Rheumatolody Dept. The song is ended... Bernstein's vocal acrobatics at the Clinico-Pathological presentation are the nearest I can get to imagining a rheumatolody, and pretty horrid it was.

Bill Docken e-mailed to suggest that Robin's lack of correspondence is entirely due to his not having his own e-mail address. Actually Robin rather likes old-fashioned letters, thank you, although it has to be admitted that they get a bit damp in the air-raid shelter, so smudges and blots occur. But, *pour encourager les autres*, Robin has taken up a Hotmail account to add to his several other addresses in other aliases. He was distressed to find impostors on Hotmail, so he is robingoodfellow_rhu@hotmail.com. Look forward to hearing from you with such lovely Royal diseases as were produced at BSR in Manchester. Prince Charles would have loved the two abstracts that talked of complimentary therapy and a deferential diagnosis. Very good, your Highness.

Robin made his own selection of favourite abstracts — more eclectic, perhaps than those covered in the concurrent and plenary sessions — so here they are. Kaushik and colleagues from St Helens found that almost no patients were happy seeing a trainee, and particularly not on their first attendance. This, of course, raises questions about how one gets trained. Robertson *et al.* found that there were significantly more people in the room at a paediatric consultation than in the adult setting. Presumably this is because parents have to come, although Robin recalls one man in his mid 50s who came with his mum. Holden and the Oxford group reported a mismatch between clinical and MRI findings in ankylosing spondylitis affecting the neck — another excuse to spend more on investigations, but justifiable if the result will aid decision-making in prescribing TNF-α blockers. The Lancaster department described the development of an e-mail advice clinic that reduced referrals and speeded management. This is clearly an innovative and popular scheme and perhaps it is hardly surprising that the team were top of the pops in the UK 'Hospital Doctor' awards. Ledingham and colleagues from Portsmouth reported out-patient activity changes over a 5-yr period; in particular the new-to-old patient ratio has declined and Robin wonders if this is, as on his patch, because RA patients are reviewed longer and discharged less (not to mention being seen with flare-ups because general practitioners seem more reluctant to manage these). Indeed Abdullah *et al.* from Gateshead underpin this, stating 'Follow-up provision for existing patients is inadequate given the current complexity of therapy', and suggest that the BSR workload guidelines need revision, with waiting list target achievement compromising the long-term care of RA. Robin resonates with that. McHenry and the Belfast group have developed a computerized care pathway for biologic therapies which sounds effective and sensible. This can go into Robin's new journal called 'Archives of Resentment-Generating Healthcare', or ARGH for short, not least because he can get no money to buy a database package, let alone anyone to input the data. If your database is free, Taggart, e-mail me. Robin wrote in April about Duthie's 1963 paper on bedrest in RA, so it was interesting to see a modern analysis of in-patient *vs* out-patient care from Dublin (Kennedy *et al.*). They found no clinical difference and are analysing the relative costs. Robin has had awful trouble trying to organize intramuscular (i.m.) methotrexate, so was relieved to read Sandhu and the Glasgow group's abstract showing that i.m. treatment produced 'a small but probably clinically insignificant' improvement. Saravanan and colleagues surveyed attitudes to lung screening before administration of methotrexate; it would appear their concern was over the allergic pneumonitis sometimes induced, though what test would screen for that Robin has no idea and he knows of no evidence that pre-existing fibrosis is a predisposing factor in its development. Guideline time, perhaps?

Robin was, however, tempted to invent another new title — the Journal for Unfinished Research. One (nameless) abstract reported a systematic review and its conclusion was 'Study is ongoing'. Are abstracts *so* important that they cannot wait until there are results? A stink of salami suddenly supervenes.

From the BHPR meeting came one interesting abstract, to Robin anyway — that from Hough *et al.* reporting on their multidisciplinary 'Clinic at home'. It seems a very elegant idea, although taking staff away from their base can only work if there are enough to carry on the rest of the service. This may not, therefore, be practical for many overworked departments.

Can we stop post-viral fatigue syndrome with intravenous immunoglobulin? Yes, say Kerr and colleagues (who include the eponymous Bernstein — don't give up the day job, my boy — Clinical Infectious Diseases 2003;36:e100–6). Parvovirus induced symptoms cleared rapidly, although only three patients are reported. However this might prove to be another excuse for rheumatologists to use expensive effective therapy, expand budgets and gain respect (and after all Robin has said about chronic fatigue over the years, what a blessing it would be to get rid of it as a problem).

Robin noticed that he failed to follow up April's blast from the past as he had promised, but is pleased to remind people of West's report entitled 'Ten years of ACTH therapy' (Ann Rheum Dis 1962;21:263–71). The patients fared better than a comparable group from the Empire Rheumatism Council gold trial of gold, not least because of the dramatically superior suppression of erosions. Andrade, McCormick and Hill (*ibid.*, 1964;23:159–62), studying oral prednisolone, concluded 'If doses... in the range 5 to 7.5 mg are not exceeded, treatment with corticosteroids is justifiable in early and mild cases of rheumatoid arthritis'. Nothing new, then, and funny that there is still such hysteria about using steroids. Ennevaara and Oka (*ibid.*, 1963;22:336–41 and 1964;23:131–8) discussed amyloidosis in ankylosing spondylitis and RA. Robin has not seen a single case of amyloid in any connective tissue disease for 20 years, and wonders where and why it has gone. Better and earlier treatment, perhaps? As an aside Robin is quietly, if xenophobically, amused that the current 'Annals' is only in English despite now being the official EULAR journal, for in the 1960s each article was followed by abstracts in French and Spanish. The times they are a-changing, nicht wahr?

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