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Steroid treatment should be started without delay to avoid the high risk of blindness.

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Arthritis and Spondylodiscitis Caused by Mycobacterium xenopi in a Patient with Systemic Lupus Erythematosus

Sir—We read with interest the article by Coombes et al. [1], on a case of tenosynovitis in an immunocompetent patient involving Mycobacterium xenopi, and would like to report a patient with arthritis of the left shoulder and spondylodiscitis due to M. xenopi.

A 56-yr-old woman presented to the out-patient clinic with a painful left shoulder. This pain started 2 months before, and gradually increased. The patient had been suffering from systemic lupus erythematosus (SLE) for >20 yr, which was treated with a combination of low-dose corticosteroids and azathioprine. She had never before experienced painful joints. Apart from the painful left shoulder, she had some dyspnoea on exertion. Physical examination was unremarkable except for a swollen left shoulder with a solid, 2.5 cm tumour on top of the acromioclavicular joint. Movements of the shoulder were tender and moderately limited in all directions. Laboratory examinations revealed a slightly elevated ESR (28 mm/h); renal and liver function tests, and blood counts were in the normal range. Aspiration yielded 2.5 ml of clear synovial fluid, without crystals on microscopic examination. Gram and Ziehl–Neelsen stains were negative, as were routine bacterial and fungal cultures. Aspirate was inoculated onto Lowen-
caused by *M. xenopi* has not been reported before. It illustrates that in patients with rheumatic diseases with recent onset inflammation of any part of the musculoskeletal system, mycobacteria should be considered as a possible causative agent, especially when immunosuppressive drugs are used.

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**Informing the Public About Treatment Advances**

Sir—In their viewpoint article, Deighton and Doherty [1] propose guidelines for the publicity of therapeutic research advances. Unfortunately, their proposals serve no useful purpose and do not relate in any way to the process by which the media report and comment upon scientific developments. Your journal would do better to have commissioned an article from those who have dealt more fully with this area and have consulted more widely.

In the case of the developments with which I was involved [2] and which Deighton and Doherty quote, the initial publicity was generated by a national charity at the time of the award of the research grant which made the study possible. It was reinforced by the learned society which decided to issue a press release at the time of the award of the research grant which would do better to have commissioned an article from those who have dealt more fully with this area and have consulted more widely.

In the wake of the publicity. Dr Kirwan believes it to be [3].

Publicity cannot be controlled. Deighton and Doherty’s suggestions are unenlightened, naive and impossible to implement. Openness with information and honest debate can at least make the processes of science accessible to the public.

**Reply**

The response by Dr Kirwan unfortunately reinforces the concerns expressed in our viewpoint article [1]. His perspective as the principal investigator, echoed widely by the media, was that low-dose corticosteroid ‘is a new and important therapeutic advance’. This treatment was not new, was not a major advance, did not have its potential caveats discussed, and was not placed in the context of other treatments. Subsequent to its publication [2], the study has not been widely perceived as the seminal work Dr Kirwan believes it to be [3].

Public ‘education’ at the time of his grant award, when the abstract was first presented, and then on the day the paper appeared, was hardly likely to encourage balanced appraisal of the merits of the work. Because corticosteroids were ‘immediately available’, considerable re-education of disappointed patients was required in the wake of the publicity. Dr Kirwan does not concede this problem and may have missed it whilst engaged with the media.

We may be naive and uninformed in many matters, but between us have preceded and succeeded Dr Kirwan on the ARC Education Committee, have been involved in *British Medical Journal* policy on national media coverage, and have been directly involved in newspaper, radio and television ‘news items’. Before writing the viewpoint, we canvassed opinion from GPs, rheumatologists and uARC officers, many of whom shared our concerns. Dr Kirwan accepts the immediacy of the press and believes it leads to honest debate. His own example, however, does not inspire confidence. We do not accept the inevitability of media domination, but favour continuing debate on how to improve mechanisms that impart accurate information with minimal bias and sensationalism.

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