Emeryville, CA, USA). Informed consent was obtained from all patients.

In three patients, HCV infection was community acquired and in the fourth it occurred after blood transfusions. Two patients had consistently negative results both on serum and SF. One patient had consistently positive results in the serum on four occasions (26.09 to 61.35 \( \times 10^5 \) copies), whereas all three SF specimens were negative. In the fourth patient, HCV RNA was not detected in three different tests in the serum, but was present at the low concentration of 5.92 \( \times 10^4 \) copies in 1/3 SF specimens. HCV RNA was searched for in an arthroscopic biopsy of the SM by PCR with a negative result. Her disease was classified as Still's disease, although the criteria for RA were also fulfilled. The patient had complained of arthritis since age 4 after smallpox vaccination. She had a remission at age 12, but later arthritis recurred with high spiking fever, severe anaemia, leucocytosis, pericarditis, and hepatosplenomegaly. IgM rheumatoid factor (RF), ANA, anti-DNA and anti-ENA antibodies were negative. Interestingly, arthritis recurred a few years after the blood transfusions that most probably caused HCV infection.

In our experience, HCV did not show a tropism for the SM, despite the inflammation-related increase in permeability and vascularization, since even the patient with consistently positive tests in the serum had no detectable amounts of HCV RNA in the simultaneously aspirated SF samples. Moreover, the only positive test in the SF was not confirmed when the SM was evaluated. The diagnosis of HCV infection was made on the basis of positive ELISA and Western blot tests, and should not have been influenced by the possible interference of IgM RF [6] or by the serum on four occasions (26.09 to 61.35 \( \times 10^5 \) copies), whereas all three SF specimens were negative. In the fourth patient, HCV RNA was not detected in three different tests in the serum, but was present at the low concentration of 5.92 \( \times 10^4 \) copies in 1/3 SF specimens. HCV RNA was searched for in an arthroscopic biopsy of the SM by PCR with a negative result. Her disease was classified as Still's disease, although the criteria for RA were also fulfilled. The patient had complained of arthritis since age 4 after smallpox vaccination. She had a remission at age 12, but later arthritis recurred with high spiking fever, severe anaemia, leucocytosis, pericarditis, and hepatosplenomegaly. IgM rheumatoid factor (RF), ANA, anti-DNA and anti-ENA antibodies were negative. Interestingly, arthritis recurred a few years after the blood transfusions that most probably caused HCV infection.

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Accepted 22 September 1996


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**TABLE I**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
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<th>IgM RF</th>
<th>Serum</th>
<th>Synovial fluid</th>
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<td>M</td>
<td>+</td>
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<td>negative</td>
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<td>-</td>
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<td>negative</td>
</tr>
<tr>
<td>4</td>
<td>33</td>
<td>F</td>
<td>-</td>
<td>negative</td>
<td>positive (?)</td>
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</table>
Y-90 colloid with saline. The injections in the knee joint were followed by collection of the urine for 48 h and the radioactivity in the urine was measured.

Fifteen patients with an active chronic synovitis of the knee joint, which persisted after adequate treatment with anti-inflammatory drugs and i.a. corticosteroid injections, were included in this study. Patients who were treated with Y-90 colloid i.a. in both knees simultaneously were excluded for this study. All patients had given informed consent. The design of the work conforms to standards currently applied in the Netherlands. The patients were randomly divided into three groups of five patients: one group of five patients received an i.a. injection of 1 ml Omnipaque (Nycomed) containing 0.1 mg EDTA, a second group of five patients received i.a. 1 ml Urografine 60% (Scheding) without EDTA and a control group of five patients received i.a. 1 ml saline. Thereafter, each patient received an i.a. injection of 185 MBq (5 mCi) Y-90 citrate colloid (CIS bio international).

Preceding the Y-90 colloid treatment, the following inflammatory activity variables of the knee joint were scored: tenderness, swelling, effusion and warmth on a four-point scale (0 = absent, 1 = slight, 2 = moderate, 3 = severe). Furthermore, the ESR, the CRP, serum creatinine and an X-ray of the knee joint were performed. The X-rays were scored according to Larsen et al. [8]. The method for radiation synovectomy has been described before [2, 3]. Briefly, 185 MBq Y-90 colloid were diluted in the vial up to 3 ml with saline and transferred into a 5 ml syringe. With the patient in a supine position and using an aseptic technique, the injection site was cleaned. With a standard medial or lateral approach, a needle was inserted into the synovial cavity and the knee was drained as completely as possible. Using a three-way tap, 1 ml of one of the contrast media or 1 ml of saline was injected and followed by 185 MBq Y-90 colloid, then the needle was flushed with 1 ml of saline. Next, the needle was withdrawn, pressure applied to the injection site and the knee flexed twice before being immobilized in full extension with a bandage and/or a splint. The patient was then confined to bed for 3 days.

The urine of each patient was collected for 48 h. The total volume of each urine sample was determined and 4 ml of each urine sample were used for counting the radioactivity. Five microlitres of the solution of the injected doses were used as a standard and mixed with 4 ml of blank urine. Also 4 ml of blank urine were counted. To each urine sample of 4 ml, 16 ml of scintillation solvent were added (Hionic Fluor Packard). The β-radiation of the Y-90 was counted in a liquid scintillation counter for 10 min. Calculation of the percentage Y-90 in the urine was performed as follows: % of the dose in the urine = [(A/4) × (C – B)]/[3000 × (S – B)] × 100, where A is the volume of a urine sample, C is the count of the urine sample in c.p.m., B is the count of the blank urine sample in c.p.m. and S is the count of the standard in c.p.m.

Quality control of three batches of Y-90 citrate colloid was performed by paper chromatography (Whatman 3 in acetone).

About 3% of the radioactivity administered into the joint was found in the 48 h urine sample (Table I). No differences in radioactivity counts were found between the three patient groups. There was no correlation between the radioactivity in the urine and the inflammatory activity variables of the knee joints, such as tenderness, swelling, effusion, warmth, ESR and CRP. Serum creatinine was normal. No relationship was found between the radiological score [8] and the amount of radioactivity in the urine. Our radiochemical quality control showed a purity of Y-90 colloid of >99%.

In this study, no significant differences in radioactivity excreted in the urine were found between the three groups of patients treated with radiosynovectomy for a knee joint synovitis, whether or not a contrast medium, with or without EDTA, was added. Although on theoretical grounds one could expect some differences between these patient groups, no such differences could be determined. There was also no relationship between the inflammatory activity parameters or the radiological score [8] of the treated knee joint and the radioactivity excreted in the urine. In this small group of patients, we cannot confirm the suggestion in the EANM information sheet that for radiation synovectomy simultaneous administration of Y-90 colloid i.a. and iodine contrast media containing EDTA should be avoided.

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7. EANM. Monograph of the Task Group Radionuclide Therapy from the European Association of Nuclear Medicine, 1993. Radionuclide therapy: from palliation to cure.

Re: Rheumatology in Israel
SIR—We have read with interest the International Letter ‘Rheumatology in Israel’ by Ehrenfeld et al. (British Journal of Rheumatology 1996;35:778–80).

Your readers may be interested to learn of the important part played by British rheumatology in the development of rheumatology in Israel. The Rheumatology Department of the Rambam Medical Centre in Haifa, which opened its doors in 1974, was firmly established in the best traditions of Taplow, Guy’s and the Kennedy where Professors Yehuda Scharf and Menahem Nahir (neither mentioned in the Ehrenfeld article) received their specialist training in the 1970s. The Rambam unit remains, to this day, the only designated university rheumatology in-patient unit in Israel, having 12 beds (not 18 as reported in the article) dedicated for the treatment of rheumatic diseases.

It was from there that the first president of the fledgling Israel Society of Rheumatology was elected in 1984, that the successful struggle leading to the heavily resisted recognition of the speciality was waged, that the curriculum of the Specialty Board in Rheumatology was developed and where, until 1994, all qualifying examinations for the boards were held. Over the years, an impressive, modern and popular service has been built up spanning rheumatology in the widest sense, and matched by a commensurate academic programme that the curriculum of the Specialty Board in Rheumatology was developed and where, until 1994, all qualifying examinations for the boards were held. Over the years, an impressive, modern and popular service has been built up spanning rheumatology in the widest sense, and matched by a commensurate academic programme.