

Pseudothrombophlebitic onset of septic arthritis in a patient with systemic lupus erythematosus

SIR, We read with interest the article by Dawes *et al* which describes a case of gonococcal arthritis presenting as pseudothrombophlebitis.¹ We have recently observed the pseudothrombophlebitic onset of septic arthritis in a patient with systemic lupus erythematosus (SLE).

The patient was a 34 year old woman with a 10 year history of SLE which was controlled with prednisone 20 mg daily. Six days before admission she experienced fever, polyarthralgia, and a swollen right knee. Subsequently there was a sudden onset of pain and swelling of the right calf. Examination showed a febrile patient (axillary temperature 38°C) in good general condition; there was arthritis of the right knee joint and swelling of the adjacent calf, suggesting popliteal cyst rupture. Ultrasound confirmed this clinical diagnosis. Fluid obtained from arthrocentesis as well as from aspiration of the swollen calf contained pus, which on culture grew *Staphylococcus aureus*. Laboratory tests included an erythrocyte sedimentation rate of 75 mm/1st h, haemoglobin 116 g/l, white blood cell count $7.46 \times 10^9/l$ (differential count normal), and normal routine blood biochemistry. Urine analysis showed no proteinuria or other abnormalities. Blood cultures were negative. Therapy was started with intravenous cloxacillin 12 g daily and multiple aspirations; since the clinical picture did not clearly improve, arthrotomy and drainage of the knee was carried out, resulting in a satisfactory outcome.

Baker's cysts are an infrequent complication of SLE.

Thus Stevens points out that only 5% of his patients showed this change,² and in the series of 34 cases of pseudothrombophlebitic syndrome (PTP) collected by Katz *et al* only two had SLE.³ The association of PTP and septic arthritis has been reported infrequently.^{1, 4, 5} We are aware of no cases of pseudothrombophlebitic onset of septic arthritis reported in patients with SLE. We would stress the usefulness of ultrasound in the diagnosis of this clinical entity.⁶

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Book reviews

The Clinical Pharmacology of Anti-Inflammatory Agents. By P M Brooks, W F Kean, W Watson Buchanan. Pp. 150. £16.00. Taylor and Francis: London. 1986.

This slim volume (150 pages, >10p per page) aims to provide a readable survey of drugs currently used in the treatment of inflammatory joint disease. Opening chapters on the pathogenesis of inflammation and its assessment are followed by descriptions of individual anti-inflammatory agents, in which their chemistry, pharmacology, toxicology, and clinical effects are reviewed. Suggestions for further reading are given at the end of each chapter (an unreasonable proportion of which are to the authors' own publications!), but the book is otherwise entirely unreferenced. The index is inadequate, a scant two pages.

It is difficult to decide for whom this book has been written. Structural formulae abound and much of each

chapter is concerned with the chemistry and pharmacokinetics of individual drugs, yet the approach is altogether too superficial for the serious student of pharmacology. On the other hand, detailed descriptions of drugs not yet generally available (auranofin) or recently withdrawn from sale (fenclofenac) are unlikely to be of great interest to the practising rheumatologist. There are several areas of inaccuracy (e.g., the physiology of the hypothalamic-adrenal axis) and some of inadequate content (e.g., renal effects of non-steroidal anti-inflammatory drugs); the units used are American (e.g., mg/dl) and not English.

Although several weighty and highly expensive textbooks on anti-inflammatory drugs have been published recently, there remains a need for a short, accurate, and well referenced résumé of currently used drugs. Unfortunately this book does not fulfil that need.

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