

patients would not be diagnosed as having SS if the US-Eur criteria were followed. Given that the patient in question is a present or past smoker should lead to the consequence that a focus score ≤ 1 and/or absence of anti-SSA/B autoantibodies (item IV and VI) cannot be trusted and consequently should be disregarded. Besides personal/family consequences it might have great social effects in some countries. In Sweden, for example, patients might get their dental repair bill subsidised by the State if they have SS diagnosed according to the Copenhagen criteria and, in addition, have abnormal unstimulated and stimulated whole sialometry, measured by 15 and 5 minutes, respectively.

I agree with Zandbelt and van den Hoogen that we do not have specific SS autoantibodies and neither do I think that the last autoantibody has been found. Classification criteria should not, therefore, concentrate solely upon the SSA/B autoantibodies but be open to newer ones as well. As mentioned in the leader the newly discovered BAFF (B cell activating factor from the tumour necrosis factor family) seems promising.

The fact that Japanese SS specialists simultaneously present their new classification criteria (also termed Japanese III), which look rather different from the US-Eur consensus criteria, might be considered very disturbing and disappointing for clinicians. However, they do look more acceptable, are based upon the results of a greater number of patients, and focus more on objective assessments—as asked for by Zandbelt and van den Hoogen. However, Zandbelt and van den Hoogen forget that the original set of SS criteria, the Copenhagen criteria of 1975, were based purely on objective data. The history of the various classification criteria for SS from that date can simply be represented by a nearly closed circle (see fig 1 in the June leader).¹

At the VIIIth International SS symposium held in mid-May 2002 in Kanasawa, Japan, both the new criteria were presented and discussed. The proposal put forward by the president of the symposium, Professor Susumu Sugai, that an international group of SS researchers should be inaugurated with representatives from Europe, America, China, and Japan was very much applauded. I hope that this international group of SS experts will not repeat the error from the systemic lupus erythematosus (SLE) criteria,² where the specificity of the proposed SLE criteria were tested against only two cases of SS. My qualified guess would be that the final proposal from this international group will not look like the newly presented US-Eur criteria. These criteria would seem to have a rather short timespan and therefore it may not pay to introduce them immediately as classification criteria for use in the clinic.

R Manthorpe

Sjögren's Syndrome Research Centre, Department of Rheumatology, Malmö University Hospital, SE-205 02 Malmö, Sweden

Correspondence to Dr R Manthorpe; Manthorpe@inet.uni2.dk

References

- 1 **Manthorpe R.** Sjögren's syndrome criteria. *Ann Rheum Dis* 2002;61:482-4.
- 2 **Tan EM, Cohen AS, Fries JF, Masi AT, McShane DJ, Rothfield NF, et al.** The 1982 revised criteria for the classification of SLE. *Arthritis Rheum* 1982;25:1271-7.

A brief history of spa therapy

We read with great interest the paper entitled "A brief history of spa therapy" by van Tubergen and van der Linden in the March edition of the *Annals*.¹ Spas have certainly played an important part throughout the centuries not only in recreation but also in restoring physical and mental health. In fact, several spa doctors have greatly influenced the progress of rheumatology—for example, Bruce from Scotland described polymyalgia, Forestier introduced gold treatment for rheumatoid arthritis in France, and Sitaj and Zitnan from Piestany described polyarticular chondrocalcinosis.

We regret that this paper failed to mention the famous spas of the Czech Republic, Slovakia, Hungary, and Romania. From their conception, Czech and Slovak spas became gathering places not only for aristocrats but also for kings and emperors. Hungary, one of the richest countries of thermal waters in the world, has a bath culture dating back to the pre-Roman Celtic times. Budapest is a capital unique for its thermal waters. It is also renowned for Lake Hévíz, the second biggest hot lake in the world, second to Rotorua, New Zealand.

We are proud to have published in English the first double blind controlled trials with thermal water treatment.² Hungary is the only country where medical use of thermal waters is practised based on its efficacy proved in controlled trials.

We profoundly disagree with the authors, that "taking the water, balneotherapy, spa therapy, hydrotherapy are more or less interchangeable". We are certain that they are not. Even in their paper, they quote Priessnitz and Kneipp, who distinguished between thermal water (balneotherapy) and hydrotherapy.¹ Hydrotherapy uses only the physical qualities of water (buoyancy of water, resistance, sometimes its temperature either cold or warm), whereas thermal waters are not only naturally warm ($>20^{\circ}\text{C}$) but their mineral content is also significant. In Hungary a recognised mineral water should have minerals 1 g/l or more, but no nitrates, nitrites, or bacterial growth. It is not known whether the minerals of mineral water penetrate the body surface, but they are known to cause a so-called spa or mineral water reaction.² The mineral water reaction includes tiredness and fatigue especially after 5-8 baths with an associated rise in the leucocyte count and erythrocyte sedimentation rate even within the normal range. The mineral water reaction passes away after 5-10 baths, and the optimal "taking the waters" is a total of 15-22 baths taken daily.

There is no equation between thermal mineral waters and spa therapy either. As we pointed out in a debate in the columns of the *Journal of Rheumatology*³⁻⁵ the effect of thermal mineral waters and the effect of complex spa therapy should be distinguished. We performed our double blind trials on inhabitants of ordinary Hungarian towns and villages with no spa facilities to exclude the placebo effect of a change in environment, physiotherapy, and being in a holiday atmosphere. In spa surroundings no double blind trials can be done. The results of follow up of these subjects suggest that non-spa treatment can be used as a control for future studies. Furthermore, the effect of spa water and heated tap water can be used for local residents to exclude the placebo effect of spa atmosphere, associated physiotherapy, etc. If we really want to have evidence based proof for thermal mineral water or spa treatment, or both, we should keep strictly to these rules.

We agree that spa resorts are excellent places for the rehabilitation of patients with

rheumatic diseases, especially ankylosing spondylitis. In addition, rehabilitation treatments are available for patients with fibromyalgia, a group who are frequent users of spa facilities. Most of the German, Czech, Slovak, Hungarian, and Russian spas also function as rehabilitation centres. In Hungary, thermal mineral water and spa treatment is a recognised treatment for rheumatic patients, although hard data are lacking. The Hungarian government has launched a 10 year spa programme for the development of Hungarian spas. In addition, the Hungarian National Activity Network of the Bone and Joint Decade was given the task by the minister of health to start evidence-based research about the effect of mineral water and spa treatment. Hungary organises the 34th World Congress of the International Society of Medical Hydrology and Climatology at Budapest and Hévíz in October this year. Attendance by rheumatologists and rehabilitation experts is expected.

We feel it is time to create European co-operation in rheumatology spa and mineral water research. We are convinced that multicentre trials would be valuable despite differences in mineral concentration, temperatures, cultures and beliefs. Underdevelopment of evidence-based physiotherapy is partly due to lack of funding for necessary trials. The situation is similar for balneotherapy and spa treatment trials. This problem may be overcome by conducting multicentre trials in many countries. Such trials may result in an evidence-based approach to therapeutic or recreational bathing.

T Bender

Polyclinic of The Hospitaller Brothers of St John of God in Budapest, 1025 Budapest, Arpad fejedelem u.7., Hungary

P V Balint, G P Balint

National Institute of Rheumatology and Physiotherapy, 1023 Budapest, Frankel L. u. 38-40, Hungary

Correspondence to: Dr T Bender; balneo@axalero.hu

References

- 1 **Van Tubergen A, van der Linden S.** A brief history of spa therapy. *Ann Rheum Dis* 2002;61:273-5.
- 2 **Szucs L, Ratko L, Lesko T, Szoor I, Genti Gy, Balint G.** Double blind trial on the effectiveness of the Puspokladany thermal water on arthrosis of the knee joint. *Roy Soc Health J* 1989;109:7-9.
- 3 **Fam AG.** Spa treatment in arthritis: a rheumatologist's view. *J Rheumatol* 1991;18:1775-7.
- 4 **Bell MJ.** Spa therapy in arthritis: a trialist's view. *J Rheumatol* 1991;18:1778-9.
- 5 **Balint G, Bender T, Szabo E.** Spa treatment in arthritis. *J Rheumatol* 1993;20:1623-5.

Authors' reply

We thank the Drs Bender, Balint, and Balint for their comments on our study and their additional remarks. We did not intentionally exclude the spas in countries such as the Czech Republic, Slovakia, Hungary, and Romania. In our paper we provided some examples of spas in European countries which we had found mentioned in published reports. We are, however, well aware of the central role of spas elsewhere in the world both in the past and the present, and their major influences on the development of rheumatology as a medical profession.^{1,2}

We fully agree that because spa therapy has an important role in rheumatology in many countries more research should be done and

also support the idea of multicentre studies. We regret, and we have experienced this, that those who finance research projects are extremely reluctant to fund trials in this field. We hope that, as has been suggested, with the creation of European cooperation in rheumatology spa and mineral water research we will be able to provide strong scientific evidence for the effectiveness of spa therapy in the near future.

A van Tubergen, Sj van der Linden

Department of Internal Medicine, Division of Rheumatology, University Hospital Maastricht, PO Box 5800, 6202 AZ Maastricht, The Netherlands

Correspondence to: Dr Sj van der Linden; sli@sint.azm.nl

References

- 1 **Calin A.** Royal National Hospital for Rheumatic Diseases—Bath. A 250th birthday party [editorial]. *J Rheumatol* 1988;15:733–4.
- 2 **Cantor D.** The contradictions of specialization: rheumatism and the decline of the spa in inter-war Britain. *Med Hist Suppl* 1990;10:127–44.

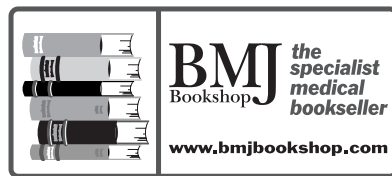
BOOK REVIEW

Pathological basis of orthopaedic and rheumatic disease

N A Athanasou. (Pp385, £95.) London: Edward Arnold, 2001. ISBN 0-3407-6382-5

The author provides an overview of the pathology of orthopaedic and rheumatic diseases which could help pathologists in finding the correct diagnosis and also support clinicians and rheumatic disease oriented researchers in obtaining information about a broad range of distinct pathological disorders.

There are eight chapters starting with skeletal structure development and progressing to injuries, infections, disorders of the skeletal development, and metabolic and other generalised diseases of the skeleton. Final chapters deal with diseases of articular tissues, including osteoarthritis and rheumatoid arthritis, and also describe tumours and tumour-like lesions of bone and soft tissue. The last two chapters covering tumour pathology comprise 40% of the content.



Each chapter stands by itself and, therefore, it is possible to focus directly on the matter of interest. The structure of description of the particular disease is consistent and logical and helpful to the reader. The normal format is a short introduction to the disease, some clinical features, radiological features, gross pathology, and histopathology. Every chapter ends with a list of references. The author quotes more than 1500 citations. More than 250 figures including histology, gross pathology, radiological pictures, and schematic diagrams and many tables enrich the quality of the volume.

In a future edition, inclusion of colour figures and an indication of the magnification of the histology pictures would be helpful. From our point of view working in the field of rheumatoid arthritis, the subchapter dealing with the disease could be extended, because the incidence of rheumatoid arthritis is 1–3% in Western countries.

What is missing is any reference throughout the text to the molecular and cellular mechanisms of the diseases. However, we suggest that this single volume would be useful for everyone interested in a summary of histological features of numerous orthopaedic and rheumatic diseases as seen in the clinic.

C A Seemayer, R E Gay, S Gay

FORTHCOMING EVENTS

7th International Conference on Eicosanoids and Other Bioactive Lipids in Cancer, Inflammation and Related Diseases

14–17 Oct 2002; Nashville, Tennessee, USA
Contact: Lawrence J Marnett, Biochemistry Department, Vanderbilt University, School of Medicine, Nashville TN 37232-0146, USA
 Tel: (615) 343 7329
 Fax: (615) 343 7534
 Website: www.eicosanoids.science.eayne.edu

3rd International Conference on Sex Hormones, Pregnancy, and the Rheumatic Diseases

21–24 Oct 2002; New Orleans, LA, USA
Contact: Anne Parke
 Tel: 860 679 8190
 Fax: 860 679 1287
 Email: parke@nso.uchc.edu

66th American College of Rheumatology AGM

25–29 Oct 2002; New Orleans, USA

Contact: ACR, Ronald F Olejko, Director of Conferences and Meetings, 1800 Century Place, Suite 250, Atlanta, Georgia 30045–4300, USA

Tel: +1 404 633 3777
 Fax: +1 404 633 1870
 Email: acr@rheumatology.org
 Website: www.rheumatology.org

Third International Meeting on Social and Economic Aspects of Osteoporosis and Osteoarthritis

7–9 November, 2002; Barcelona, Spain
Contact: Yolande Piette Communication, Boulevard Kleyer 108, 4000 Liège, Belgium
 Tel: 32 4 254 12 25
 Fax: 32 4 254 12 90
 Email: ypc@compuserve.com

Certifying Examination in Pediatric Rheumatology

18 Nov 2002
Contact: American Board of Pediatrics, 111 Silver Cedar Court, Chapel Hill, NC 27514-1513, USA
 Tel: 919 929 0461
 Fax: 919 918 7114 or 919 929 9255
 Website: www.abp.org

10th APLAR Congress of Rheumatology

1–6 Dec 2002; Bangkok, Thailand
Contact: APLAR 2002 Secretariat
 Fax: 66 2 716 6525
 Email: secreariat@aplar2002.com
 Website: www.aplar2002.com

Eleventh Intensive Applied Epidemiology Course for Rheumatologists

24–28 Feb 2003; ARC Epidemiology Unit, Manchester
 No previous experience in epidemiology is required. The course is residential and limited to 25 places
Contact: Ms Lisa Mc Clair, ARC Epidemiology Unit, Manchester, Oxford Road, Manchester M13 9PT, UK
 Tel: +44 (0)161 275 5993
 Fax: +44 (0)161 275 5043
 Email: Lisa@fs1.ser.man.ac.uk

Future EULAR congresses

18–21 June 2003; EULAR 2003 Lisbon, Portugal
 9–12 June 2004; EULAR 2004 Berlin, Germany
 8–11 June 2005; EULAR 2005 Vienna, Austria
 21–24 June 2006; EULAR 2006 Amsterdam, The Netherlands