References

1 Scott D L, Spector T D, Pullar T, McConkey B. What should we hope to achieve when treating rheumatoid arthritis? *Ann Rheum Dis* 1989; **48:** 256–61.
2 Nordstrom D M, West S G, Andersen P A, Sharp J T. Pulse methotrexate therapy in rheumatoid arthritis. *Ann Intern Med* 1987; **107:** 797–801.
3 Borg G, Allander E, Lund B, *et al.* Auranofin improves outcome in early rheumatoid arthritis. Results from a 2-year, double-blind, placebo controlled study. *J Rheumatol* 1988; **15:** 1747–54.
4 Symmons P M, Dawes P T. Summary and consensus view. *Br J Rheumatol* 1988; **27:** (suppl 1):76–7.
5 McConkey B, Crockson R A, Crockson A P, Wilkinson A R. The effects of some anti-inflammatory drugs on the acute-phase proteins in rheumatoid arthritis. *Q J Med* 1973; **17:** 785–91.

SIR, Dr Larsen raises several interesting and relevant issues. This is appreciated as the viewpoint article was intended to stimulate discussion. Because it was based on a consensus meeting some individual opinions, often held for a considerable period of time, were influenced by the arguments advanced at the meeting; but it is appropriate that opinions should be modified in the light of further experience.

There are undoubtedly occasions for using visual analogue scales, the clinical score, an articular index, radiological assessments, and measures of patients' opinion, but these are not necessarily the most relevant measures to use. For too long rheumatologists have used multiple variables to assess response, and we think the time has come to adopt a more rational approach. This was the basis of our article.

Patients' opinions are relevant; no one could use an antirheumatic drug if all their patients held a poor opinion of it. To argue that patients' opinions should form the mainstay of judging the effectiveness of treatment is probably incorrect, however. Effective treatment must be acceptable to patients and, more importantly, should have a demonstrable and clinically valuable influence upon the disease itself. The viewpoint article addressed the question of what we should consider a 'clinically valuable' effect. No matter how many trials use radiographs to evaluate drug treatment it seems common sense that these are not the most important thing to look at.

There was a feeling at the consensus meeting before the viewpoint article that less weight should now be given to radiological assessments. That is not to deny their relevance nor to overlook the valuable work contributed by Dr Larsen in this field. Clearly, rheumatological ideas move on, and this certainly happened with the views expressed in the viewpoint article on the value of *x* rays. Ten years ago many rheumatologists were convinced that plain radiology provided the gold standard to assess the progression of rheumatoid arthritis. It takes time for such views to become less pronounced, but the moment has now arrived. Clinical trials usually reflect the prevailing opinions when they were set up and so it is hardly surprising that recently published trials of antirheumatic drugs have used *x* rays, but in future their use may be more restricted.

There are no methods of assessing RA which are appropriate in all circumstances, but there is a need for new approaches; this need lay at the heart of the viewpoint article.

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Hepatic veno-occlusive disease and herbal remedies

SIR, The recent report by Lemley *et al*[1] of a patient who developed hepatic veno-occlusive disease while taking azathioprine is of interest to us.

We have recently seen a patient with veno-occlusive disease and another chronic disease—namely, multiple sclerosis. This patient was taking no drugs but was discovered to be an avid taker of herbal remedies, including comfrey tea.

It has been established that this herbal medicine can result in veno-occlusive disease.[2 3] We note the comment of Lemley *et al* that 'despite years of experience with azathioprine in RA, veno-occlusive disease has never been previously reported in this population'. Although the orthodox drugs taken by this patient are listed, no mention is made of whether he took any herbal remedies or other alternative medicine. Although azathioprine may have caused veno-occlusive disease in the patient described, we feel it is important to remind practitioners treating people with chronic diseases that not all alternative treatments are harmless and also that the side effects of such treatments may be mistakenly assigned to orthodox drugs.

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References

1 Lemley D E, Delacy L M, Sceff L B, Ishak K G, Nashel D J. Azathioprine induced hepatic veno-occlusive disease in rheumatoid arthritis. *Ann Rheum Dis* 1989; **48:** 342–6.
2 Weston C F, Cooper B T, Davies J D, Levine D F. Veno-occlusive disease of the liver secondary to ingestion of comfrey. *Br Med J* 1987; **295:** 183.
3 Ridker P M, McDermott W V. Comfrey herb tea and hepatic veno-occlusive disease. *Lancet* 1989; **i:** 657–8.