purchasers might consider "buying" inadequately evaluated therapies, on the same basis that physiotherapy was derided for accepting electrotherapy by ". . . giving credence to unscientific hype".[1] Caveat emptor.

I fully endorse the author's call for more research into the efficacy of physiotherapy, and already many of the obstacles that impeded physiotherapy research are being addressed. In a recent letter in the *British Journal of Rheumatology*[5] I explained that through the creation of university departments, the expertise and career structure exists to enable us to advance research in physiotherapy. We are now successfully competing for funding to critically evaluate our treatments, so that we can deliver the most effective treatment to our patients with the optimal use of resources.

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AUTHOR'S REPLY: I am delighted that Dr Hurley agrees with me that much physiotherapy requires proper evaluation. This does not, however, imply repeating experiments indefinitely until the answer the researcher wishes has been obtained. One well conducted piece of research may well be all that is necessary to answer a question, and at the very least it requires an equally scientific reply rather than prejudice hidden behind words such as "measured judgments".

Had Dr Hurley read my editorial carefully he would have realised that I nowhere advocated the use of massage. He must accept, though, that massage and other complementary therapies are already high on the list of purchasers' wishes. A recent survey by the National Association of Health Authorities and Trusts showed that 65% of District Health Authorities and 70% of Family Health Services Authorities favoured purchasing such therapies as part of their NHS provision.[1] Probably many of them act only by a placebo effect, but few are likely to be purchased if they advocate, as Dr Hurley does for physiotherapy, the use of complex pieces of electrical equipment such as lasers as placebos.

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1 Complementary Therapies in the NHS. National Association of Health Authorities and Trusts, 1993.

Distinction between initiation and progression of the osteoarthritis process

I read with positive interest but negative feelings the article by Cumming *et al.*[1]

Their conclusion that osteoarthritis of the hip should be included in the list of factors that protect against hip fracture, is in line with our previous observation on the inverse relationship between osteoarthritis and osteoporosis,[2 3] and in particular with the recent epidemiological evidence revealed in the MEDOS Study.[4] The MEDOS study is also based on self-reported osteoarthritis in a large series of controls and hip fracture cases. In both studies the inverse relationship between osteoarthritis and osteoporosis is independent of body weight, which supports the hypothesis that there is a direct causal relationship between osteoporosis and osteoarthritis.

A disturbing element in the paper by Cumming and Klineberg is the confusing terminology used throughout the paper. The term 'arthritis' is used interchangeably with 'osteoarthritis'. We do not agree that this interchangeable terminology should be used in an international rheumatology journal. The term arthritis is so bound to many other forms of arthritis, in particular rheumatoid arthritis, gout and pelvispondylitis, that this will inevitably lead to confusion in later citations. Although the term osteoarthritis is also not the best one, this term is now well accepted as an alternative to osteoarthrosis. According to our opinion and to many others, such as, Radin,[5] clear distinction should be made between initiation of the osteoarthritis process and progression. That secondary inflammation might be involved in the progression of osteoarthrosis is well accepted, but whether inflammation is the primary trigger of osteoarthritis is doubtful. A number of studies on the initiation of the osteoarthrosis process support the possibility that the increased bone density reduces the mechanical ability of subchondral bone to deform under impact loads with resulting damage to the articular cartilage and osteoarthritis.[6 7]

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AUTHORS' REPLY: We regret that the use of the terms 'arthritis' and 'osteoarthritis' appear to have been used interchangeably in our recent paper. We can assure Drs Dequeker and Westhovens that we gave careful thought to the use of these two terms. We tried to use the term 'osteoarthritis' whenever possible (particularly in the Introduction and Discussion sections of our paper). However, our data were based on self-reported joint symptoms; we did not ask subjects about osteoarthritis specifically. Thus we tried to use the term 'arthritis' whenever we were referring to the data from our study (particularly in the Results section and in the tables). We thought it would be misleading to readers if, for example, we wrote about 'self-reported osteoarthritis of the hip'.

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