significant short term benefit in adhesive capsulitis, but benefits are not maintained beyond 6 weeks''.

Although the authors were careful with their inclusion criteria, they failed to set a cut off point from the time of onset of pain and stiffness of the shoulder. Their subjects had a mean (SD) duration of symptoms of 25.3 (13.2) weeks. This indicates that some of the participants in this study had had a frozen shoulder for 38.6 weeks or approximately 9 months. The treatment period was limited to 3 weeks, regardless of the duration of symptoms. There were no other interventions.

Other reported studies have also included patients with long established adhesive capsulitis.[2 3] The latter with a mean duration at presentation of 5.5 months before oral corticosteroids were used in a trial.

This study makes an important contribution to the subject, but the authors make the point that future research should evaluate different combinations of treatment and their optimal duration.

Based on my experience, I support this recommendation. I have reported the treatment of 30 patients with idiopathic frozen shoulder (IFS). The mean duration of symptoms before referral was 9 weeks. The treatment was with 1–3 intra-articular injections of betamethasone (Celestone Chronodose) followed by oral prednisone 15–20 mg daily, initially for 2 weeks. A home exercise programme was advised. All 30 patients regained full range of movement of the affected shoulder with freedom from pain and without relapse.[4]

Future trials should incorporate a treatment group that includes a combination of oral and intra-articular corticosteroids. Double blind trials are problematic given the generally poor outcome for untreated IFS.[5] Patients with frozen shoulder with an onset greater than 16 weeks should be excluded from further trials.

IFS is a debilitating condition that is currently perceived as having a poor prognosis. Although it is not life threatening, it has a major impact on quality of life. It is therefore important that rheumatologists establish best practice for the management of this condition and educate other medical practitioners of the value of early, active treatment in achieving good outcomes.

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References

1 **Buchbinder R**, Hoving JL, Green S, Hall S, Forbes A, Nash P. Short course prednisolone for adhesive capsulitis (frozen shoulder or stiff painful shoulder); a randomised, double blind, placebo controlled trial. *Ann Rheum Dis* 2004;**63**:1460–9.
2 **Blockey NJ**, Wright JK, Kellgren JH. Oral cortisone therapy in periarthritis of the shoulder. *BMJ* 1954;**1**:1455–7.
3 **Binder A**, Hazelman BL, Parr G, Roberts S. A controlled study of oral prednisolone in frozen shoulder. *Br J Rheumatol* 1986;**25**:288–92.
4 **Douglas WA**. Treatment of idiopathic frozen shoulder with oral and intra-articular corticosteroids. *Aust Musculoskeletal Med* 2004;**9**:7.
5 **Schaeffer B**, Tibone JE, Kerian RK. Frozen shoulder – a long term follow-up. *J Bone Joint Surg Am* 1992;**74**:738–46.

Author's reply

I thank Dr Douglas for his interest and observations about our trial. He has documented his positive anecdotal experience in treating 30 patients with adhesive capsulitis with a combination of intra-articular and oral corticosteroids in a brief letter to the editor.[1] Unfortunately, this has not been published as a full report so no details are provided. It is not clear whether this was an open prospective trial or a retrospective chart review, and, if the latter, whether all patients with adhesive capsulitis were included in the review. Similarly, no numerical data are provided and the time interval between the 1–2 intra-articular steroid injections and the start of oral prednisone was not reported. None the less, his claim that all patients fully recovered, on average 4.5 weeks from initiation of treatment (although no measure of variance is provided) is noteworthy, lends broad support to the conclusions of our trial,[2] and, we agree, may warrant a formal trial.

We disagree that double blind trials pose a problem trial in studying adhesive capsulitis, as this is the best method for minimising bias in assessment of treatment outcome. Placebo controlled trials are appropriate when there are no known effective treatments, and controlled trials are essential for self limiting conditions such as adhesive capsulitis. While we agree that adhesive capsulitis is a painful, disabling condition, most studies have in fact established that it has a good prognosis, with resolution of symptoms in 2–3 years, on average, in the majority of patients.[2]

We also disagree with the suggestion that potential trial participants should be excluded if symptoms have been present for longer than 16 weeks. Although we agree that corticosteroids may be more effective in the earlier phase of adhesive capsulitis, and therefore attempting to limit participation in trials of corticosteroids to those with recent onset of symptoms may appear to have merit, early recruitment has proved universally difficult for trialists in this field.[2]

Furthermore, our positive trial, which included participants with an average of 21–25 weeks of symptoms, provides clear evidence that this constraint is not necessary.

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References

1 **Douglas WA**. Treatment of idiopathic frozen shoulder with oral and intra-articular corticosteroids. *Aust Musculoskeletal Med* 2004;**9**:7.
2 **Buchbinder R**, Hoving J, Green S, Forbes A, Hall S, Nash P. Short-course prednisolone therapy for the stiff painful shoulder (adhesive capsulitis or frozen shoulder): a randomised placebo-controlled trial. *Ann Rheum Dis* 2004;**63**:1460–9.

CORRECTION

doi: 10.1136/ard.2004.023564corr1

Prevalence and pattern of radiographic hand osteoarthritis and association with pain and disability (the Rotterdam study) (Dahaghin S, Bierma-Zeinstra S M A, Ginai A Z, Pols H A P, Hazes J M W, Koes B W. *Ann Rheum Dis* 2005;**64**:682–7.)

Figure 3 in this article should have been published in colour but mistakenly appeared in black and white. The correct figure has now been inserted in the Online version and subscribers to the journal can see the amended article at http://ard.bmjjournals.com/cgi/content/full/64/5/682

FORTHCOMING EVENTS

Second EULAR Course on Systemic Lupus Erythematosus

4–9 September 2005; San Miniato, Italy
This course for 70 young rheumatologists (age <40) has been designed to provide comprehensive, intensive training on various aspects of this disease. It will deal with the following topics:

- Treatment of SLE, molecular basis of drug action, and pharmacogenetics
- Evaluation of patients with SLE: disease activity, damage, response to treatment
- Renal disease in SLE
- Neurological disease in SLE
- Skin disease in SLE
- Particular problems in SLE: fever, vaccination, pregnancy, haematological manifestations

Contact: Organising secretariat: c/o Clinical and Experimental Rheumatology, Via Santa Maria 31, I-56126 Pisa, Italy.
Tel.: +39-050-40124
Fax: +39-050-502299
Email: slecourse@clinexprheumatol.org

Third International Conference on Neuroendocrine Immune Basis of the Rheumatic Diseases

10–12 September 2005; Genova-Santa Margherits, Italy
Topic: The clinical translation of the neuroendocrine immune mechanisms of the rheumatic diseases for a better understanding and management of their diagnosis and treatment.
Local organiser: Professor Maurizio Cutolo, Division of Rheumatology, DIMI, University of Genova, Italy
Email: mcutolo@unige.it
Contact: Organising secretariat: Michela Civelli, EDRA spa, Viale Monza , 133 – 20125, Milan, Italy
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XI Mediterranean Congress of Rheumatology

22–24 September 2005; Heraklion Crete, Greece
The meeting is organised by the Departments of Medicine, Rheumatology, and Clinical Immunology and Allergy, University of Crete.
Contact: Organising Bureau (secretariat and travel office) of the Mediterranean Congress of Rheumatology
Tel: 00 30 210 9006000
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Future EULAR congresses

21–24 June 2006; EULAR 2006; Amsterdam, The Netherlands
13–16 June 2007; EULAR 2007; Barcelona, Spain
11–14 June 2008; EULAR 2008; Paris, France