

keeping with their consultation, 98% understood all/most of the letter, and 100% found it useful or very useful [3].

The benefits of sending copy letters to rheumatology patients have been known for nearly 20 yr [4]. Several subsequent studies from oncology, paediatrics and primary care in the 1990s showed a generally positive response from patients [5, 6]. Despite the overwhelming evidence that patients want copy letters, the practice has been slow to take off. The Department of Health guidelines and changing attitudes among health-care professionals may make a difference. McConnell *et al.* investigated the opinions and practice of provision of audiotapes and letters by surgeons, oncologists and GPs [7]. They found that younger clinicians were more likely to make information from the consultation available to patients, which may reflect changes in emphasis in medical education.

There are some drawbacks to copying letters. There is an increased secretarial workload and administrative cost. Our survey suggests that secretaries are supportive of the process. A pilot study in 2002 in a Northeast GP surgery found that the cost of each letter was around £1, with a cost to the practice of £5000 per annum [8]. However, the study by Tomkins *et al.* in a dermatology department found the cost to be 25.3 pence per patient: 2 pence in paper and printing, 1 pence for the envelope, 19 pence in postage and 3.3 pence in secretarial time [3]. They felt the cost to be small in comparison with the benefits gained. If copying letters can improve compliance, hospital attendance and reduce the need for follow-up appointments, costs overall may be reduced, but this is yet to be proven.

One of the other issues is the communication of sensitive issues. Two specialties where this is most relevant are oncology and psychiatry. A Cochrane review found that between 83 and 96% of patients found recordings or summaries of their oncology consultations valuable [9]. Although patients with cancer found receiving the letter distressing to some extent, they still thought it was useful [6]. Nandhra *et al.* conducted a study on 76 psychiatry patients and found that 83% of the patients wished to continue to receive letters, and most found it helpful to receive letters despite 18% finding the letters distressing [10].

Our survey confirms that patients want to receive copy letters and find it very useful. The beneficial effects outweigh the drawbacks, which can easily be overcome. We suggest that the benefits of copying letters should be recognized and the process welcomed voluntarily rather than eventually responding to an imposed compulsory directive.

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### Caveats to the use of parenteral methotrexate in the treatment of rheumatic disease

SIR, methotrexate (MTX) remains the most widely prescribed of the disease-modifying anti-rheumatic drugs (DMARDs), but its clinical benefit is limited by gastrointestinal side-effects and a marked inter-individual variability in efficacy [1]. Parenterally administered MTX produces higher serum concentrations and more complete absorption than the orally administered drug at the top end of the dose range [2]. A recent open prospective study suggested improved efficacy with no reduction in safety on switching from oral to intramuscular (i.m.) administration in patients with active rheumatoid arthritis [3]. The parenteral route is well tolerated and there are no significant differences in bio-availability between MTX administered subcutaneously and I.M., making the two routes interchangeable [4]. On the downside, parenteral MTX costs more than seven times [5] as much as the oral preparation even before one takes associated expenses such as equipment, nurse and clinic time into account. It is imperative, therefore, that all reasonable steps are taken to ensure that patients are given an adequate trial of the oral drug before switching to the parenteral form.

We analysed the notes of 102 of the 115 patients receiving parenteral MTX for a variety of conditions in the 3 months leading up to and including June 2002. Ninety-one patients were using the subcutaneous as opposed to the i.m. route and of these, 77 had successfully been taught to self-inject.

All of the patients had received oral MTX prior to being switched and all had been receiving the parenteral drug for at least 3 months (mean duration 22.9 months). We documented the reasons prompting the switch and whether or not appropriate alternative measures had been tried beforehand. Each patient's perception of the 'efficacy' and 'tolerability' of the parenteral as compared with the oral preparation was gleaned from the notes, in clinic or over the telephone. A simple three-point scale was used: 'no difference', 'better' and 'worse'. The erythrocyte sedimentation rate (ESR) (mean of three) was noted in the 3 weeks prior to the switch and at the time of analysis. The same three-point scale was used, with 'better' being defined as a 20% fall and 'worse' as a 20% rise in the baseline ESR. Disease control measures employed subsequent to switching, such as corticosteroid administration (via any route), were recorded.

Prior to switching, patients had taken oral MTX for a mean duration of 30.35 months (range 3 to 135 months). Of the 44 patients (43.1%) switched purely due to lack of efficacy, only 27 (61.4%) had received an oral dose of 17.5 mg/week or higher. Twenty-one of the 44 (47.7%) said they 'felt better' on the equi-

patients (72.7%) but in 26 of these (81.3%) other disease control measures had been employed.

Twenty-nine patients (28.4%) were switched following the advent of nausea. Twenty-one (72.4%) of these reported improved symptoms on the parenteral drug but only 14 (48.3%) had received an anti-emetic and only seven (34.5%) had been advised to try splitting their oral MTX dose prior to the switch. Three of the four patients switched after developing mucositis reported an improvement; only one of these had been advised to use increased folate supplementation and none of them had tried splitting the oral dose.

Other reasons for switching included non-specific malaise (five patients), abdominal pain (four patients) and weight gain.

A significant number of patients on suboptimal doses of oral MTX are switching to the parenteral form (and presumably other DMARDs or biologics) without adequate attempts at dose escalation. Similarly, simple symptom control measures are not routinely being employed to deal with common side-effects. Parenterally administered MTX is generally better tolerated and there is a suggestion that it is more efficacious but firm conclusions cannot be drawn due to the retrospective nature of this analysis and the lack of an appropriate control.

<i>Rheumatology</i>	Key messages
	<ul style="list-style-type: none"> <li>• Attempts at dose escalation and simple symptom control measures should be employed before switching from oral to parenteral methotrexate.</li> </ul>

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### Use of intravenous cyclophosphamide in the prevention of corneal melt: justified or not?

SIR, Peripheral ulcerative keratitis (PUK), or corneal melt, is an aggressive destructive or necrotizing ulceration of the peripheral cornea presumed to be due to a microangiopathic vasculitis. It can occur following surgery that involves the cornea or sclera. It can lead to rapid (hours to days) corneal melting (keratolysis), perforation and eventual complete visual loss. Importantly, it heralds the onset of a systemic vasculitis in more than 50% of cases and is associated with a high mortality [1].

PUK poses a significant problem in patients with rheumatoid arthritis (RA) undergoing surgery on the anterior segment of the eye, such as cataract surgery. Messmer *et al.* [2] reported that the development of necrotizing scleritis or PUK was associated with prior cataract surgery in 31% of their study population. They suggested special vigilance should be exercised in these patients postoperatively for 12 months and those patients with high risk should be immunosuppressed prior to surgery. Unfortunately, once PUK has developed, its treatment after cataract surgery has a poor ocular prognosis, despite immunosuppression and surgery, and the results are devastating (Fig. 1).

We have successfully used intravenous cyclophosphamide in two cases as prophylactic therapy prior to cataract surgery. These two cases were considered to have high risk of developing PUK in that both had previously lost the sight in one eye due to PUK and required cataract surgery in the remaining eye.

Case 1 was a 47-yr-old Caucasian lady with a 30-yr history of seropositive erosive RA controlled with D-penicillamine. She underwent routine cataract surgery in January 1995. There was no previous history of ocular or extra-articular manifestations of her disease. Unfortunately, she developed post-surgical PUK, eventually resulting in loss of vision. Her rheumatoid disease remained quiescent over the following 2 yr but she then developed a dense cataract in the remaining left eye.

On this occasion she was prophylactically pulsed with intravenous cyclophosphamide. This was given over a 6-month period; she received 1 g monthly 3 months prior to surgery and 3 months after surgery.

Case 2 was a 72-yr-old Caucasian lady with a 40-yr history of nodular, seropositive RA with associated Sjögren's syndrome. She had been treated previously with various second-line therapies and then maintained on oral prednisolone (2.5 mg). In 1993 she presented with a painful inflamed left eye consistent with PUK, which was treated with local therapy. This failed to respond, necessitating a corneal tectonic transplantation. No systemic therapy was given and her eye failed to recover, becoming phthisical. In 1995 she developed a PUK of her right eye. Again, she received extensive topical therapy and corneal tectonic transplantation but on this occasion also received systemic immunosuppression with two doses of intravenous cyclophosphamide totalling 1.5 g. Her eye settled, but later she developed a dense cataract. Prior to cataract surgery she received intravenous cyclophosphamide: four pulses prior to surgery and four pulses following surgery. A total dose of 6 g was given.

Surgery was successful in both cases and there was no reoccurrence of PUK or complications related to immunosuppression. Throughout, their articular disease remained quiescent and to date there has been no evidence of systemic vasculitis.

PUK is a sight-threatening condition characterized by collagen destruction, cellular infiltration and limbal vascular changes indicative of vasculitis [3, 4].

Corneal fibroblasts are responsible for the continual turnover