Comment

Indomethacin is effective in the control of certain cases of rheumatic diseases. The high percentage of good and excellent results in nonrheumatoid benign rheumatic diseases would suggest that it is the treatment of choice. The initial dose may be 25 mg once or twice daily. In this group of diseases, it is seldom necessary for the physician to exceed a total daily dose of 100 mg or 125 mg at the most. However, even with low dosage the physician must be on guard for the occasional patient who might develop gastric upset or even ulceration, as well as the unusual patient who is highly susceptible to cerebral side-effects.

In rheumatoid arthritis, indomethacin is also effective, producing a good and excellent result in an appreciable number of cases, and because of its limited hazards, it should be included among the therapeutic weapons to be used in the treatment of this difficult disease. However, it should not be inferred that indomenthacin replaces or eliminates the need for a sound basic therapeutic program for the patient with rheumatoid arthritis which should include increased rest, salicylates, physical therapy, and other adjunctive or supportive measures. The patient with rheumatoid arthritis who is not responsive to the basic program of therapy may have this supplemented by the cautious prescribing of indomethacin beginning with a dose of 25 mg two or three times daily, best given after meals and at bedtime with a glass of milk. The daily dose may be increased in increments of 25 mg at perhaps weekly intervals. If disease activity persists, the physician would be justified in increasing the total daily dose to 150 to 250 mg daily, according to tolerance. As the higher dosage of indomethacin is approached, the physician must increase his caution regarding the possible development of gastric ulcer and in some patients must be prepared to cope with the distressing symptoms of headache, lightheadedness, and disturbances of sensorium. If the rheumatoid arthritic process continues to remain actively painful and disabling, the physician may cautiously add to the overall program such therapy as gold and low-dosage corticosteroid therapy as recommended in previous reports.[7,8]

"Dropouts"

In accordance with the suggestion of Mainland and Sutcliffe,[9] an explanatory note is appended regarding patients who were dropped from the study.

Twenty-three patients who began therapy, for one reason or another, became dropouts. They are grouped in four main categories: (1) Five patients were simply lost to followup for inexplicable reasons. Some were doing well and some were not doing so well. (2) There were four patients in whom the original diagnosis was determined to be incorrect. (3) Six patients were finally determined to be impossible to evaluate, despite the liberal use of placebo. Some of these at one time were considered to yield excellent results and at another time, seemed to be therapeutic failures. However, while honest and objective appraisal was attempted, retrospectively it was decided that there was too much uncertainty regarding their evaluation to permit conclusions in one direction or another. (4) Eight patients were receiving the drug for so brief a time that no conclusions could possibly be warranted. Most of these were too disturbed at the prospect of experimentation, after they had to sign "release form." Two others unexpectedly had to move out of town within a week after therapy was started.

Generic and Trade Names of Drugs

Indomethacin—*Indocin.*
Phenylbutazone—*Butazolidin.*
Chloroquine phosphate—*Aralen Phosphate.*
Prednisone—*Deltasone, Deltra, Meticorten, Paracort.*
Probenecid—*Benemid.*
Sulfinpyrazone—*Anturane.*

[7] Rothermich, N. O.: Local Steroid Injection Therapy in Rheumatic Diseases, *Postgrad Med* 30:283–292 (Oct) 1961.
[8] Rothermich, N. O.: Corticosteroid Therapy in Rheumatoid Arthritis, *Postgrad Med* 36:117–128 (Aug) 1964.
[9] Mainland, D., and Sutcliffe, M. I.: *The General Problem of Dropouts, ARA Coop Clin Committee Bull* 18:6 (Dec 7) 1964