are trends and not conclusive evidence. Secondly, in the measurement of activity of disease in rheumatoid arthritis there is also apparent universal agreement that there is still no satisfactory means of doing this. Lansbury's criteria, measurement of the inflammation of the joints, the swelling, mobility, general well-being of the patient, etc., all have a certain subjective element and a wide standard deviation. Typical example is the objective measurement of the knuckle circumference or the knee circumference. This requires no judgment on the part of the patient; however, in order to arrive at a probable accurate mathematical figure, the measurement of his joint must be done by the same person at each observation and several times each observation, even then, the other variables of swelling of the extremities due to causes not related to rheumatic disease are never determinable. This same problem can be applied to all the other objectives and are certainly applicable to the subjective measurements for rheumatic activity. But, I repeat, that this is all that we have at this time and I eagerly search the literature and discuss with my colleagues any developments in this area.

Regarding Indocin and its effectiveness—Indocin is presented as an anti-inflammatory drug and is ranked with aspirin, phenylbutazone, adrenocortical steroids and lesser anti-inflammatory agents. Whether antimalarials are actual anti-inflammatory in the sense of these drugs has never been really determined I think organic gold salts are not considered primarily anti-inflamatory. Of all these drugs, gold in my impression and the impression of the literature has been the one that has stood the test of time and double blind study as being *probably* causative in the induction of remission in rheumatoid arthritis. Thus, indomethacin, an anti-inflammatory drug, cannot offer the promise of remission, but rather a reduction in pain and swelling, and perhaps a delay of the destructive consequences of sustained synovitis. This latter has not been proven even for aspirin and definitely has not been proven for steroids. Steroids may prevent ankylosis and result in a mobile destroyed joint, which is more amenable to surgical therapy. Perhaps a good and consistent use of other anti-inflammatory drugs like Indocin would do the same and have this benefit.

My colleagues in West Virginia, realizing my interest in rheumatology and my experience with the use of indomethacin have asked me—what do I think of the drug? I tell them at this point that indomethacin is a definite anti-inflammatory drug and it is as good as the other anti-inflammatory agents mentioned above. The next question is—why should I use it above the others? I refer them to the serious side effects of phenylbutazone and adrenal steroids, which brings us down to the discussion as to whether it should be used in addition to or rather than salicylates; and this apparently is the issue that has appeared in the literature. I then say that effective salicylate therapy demands the continuous administration of sub-tinnitis dosage of the drug and this means that the patient must be experiencing from time to time tinnitis as well as diaphoreasis, cerebral symptoms, etc., and requires a dosage from 12 to 18 tablets a day. I submit that the problem of getting the patient to take that number of tablets every day for years is in some cases insurmountable; but the same can be accomplished with approximately 6 capsules of Indocin a day. This is then the current pragmatic feeling on my part regarding the use of indomethacin in the spring of 1968. We are currently in the process of retrospective analysis of patients treated 18 months or more with all the above drugs, singly or in clusters, including indomethacin. These are in the hands of our biostatistician and will be made available when completed.

Very truly yours,

DANIEL HAMATY, M.D., *F. A. C. P.*

MEDICAL COLLEGE OF VIRGINIA,
Richmond, Va., April 22, 1968.

MAX TISHLER, Ph. D.,
Merck & Co., Inc.,
Rahway, N.J.

DEAR DR. TISHLER: It has recently come to our attention that in the near future inquiries will be held concerning the efficacy of Indocin (Indomethacin).

Indocin is no panacea in the treatment of rheumatoid arthritis but it definitely has a place in its treatment and in the treatment of other rheumatic disease such as gout, osteoarthritis, and ankylosing spondylitis.

The management of rheumatic arthritis involves a treatment program of some complexity. No rigid set plan of drug therapy should be followed. A program