grade fever. Her medical history was otherwise unremarkable except for a hereditary cerebellar cortical degeneration. Her family history was negative for rheumatic diseases, including spondarthritis.

Physical examination showed tenderness and limitation of cervical and shoulder movement. The typical gait and abnormal stance of cerebellar ataxia were also present.

Laboratory evaluation disclosed an erythrocyte sedimentation rate (ESR) of 72 mm/1 h (Westergren) and a C reactive protein (CRP) concentration of 80 mg/l (normal <5). Tests for rheumatoid factor, antinuclear antibodies, and serum tumour markers were negative, and HLA typing did not show the B27 antigen.

Methylprednisolone at a dose of 16 mg/day was started and symptoms rapidly disappeared. ESR and CRP were normal after one month of treatment.

Nine months after starting treatment, when the dose of methylprednisolone was 6 mg/day, the patient experienced pain in her shoulder girdle and right foot. Physical examination showed an enlarged and painful right retrocalcaneal bursa. There was no pain and swelling along her right Achilles tendon and at its calcaneal insertion. Magnetic resonance imaging (MRI) showed an enlarged retrocalcaneal bursa with no sign of Achilles tendonitis or enthesitis (fig 1). An anteroposterior view of her pelvis showed normal sacroiliac joints. Both shoulder girdle symptoms and retrocalcaneal bursitis disappeared promptly when the dose of methylprednisolone was increased and have not reappeared so far, 12 months after discontinuation of treatment.

Our patient had PMR and showed retrocalcaneal bursitis as a distal manifestation of the disease. The prominent involvement of the extra-articular synovial structures in both peripheral and distal inflammatory processes of PMR has only recently been demonstrated.2 3 The distal manifestations of PMR include tenosynovitis in addition to joint synovitis.4 5 Extensor tenosynovial sheath involvement, which may give swelling with pitting oedema over the dorsum of the hands and feet, is common and has been recorded by MRI.6 7 Tenosynovitis under the transverse carpal ligament may cause carpal tunnel syndrome.8 The involvement of the flexor, posterior tibial and peroneal tendons may occur and has been documented with MRI.9 10 11

To the best of our knowledge retrocalcaneal bursitis has never been reported in association with PMR. Chuang et al found “bursitis-tendinitis” in 48/96 (50%) patients with PMR.12 Although they considered these as part of the disease, no mention of the affected bursae was made in their article. Possibly, some of the 48 patients developed retrocalcaneal bursitis. The retrocalcaneal bursa differs from other deep bursae, such as the subacromial and subdeltoid bursa and the gastrocnemius-semimembranosus bursa.13 The retrocalcaneal bursa is present only at its roof while its anterior wall is fibrocartilage layered onto the calcaneus and its posterior wall sesamoid fibrocartilage differentiated in the Achilles tendon. This anatomical arrangement makes the bursa an integral part of the Achilles enthesis. In spondarthritis, which is a disease of the enthesis, retrocalcaneal bursitis often occurs in association with Achilles enthesitis.14 In contrast, retrocalcaneal bursitis tends to occur in isolation in rheumatoid arthritis, suggesting that the synovial membrane at the top is the primary site of inflammation.15 The same may be valid for PMR. Our patient had no clinical sign of Achilles tendon involvement and MRI showed no sign of enthesitis, that is to say, tendon swelling and bone oedema. In conclusion our report suggests that the synovial membrane of distal bursae may also be affected in PMR.

Figure 1 Sagittal T1, (A) and axial T1, (B) weighted images of the left Achilles tendon showing the distension of the retrocalcaneal bursa by fluid collection (arrows) together with normal Achilles tendon and enthesis.

Retrocalcaneal bursitis in polymyalgia rheumatica

Polymyalgia rheumatica (PMR) is a relatively common disease of the elderly affecting the synovial membrane.1 2 Recent studies have emphasised the prominent involvement of the extra-articular synovial structures in both proximal and distal regions of both the arms and legs.3 4 In the distal part of the arms tenosynovial membrane inflammation is responsible for carpal tunnel syndrome, distal swelling of hands and feet with or without pitting oedema, and localised episodes of distal tenosynovitis.5 6 We recently observed the case of a patient with PMR showing retrocalcaneal bursitis, which we describe briefly here. A 68 year old woman was referred to us for evaluation of a three month history of marked aching and morning stiffness in her neck, shoulders, and hip girdles associated with low


CORRECTION

Comorbidity and lifestyle, reproductive factors, and environmental exposures associated with rheumatoid arthritis

(Reckener Olson Å, Skogh T, Wingren G. Ann Rheum Dis 2001;60:934–9.)

The authors regret that an error is present in the fourth paragraph of the “Results” section. The first sentence should read: “A non-significant increased risk of RA was seen in both men and women who consumed at least 75 ml of alcohol per drinking session at the age of 25 compared with total abstainers” and not “750 ml” as stated.

(Note: Corrections printed in the journal also appear on the Annals web page (www.annrheumdis.com) and are linked to the original publication.)

EULAR training bursaries

Up to 10 scholarships for clinical or laboratory work (3–6 months) in a foreign unit will be made available for applicants from countries where there is a clear educational need.

The value of each bursary is 7000 euros. Candidates should be under 35 years of age and the grant will not be made if the applicant is already abroad in training.

A curriculum vitae, a statement of qualification, a project outline, and a written confirmation from the host hospital that training is possible must be received at the EULAR Secretariat no later than 28 February 2002.

EULAR prize

The prize, to the value of 30 000 euros, is awarded by EULAR for an outstanding contribution in the field of rheumatology in recent years.

The competition is open to both scientists and clinicians working in the field of rheumatology. The prize will be awarded for the work of a group and not to an individual person.

The documents submitted in support of an entry may take the form of an essay or a description of the project. The prize will not be awarded for a publication or an abstract.

The essay with the CV of the head of the group and a publication list must be received at the EULAR Secretariat in Zurich no later than 28 February 2002.

EULAR young investigator awards

Three awards for a scientific (clinical or basic) research project of 30 000 euros each, will be made available for laboratory/research work in the field of rheumatology.

Candidates must submit a project outline, a CV, and expense budget and should be under 35 years of age.

Entries for the Young Investigator Awards must be received at the EULAR Secretariat in Zurich no later than 28 February 2002.

AMGEN/EULAR young investigator award

AMGEN (Europe) will make an award of 30 000 euros for a scientific (clinical or basic) research project in the area of rheumatoid arthritis. The prize money is intended to support laboratory/research work.

Candidates must submit a project outline, a CV, and expense budget and should be under 35 years of age.

Entries for the award must be received at the EULAR Secretariat in Zurich no later than 28 February 2002.

Endowment of the awards

The EULAR prize, the EULAR young investigator awards, and the AMGEN/EULAR young investigator award will be endowed at the opening ceremony of the Annual European Congress of Rheumatology to be held in Stockholm, Sweden, on 12 June 2002.

www.eular.org

Bursaries, the EULAR prize, and the Young Investigator Awards are also announced on www.eular.org

Applications should be forwarded to:
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