


A Rose by Any Other Name: Classified Accelerated Erosive Osteoarthritis or Calcium Pyrophosphate Deposition Disease, a Clarion for Aggressive Intervention

To the Editor:

The analysis of accelerated osteoarthritis (OA) by Davis, *et al*¹ noted the predominantly interphalangeal joint distribution of associated erosions and suggested a likely inflammatory derivation of the process. That description, however, is also applicable to a disorder long recognized as inflammatory in character: calcium pyrophosphate deposition disease (CPPD)².

Several studies document the development of destructive arthropathy in CPPD^{3,4,5} and the association of distal and proximal interphalangeal joint erosions with other manifestations of CPPD^{6,7}. Such correlation does not assure causality, but does direct consideration of therapeutic intervention. Hydroxychloroquine has not proven effective in treatment of OA⁸, but has documented efficacy in CPPD⁹, especially protecting the small joints of the hand. What has been referred to as erosions of those joints has a unique appearance. Rather than the sharply defined erosions characteristic of rheumatoid arthritis and spondyloarthropathy, high magnification views of articular surfaces reveal that the erosions of CPPD have smudged edges suggesting a crumbling rather than an “excised” derivation¹⁰. Davis, *et al* have expanded the spectrum of what has been referred to as erosive OA, suggesting that it represents a unique phenotype¹. The destructive phenomenon to which they refer, independent of its labeling/classification as erosive OA or as CPPD, appears significantly more responsive to medical intervention than does nonerosive, nondestructive OA. Thus, its recognition should stimulate more aggressive intervention than that limited to the nonsteroidal antiinflammatory drugs that have been standard treatment for OA.

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