Most patients on anti-TNF therapy (but not all on adalimumab) are co-prescribed methotrexate, which itself may of course precipitate acute pneumonitis. This is also more likely to occur in the context of pre-existing IPF [3]. In this context, it is important to note that the BSRBR has reported a 2 fold increase in the incidence of clinically apparent respiratory disease in RA patients on anti-TNF agents when compared with the 'control' group on methotrexate alone.

Gross reduction in gas transfer is typical of advanced IPF and is a much more sensitive marker of this condition than a pre-treatment chest X-ray. We fully agree with the authors that caution should be exercised with all anti-TNF drugs in treating RA patients with prior lung disease, but would exhort colleagues to consider pulmonary function testing if there is clinical concern about IPF, as a chest X-ray alone may provide false reassurance. If pulmonary function is significantly reduced (vital capacity or gas transfer <70% predicted) then a high-resolution CT scan is indicated to define the cause. The presence of IPF (or established bronchiectasis) should then be considered a relative contra-indication to proceeding with anti-TNF therapy [4].

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Rheumatology nurse specialists—do we need them?

Sir, I respond to the Editorial by Hill [1] and agree wholeheartedly with the views expressed.

As outlined in the Hill's article, much of the focus on the value of all specialist services rests almost entirely on cost savings rather than quality indicators. The challenge for us all, but particularly the Rheumatology Nurse Specialist (RNS) is that of ensuring that the 'real' clinical data reviewed by Commissioners and Finance Directors, demonstrates activity related to these roles and is seen in the context of improved outcomes. Equally in many cases if RNS activity is collected the relevant codes and ultimately costs are either not collected or not submitted for national collection/review and dissemination. Such a flawed level of data can be seen in the analyses undertaken by Dr Foster's Intelligence (www.doctorfosterintelligence.co.uk).

Telephone support provided by specialist teams is a perfect example of this issue. A recent patient survey prepared by the National Rheumatoid Arthritis Society (NRAS) in collaboration with the Royal College of Nursing Rheumatology Forum and posted on the open access section of the NRAS website outlined the views of the 964 respondents who completed the survey (www.rheumatoid.org.uk).

Respondents were asked if they did not have access to telephone advice line service how they would resolve their problem; 54% stated that they would seek a GP appointment and 35% would call the hospital secretary or clinic for an out-patient appointment. This concurs with the Hughes *et al.* [2] 2002 paper showing that without the telephone advice line 60% of patients would seek a GP appointment costing the primary care trust (PCT) £15 100 annually.

The NRAS survey shows that respondents found that the services were responsive to their needs with 93% saying that they found the RNS support helpful; equally 68% of patients reported receiving a response in relation to a bad flare or what they perceived as an emergency within 24 h.

As Hill outlined there are some excellent models of care that have focused on using telephone support to reduce follow up appointments but the future now rests with PCTs recognizing the value of this work by contracting such services.

However, some activities that RNS are involved in, will not be considered in the same light - for example, in some Trusts a short term financial 'gaming' approach to retrieving funds from the PCT has been that of the charges for day case activity with the ability to be coded creatively resulting in charges as high as £660 perhaps for a day case activity for a joint injection of subcutaneous administration of a treatment. This appears an admirable idea from a secondary care point of view generating additional or higher levels of income but in reality it allows the focus of the PCT's to consider cost management approaches such as exploring non-NHS providers who will deliver the services outside the hospital and be tightly commissioned and controlled to deliver such service [3].

PCTs will consider alternative methods of delivering many components of services if they cannot achieve acceptable terms in negotiation. These will include commissioning telephone follow up services using independent providers, day case interventions such as training patients to administer subcutaneous therapies or administer intravenous infusions and worse still the long-term conditions follow-up model.

I note a recent consultation document issued by the Department of Health is considering options for the future of payment by results (September 2008/9 to November 2010) for a focus on changes to out-patient commissioning data set, which 'will enable the national currencies to be applied to a wider range of out-patient services, particularly to those services led by allied health professionals and midwives'. The states document that telephone consultations constitute an overhead and 'we plan, where possible, to start pricing these consultations separately to support their greater use in place of face to face follow up appointments'. Activity data will be collected from October 2007 and will be used to inform the setting of tariff [4].

We need to start selling our services and to look at alternative ways of ensuring patients who require our specialist expertise are provided with the appropriate infrastructure that will point those we really must see in the right direction. The RNS and allied healthcare professionals really need to work constructively with our medical colleagues if we are going to be there to deliver services in the future: we also need to be thinking 'outside the box'.

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Chronic Viral Hepatitis and TNF-α blockade

Sir, We read with interest the article by Roux *et al*. [1] regarding the use of tumour necrosis factor-α (TNF-α) blocking agents in patients with hepatitis B virus (HBV) and hepatitis C virus (HCV). The authors describe three patients with chronic HBV infection (all surface antigen positive) who were successfully treated with TNF-α blockade, in conjunction with lamivudine, with no evidence of HBV reactivation at follow-up of between 10 and 32 months. The article's key message was 'Anti-TNF-α appeared to be safe when administered to patients with HBV or HCV infection. However, concomitant treatment with lamivudine or adefovir is necessary in hepatitis B.'

We have previously described our initial successful experience of using anti-TNF-α therapy in two patients with HBV without the use of lamivudine or adefovir [2], and can now report on long-term follow-up of 2 and 3 yrs. These two cases were: a 50-yr-old woman with RA and resolved HBV infection [HBV surface antigen negative (HBsAg), HBV core antibody negative, HBV surface antibody positive] who had failed treatment with five disease-modifying anti-rheumatic drugs (DMARDs), and was commenced on etanercept without combination DMARD therapy. She did not receive any antiviral therapy prior to or during anti-TNF-α treatment, and has now completed 3 yrs of treatment and with no evidence of HBV reactivation—HBV surface antigen is negative, HBV DNA undetectable, and liver function tests are normal. Etanercept was switched to adalimumab due to concerns that this may have been causing diarrhoea, however, the patient has since been successfully switched back to etanercept due to a lack of efficacy of adalimumab. The second case is a 62-yr-old woman with RA and chronic HBV infection (HBsAg negative, HBV core antibody +positive, HBV surface antibody positive) who had failed treatment with three DMARDs. She was commenced on etanercept in combination with 15 mg methotrexate s.c. No antiviral therapy was given prior to or during treatment with etanercept, and we have seen no evidence of HBV reactivation to date—HBV surface antigen is negative and LFTs are normal. She has now had 2 yrs of treatment with etanercept with no complications.

A recent review of HBV in rheumatic diseases by Calabrese *et al*. [3] summarized the published experience of patients with rheumatic disease and underlying HBV infection treated with biological agents and discussed strategies for screening and prophylaxis. The benefit *vs* risk of prophylactic antiviral therapy in patients receiving a prolonged course of immunosuppression is undetermined, and prolonged treatment with lamivudine may be linked with the development of lamivudine resistant strains of HBV [4]. Calabrese *et al*. [3] concluded that prophylactic antiviral therapy may not be necessary routinely, providing decisions are made on an individual patient basis and that regular follow-up takes place.

The article by Roux *et al*. [1] helps to further clarify the risks of HBV reactivation in patients treated with anti-TNF-α therapy. However, our clinical experience is not in keeping with the article's key message that '... concomitant treatment with lamivudine or adefovir is necessary in hepatitis B'. We believe that the currently available data suggest that TNF-α blockade is a therapeutic option in patients with RA and chronic HBV infection, though the risk/benefit ratio must be carefully assessed in each patient. Prophylactic antiviral therapy is indicated routinely in HBsAg-positive patients, but our experience is that anti-viral prophylaxis may not be necessary routinely in HBsAg-negative patients requiring an extended course of immunosuppressive therapy. As HBV is the commonest chronic viral infection in humans, this is scenario that many rheumatology centres are likely to encounter at some point. Further reporting of such cases is vital to further inform and clarify on an area where there is still a paucity of data.

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Reply: Safety of anti-TNF-α therapy in rheumatoid arthritis (RA) and spondylarthropathies (SA) with concurrent B or C chronic hepatitis

Sir, We have read the comments of Raftery *et al*. [1] and appreciate their interest in our report. The two patients they described previously, and again now, with a longer follow-up, are both HBsAg-negative (absence of ongoing infection) meanwhile our three patients are HBs Ag-positive and must be considered carriers of B hepatitis and chronic HBV infection. We fully agree with their comment 'Prophylactive antiviral therapy is indicated routinely in HBs Ag positive patients'. That situation is the most frequent in clinical practice.

Negative HBsAg test does not exclude, on a few occasions, an active HBV infection. Patients with occult HBV infection who are persistently HbsAg-negative, but with evidence of HBV DNA in the serum, have been reported [2,3]. Some of these patients have chronic HBV infection. Chronically infected patients either possess HBsAg escape mutants that are not recognized by the commercially available HBsAg assays or have very low levels of viraemia with undetectable HBsAg. Some of these patients with chronic HBV infection have anti-HBc as the sole marker of HBV infection (anti-HBc only) or can be completely negative for any serological marker of HBV infection (except HBV DNA).

This situation is infrequent, but up to 5% of the healthy blood donors have an isolated anti-HBc result [4].