majority in many parts of the Southwest, and this will amount to a kind of extension of that country into the United States. The work ethic is clearly changing as everyone tries to get more for working less, and as we give various groups in the population special competitive advantages to compensate for educational or other disadvantages. The two major countries we defeated in World War II have recovered with our help and are now efficiently outproducing us—beating us at our own game, as it were. For example, better and more efficient foreign automobiles are outselling American ones in the American market, clearly a change from what used to be the case. A persistent foreign trade deficit, worsened by the oil crisis, has replaced a favorable balance. Foreign capital is now being invested in the United States on a growing scale, favored by the relative cheapness of the dollar—with potential for good and bad that is unpredictable at this time.

It would seem that the so-called American melting pot is moving from its former and familiar independence to unfamiliar interdependence. It seems inevitable, as time goes on and with things being the way they are, that “foreigners” will control more and more of our land, our capital, our business and industry, and our political system. As this occurs America’s melting pot will come to have more international dimensions. It is noteworthy that this will be at a time when other nations, including those of the Third World, will join China and Russia in striving to reach the kind of living standard America has shown to be possible, and then they too will have all the problems of its success—in efficiencies due to overregulation, underproductivity, environmental pollution and unavoidable dependence for some essential resources upon other nations which may or may not be cooperative.

If this is to occur, where is there a role for medicine? Health, well-being and personal fulfillment are essential ingredients of the higher standard of living that a new worldwide melting pot will strive to achieve. They are also what physicians seek for their patients and for the public. Medicine with all its branches and ramifications is the human life science for health, well-being and personal fulfillment, and physicians together with other health professionals profess and practice this science and its art in the human society. If, when and as the American melting pot goes international, there will surely be new opportunities and responsibilities for American medicine throughout the world as well as at home. It certainly is not too early to dream—and it may not be too early to think and even begin to plan.

—MSMW

Rheumatic Disease—A Case of the Soil and the Seed

A SMALL RENAISSANCE is occurring in clinical rheumatology. This is largely due to better recognition of two distinctive forms of rheumatic disease. Identification of the various arthropathies associated with calcium pyrophosphate deposition disease has thrust this cartilage disorder to the fore. Also, a cleaner delineation of the seronegative spondyloarthropathies as a group of diseases “running in families” has led to the realization that many examples of forme fruste rheumatic disease belong in this category. Dr. Calin’s article elsewhere in this issue focuses on this latter group of diseases and, in so doing, indicates how the recognition of a genetic susceptibility to acute or chronic rheumatic disease naturally leads to better or earlier diagnosis, as well as to a more scientific pursuit of pathogenesis.

Diagnostic criteria might well be considered to be the Achilles’ heel of rheumatology. So many forms of arthritis lack objective and distinctive markers. Recognition of the association between the seronegative spondyloarthropathies and HLA-B27 has led to a widening of our diagnostic horizons and has pointed to the need for reappraising many conventional clinical criteria for identifying ankylosing spondylitis and the Reiter syndrome. As Dr. Calin indicates, epidemiologic data on this group of rheumatic diseases will now have to be reexamined using broader criteria including tissue typing as well as radiographic and scintigraphic methods. Indeed the old accepted adage of “radiographic sacroiliitis equals ankylosing spondylitis” needs to be reappraised, and more sensitive diagnostic tests should be designed to detect pre-radiographic osteoarticular inflammations.

The main theme of Dr. Calin’s article is that rheumatic disease results from an interaction between a genetically predisposed host and environmental factors—the “soil and seed.” This concept is based on rapidly increasing evidence indicating that a large variety of acquired human
Assuming that certain types of rheumatic disease are genetically predetermined (notably, the seronegative spondyloarthropathies), what are the environmental triggers? Dr. Calin correctly indicates the suspicious presence of various enterobacteria and certain urethral organisms preceding or accompanying the Reiter syndrome and other types of reactive arthritis.6-10 The potential role of these infectious agents in triggering a genetically controlled immune or autoimmune response that leads to connective tissue inflammation is unknown. But the possibilities are intriguing. Rheumatologists have not proved themselves very adroit as therapeutic masters of the in vivo inflammatory response. Perhaps we might shine a brighter light as purveyors of disease prophylaxis, either by excluding or avoiding environmental triggers or by interrupting or short-circuiting the aberrant (that is, pathogenic) immune response.

So it is that Dr. Calin’s article may have two different and opposite impacts on readers. Some may feel a degree of despair at the apparent inevitability of certain types of chronic rheumatic disease. Conversely, the excitement at approaching disease prevention or control by manipulation of soil or seed at a preclinical phase should dispel all such gloom.

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