Of the many treatments used in scleroderma (progressive systemic sclerosis), none has so far been shown to alter the fundamental course of the disease (see review Bywaters and Scott, 1965).

Although corticosteroids may give symptomatic benefit in the early stages (Rodnan, Black, Bollet, and Bunim, 1956), prolonged therapy is unrewarding (Zion, Goldberg, and Suzman, 1955). Several other promising treatments such as relaxin (Jefferis and Dixon, 1962) and epsilon-aminocaproic acid (Hall and Scott, 1966) have not stood the test of a controlled study.

Since their introduction in the late 1940s, dextrans have come to occupy an important place in clinical medicine. Low molecular weight dextran increases peripheral circulation by reducing both blood viscosity and intravascular red cell aggregation (Gelin and Zederfeldt, 1960) and an extensive literature has accumulated on its use in peripheral vascular disorders (Powley, 1964).

Digital ischaemia is a prominent feature of scleroderma, yet scanty information is available on the use of low molecular weight dextran in this disease. Holti (1965) convincingly demonstrated that intermittent infusions temporarily improved digital ischaemic phenomena in ten out of twelve patients with scleroderma and noted that “these patients claimed to be remarkably better in themselves with an increased exercise tolerance and softening of their indurated facial skin”.

Using Holti’s technique, Denis (1967) found a similar circulatory improvement in five of seven patients. In addition joint stiffness improved in some patients, dysphagia lessened in one, and facial telangiectasis in another. Kantor (1966) treated five scleroderma patients with single dextran infusions; in one the skin texture “improved about 50 per cent.”, and in the remainder “a decided softening of the acral skin” was noted.

Scleroderma is not primarily a vascular disease. Although dextran may temporarily improve the digital circulation, the important question of whether the course of progressive systemic sclerosis itself is influenced needed to be resolved in a carefully controlled clinical evaluation.

Material and Methods

Six patients with scleroderma were selected for this study, the duration of disease ranging from early (6 months) to late (29 years), and the severity from mild and static to rapidly progressive (Table I, overleaf). All six showed clinical evidence of digital ischaemia including pulp pitting and atrophy (Fig. 1) and painful digital ulceration.
# TABLE I
## DETAILS OF PATIENTS

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age (yrs)</th>
<th>Sex</th>
<th>Type of Scleroderma</th>
<th>Details</th>
<th>Previous Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>44</td>
<td>Female</td>
<td>Advanced progressive</td>
<td>Raynaud’s phenomenon 16 yrs&lt;br&gt;Scleroderma fingers 4 yrs, face and trunk 3 yrs&lt;br&gt;Diarrhoea 4 yrs&lt;br&gt;Facial telangiectasia&lt;br&gt;MCP erosions</td>
<td>Triidothyronine and decaser-pasyl</td>
</tr>
<tr>
<td>2</td>
<td>56</td>
<td>Female</td>
<td>“CRST syndrome” (calcinosis, Raynaud’s phenomenon, sclerodactyly, telangiectasis)</td>
<td>Raynaud’s phenomenon 29 yrs&lt;br&gt;Scleroderma hands 28 yrs&lt;br&gt;Painful digital ulcers, calcinosis with ulcerating calcium plaques (Fig. 2)&lt;br&gt;Contractures knees, elbows&lt;br&gt;Widespread telangiectasia</td>
<td>Corticosteroids&lt;br&gt;Versenate</td>
</tr>
<tr>
<td>3</td>
<td>40</td>
<td>Female</td>
<td>Early mild “acrosclerosis”</td>
<td>Raynaud’s phenomenon 4 yrs&lt;br&gt;Scleroderma fingers 4 mths&lt;br&gt;Pulp necroses fingers (Fig. 1)</td>
<td>Cervical, lumbar sympathectomy&lt;br&gt;Triidothyronine and decaser-pasyl</td>
</tr>
<tr>
<td>4</td>
<td>57</td>
<td>Female</td>
<td>Acute onset, rapidly progressive</td>
<td>Generalized scleroderma 6 mths&lt;br&gt;Contractures wrists, elbows, ankles, and fingers (hand models, Fig. 4)</td>
<td>Corticosteroids</td>
</tr>
<tr>
<td>5</td>
<td>56</td>
<td>Female</td>
<td>Progressive, with generalized oedema</td>
<td>Scleroderma hands, face, and trunk, 2 yrs&lt;br&gt;Intradermal (Fig. 3) and subcutaneous oedema&lt;br&gt;Prominent arthritis wrists, ankle&lt;br&gt;Oesophageal and small bowel involvement</td>
<td>Triidothyronine and decaser-pasyl&lt;br&gt;Vasodilators</td>
</tr>
<tr>
<td>6</td>
<td>56</td>
<td>Female</td>
<td>Steadily progressive generalized</td>
<td>Raynaud’s phenomenon 2 yrs&lt;br&gt;Scleroderma hands 1 yr, arms and face 8 mths&lt;br&gt;Oesophageal and pulmonary involvement&lt;br&gt;E.C.G. abnormal intraventricular conduction</td>
<td>Potaba&lt;br&gt;Corticosteroids&lt;br&gt;Triidothyronine and decaser-pasyl</td>
</tr>
</tbody>
</table>

Fig. 2.—Calcinosis.
DEXTRAN INFUSIONS IN SCLERODERMA

Calcinosis (Fig. 2), extensive telangiectasia, and visceral involvement (cardiac, pulmonary, oesophageal, and intestinal) were all represented. Widespread intra-dermal oedema which retained the examiner’s fingerprint (Fig. 3) was a feature in one patient.

Intravenous infusions of low molecular weight dextran (10 per cent. W/V in normal saline) were given according to the method of Holti (1965). Patients were admitted to hospital an average of four times at 3 to 5 week intervals to receive a continuous infusion of 2 l. dextran given over 48 hours on each occasion.

After a preliminary study in four patients, two of these and two others were admitted to a trial in which each patient was given a course of either dextran or normal saline, the treatment being allocated in a double-blind fashion. In patients who received both substances, at least 3 months elapsed between courses.

Assessment

The effects of treatment were assessed before and a week after the course of infusions by the following methods:

1. Detailed symptomatic enquiry.
2. Hands: Grip strengths, jeweller’s ring sizes, palm printing, or serial plaster models (Fig. 4) according to the degree of deformity.
3. Photographic recording of skin ulceration, telangiectasia, facial appearances, etc.
6. Serial chest radiograph, electrocardiograph, blood examination, and other investigations where appropriate.

Fig. 3.—Finger-printing on patient’s skin.

Fig. 4.—Plaster models showing degree of deformity before and after treatment.
Results

Table II summarizes the results of treatment in the six patients. Patients 2, 3, 5, and 6 received infusions the nature of which was unknown to them and the authors until after the final assessment. As a result of random allocation Patients 5 and 6 received courses of both dextran and saline. Five patients noted an increase in energy and sense of wellbeing with dextran, either after each infusion or as a result of the course. One of these, however, experienced the same subjective improvement with saline. Another volunteered that her hands felt looser and the skin softer for a few days after each dextran infusion, although the changes were not of a sufficient degree to be appreciated by observers.

The tendency to Raynaud's phenomenon and ischaemic finger pain or ulceration lessened with dextran in three of the four patients in whom this had been a major problem, but increased in the fourth. Measurement of augmented radiant heat emission from the finger tips frequently showed temperature differentials of greater than 0-5°C in adjacent digits in keeping with the clinical signs of peripheral vascular insufficiency and serial readings confirmed the patients' impression of increased finger warmth. On occasions the fingers were observed to become warm and pink after each dextran infusion, but this effect passed off before the next infusion 3 to 5 weeks later except in Patient 1 in whom benefit persisted over several winter months. Saline infusions did not influence the digital circulation in either of the two cases studied.

Photography confirmed that facial telangiectasia diminished in one patient but increased in another during the course of dextran infusions.

Visceral manifestations of systemic sclerosis were not improved with the possible exception of Patient 1 whose intake of codeine to control diarrhoea was halted during a course of dextran. However, at the same time, localized electrocardiographic T wave flattening first appeared, consistent with the development of sclerodermatous myocardial involvement. Patient 5 first developed dysphagia from radiologically-proven oesophageal scleroderma during a course of dextran infusions and this complaint lessened considerably 4 months later while she was receiving saline. Weight loss from intestinal malabsorption in this patient progressed throughout the period of observation.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Treatment</th>
<th>Subjective Changes</th>
<th>Objective Changes</th>
<th>Comments</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Dextran</td>
<td>Feels better; more energy; joints less painful</td>
<td>Hand function unimproved, further ulcerating calcium plaques. Telangiectasia face lessened. One elbow increased 10° in range. Fingers colder.</td>
<td>Infusion difficulties</td>
<td>Deterioration in digital circulation. Scleroderma unchanged.</td>
</tr>
<tr>
<td>3</td>
<td>Dextran</td>
<td>Each infusion gave a 2-week &quot;boost&quot; in energy; ischaemic pain temporarily lessened</td>
<td>Digital temperature improved. Sclerodactyly unchanged.</td>
<td>Infusion difficulties</td>
<td>Temporary circulatory improvement only.</td>
</tr>
<tr>
<td>4</td>
<td>Dextran</td>
<td>Hands feel looser and skin softer for a few days post-infusion</td>
<td>No change in hand deformity or digital temperature.</td>
<td>No worthwhile benefit</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Dextran</td>
<td>Feels better; more energy</td>
<td>Dysphagia developed. Joint erosion progressed. Scleroderma increased in limbs, face, and trunk. Tendon crepitus first appeared.</td>
<td>Disease progressed</td>
<td></td>
</tr>
<tr>
<td>Saline</td>
<td>Feels better; more energy</td>
<td>Dysphagia improved. Weight loss continued (malabsorption). Grip improved 30 per cent. but arthritis and sclerodactyly progressed.</td>
<td></td>
<td>Disease progressed</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dextran</td>
<td>Increased wellbeing; ischaemic finger pain less</td>
<td>Steady progression of tissue stiffness.</td>
<td>Hyper-sensitivity reaction. Infusion difficulties.</td>
<td>Temporary circulatory improvement. Scleroderma progressed.</td>
</tr>
<tr>
<td>Saline</td>
<td>No change</td>
<td>Facial scleroderma progressed. Axillary contractures lessened.</td>
<td>Infusion difficulties.</td>
<td>Scleroderma progressed.</td>
<td></td>
</tr>
</tbody>
</table>
Sclerodermatous changes in the hands, limbs, face, and trunk either remained static or progressed during treatment with both dextran and saline and in no case did the course of the disease appear to be significantly influenced by these procedures. Patient 6 experienced a lessening of axillary contractures while her facial involvement steadily increased. At the conclusion of the study it emerged that the localized improvement coincided with saline infusions.

Practical difficulties emerged in giving repeated infusions to patients with tough skin and poor circulation. The problems of siting the needle in one patient precluded consideration of further therapy and in two others the difficulty of maintaining the infusion made them dread the next hospital admission. A solution was found in the use of infant scalp vein sets (Portex, 23 Guage) inserted into small superficial veins and held in place by a plaster of paris shell. This method is recommended for similar procedures.

The dextran itself was not universally well tolerated by patients. A hypersensitivity reaction in the form of fever and generalized rash developed in one woman with a history of allergy to other agents. In another, migrainous attacks, to which she was otherwise infrequently subject, accompanied two out of five infusions and transient generalized pruritis with a fine macular rash occurred once although the causal relationship was not established with certainty.

Discussion

Dextran are the polysaccharides formed by Leuconostoc Mesenteroides cultured in a sucrose-containing medium (Ricketts, 1961). The British Pharmacopoeia contains three dextran with average molecular weights 150,000 (Dextran 150 B.P.), 110,000 (Dextran 110 B.P.), and 40,000 (Dextran 40 B.P.).

The relative properties of dextran are largely dependent on their molecular weight (Gronwall, 1957). Low molecular weight dextran increases blood flow in the microcirculation by means of a disaggregating effect on human erythrocytes (Gelin and Ingelman, 1961), a reduction in whole blood viscosity at low flow rates in excess of the effect of haemodilution (Gregersen, Peric, Usami, Chien, Chang, and Sinclair, 1963), and an increase in intravascular volume leading to increased venous return and cardiac output (Schenk, Delin, Domanig, Hahnloser, and Hoyt, 1964). The duration of action depends mainly on the renal threshold for dextran which is around molecular weight 50,000.

In view of the established place of dextran in the treatment of peripheral vascular disorders, it is reasonable that this agent should be suggested for use in scleroderma in which a regular feature is digital ischaemia due to intimal thickening of the digital arteries and peripheral microthromboses. Previous reports (Holti, 1965; Denis, 1967) and our own experience confirm that peripheral tissue perfusion is enhanced in at least 50 per cent. of patients although the benefit is usually transient.

However, ischaemia accompanies but is not the cause of scleroderma and the improvement in circulation with dextran, although welcome, does not necessarily presage an improvement in the sclerodermatous involvement of tissues. Encouraging initial reports, such as that of Klein and Harris (1955) on the use of chelation with sodium versenate, have later proved to be disappointing in other treatments in cases of scleroderma, and the results of this study suggest that this will be so with dextran.

Therapeutic assessment in scleroderma is fraught with difficulties. Subjective responses may be influenced by the desire of both patient and physician to see improvement in a disease in which previous treatments have proved valueless. Temporary hydration of the tissues with resulting softening may follow dextran infusions and natural fluctuations of the disease can further confuse assessment. Furthermore, this is a dramatic form of treatment. It involves infusions and periods of confinement to bed in hospital. This may introduce placebo responses unrelated to the basic course of the disease.

The use of saline control infusions has illustrated these aspects. One patient experienced the same subjective benefit with both saline and dextran. She felt better and was pleased with both treatments in spite of an obvious progression in her disease. Dysphagia first appeared during dextran infusions and subsided with saline. A modest improvement in one of the complaints of another patient, axillary contractures, coincided with a course of saline infusions. This may ordinarily have been ascribed to the treatment being evaluated.

Low molecular weight dextran is essentially a safe treatment, but acute renal failure (Morgan, Little, and Evans, 1966) and hypersensitivity have been reported; one patient in this study developed hypersensitivity. Furthermore, the treatment is expensive (a course of infusions costs £32) and demanding in hospital bed space, patient attendance, and medical time.

Although the number of patients in this study is small, objective evaluation suggests that no alteration
in the course of the disease of practical value is likely to be achieved by dextran infusions. Nevertheless, the peripheral circulation is improved in most patients and in a few this may persist for a prolonged period (Holli, 1965). In the occasional patient with disabling ischaemic pain and digital ulceration, who has responded well to an initial infusion of dextran, repeated infusions perhaps during each winter may well be worthwhile, but our experience suggests that the skin and visceral involvement with scleroderma will be unaffected.

Summary

Six patients with scleroderma of various patterns, duration, and severity have been treated with periodic infusions of low molecular weight dextran under controlled conditions.

Although temporary improvement to the digital circulation may occur, the course of the underlying disease appears to be unchanged.

This treatment may, however, have a place in the management of the peripheral ischaemic phenomena accompanying scleroderma.

REFERENCES


Kantor, I. (1966). Arch. Derm. (Chicago), 94, 675 (Scleroderma treated with dextran 40 (Rheomacrodex)).


Failure of low molecular weight dextran infusions in scleroderma.

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