**References**


(1972) *Arthr. and Rheum.*, 15, 434


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**Discussion**

**DR. P. J. L. HOLT (Manchester)** I am right in thinking the blood vessel itself has a fibrinolytic activity? If so, to
what extent is this independent of the serum fibrinolytic activity. When you improve the fibrinolytic activity of the serum, does the fibrinolytic activity of the vessel improve and is it dependent or secondary to the serum?

**DR. CUNLIFFE** We are finding a relationship between tissue activity and plasma fibrinolytic activity. Furthermore, patients with vasculitis have no tissue fibrinolytic activity whatsoever in their lesions, and the skin nearby where there is no rash also shows a reduced fibrinolytic activity. The fibrinolytic activity of the tissues improves with treatment.

**DR. H. L. F. CURREY (London)** In patients with vasculitis and raised euglobulin lysis times, what is the effect on the euglobulin lysis time of giving steroids?

**DR. CUNLIFFE** I have not done any work on steroids, but we found that in four patients who were on steroids there was some improvement in the fibrinolytic activity and in two there was not; but the patients who had rheumatoid arthritis were also on other drugs.

**DR. A. ST. J. DIXON (Bath)** Would it not be equally logical to conclude from the data that patients who start with a prolonged euglobulin lysis time have a good prognosis irrespective of treatment?

**DR. CUNLIFFE** This we have not found. We have been studying patients over a period of several years and at the moment one cannot draw this conclusion.

**DR. M. I. V. JAYSON (Bath)** Do you think that the prolonged euglobulin lysis time could be due to excessive fibrin deposition and be the result of vasculitis rather than being concerned in pathogenesis?

**DR. CUNLIFFE** This is our conclusion.

**DR. D. A. PITKEATHLY (Manchester)** Are you using this treatment as the treatment of choice in patients with severe vasculitis?

**DR. CUNLIFFE** I should treat the acute vasculitis with steroids, but if the patient has had it for many years and the fibrinolytic activity is impaired then I would go straight on to phenformin and an anabolic steroid.

**Discussion**

**DR. P. J. L. HOLT (Manchester)** I am not quite sure what your antiserum is raised against, because it does not seem to be basement membrane antigen and it seems to be staining the arterioles rather than the rest of the glomerulus.

**DR. SCOTT** The antiserum was raised against the whole of the glomerulus. Glomeruli were stained in the sections.

**DR. P. J. L. HOLT (Manchester)** So it is fairly crude.

**DR. SCOTT** Yes, it is a crude antiserum.

**DR. P. J. L. HOLT (Manchester)** And it stains the arterioles of the kidney in systemic sclerosis. Can you find staining in other organs in systemic sclerosis?

**DR. SCOTT** The antiserum will produce staining of reticulin in the media of normal arteries. In systemic sclerosis there are abnormalities in the distribution of this staining. These abnormalities are not associated with the deposition of globulin, but may be associated with the deposition of fibrin.

**DR. P. J. L. HOLT (Manchester)** So it is the pattern of the staining rather than the presence or the absence of the staining that is important?

**DR. SCOTT** Yes.

**DR. M. I. V. JAYSON (Bath)** Dr. Dubois has presented a series of patients with systemic sclerosis which showed the features of S.L.E., and these features responded to steroid therapy, whereas the systemic sclerosis features did not. Were you able to find any S.L.E.-like signs and symptoms in this group of systemic sclerosis patients?

**DR. R. N. MAINI (London)** Was there any correlation with immunoglobulin or complement levels in the pattern of deposition which you saw?

**DR. ROWELL** This work has been done over about 10 years. Serum complement levels were not available in this hospital in the early days.

W J Cunliffe, B Dodman and B E Roberts

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