Articular manifestations of familial hypercholesterolaemia

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Summary Familial hypercholesterolaemia is characterised by a decreased removal of low density lipoproteins and premature coronary artery disease. Tendinous xanthomata are a hallmark of the disease. The affected joints may also be the sites of inflammation and pain. Arthropathy has been associated mainly with the homozygous form of familial hypercholesterolaemia, but it is also known to occur in the heterozygous form. We report on the articular manifestations in 73 patients with heterozygous familial hypercholesterolaemia. About 40% of these patients had at least one episode of articular symptoms. The observed articular manifestations may be classified into four types: Achilles pain (18%), Achilles tendinitis (11%), oligoarticular arthritis (7%), polyarticular or rheumatic fever-like arthritis (4%). It is concluded that in heterozygous familial hypercholesterolaemia articular manifestations are frequent, diverse, and may be the first symptom of this metabolic disorder.

Key words: arthritis, tendinitis, tenosynovitis, Achilles tendons.

Familial hypercholesterolaemia is a relatively common autosomal dominant disorder, characterised by increased total and low density lipoprotein (LDL) plasma cholesterol levels, premature coronary artery disease, and tendinous xanthomata. The cause of the rise of plasma cholesterol levels is a decreased removal of LDL due to a defect in their specific peripheral receptors.1

There are two clinical forms of familial hypercholesterolaemia. In the rare homozygous form LDL cholesterol levels are above 500 mg% and xanthomata appear during infancy and childhood; coronary artery disease occurs during the second decade of life. In the heterozygous form LDL cholesterol levels are around 300 mg/dl (7-8 mmol/l), tendinous xanthomata appear in the second and third decades of life, and coronary artery disease is rarely seen before the age of 30.

It is well known that tendinous xanthoma, a diagnostic sign of familial hypercholesterolaemia,2 may frequently be the site of pain and inflammation. Some authors have described tendinitis, tenosynovitis, arthralgia, and migratory polyarthritis in both homozygous and heterozygous familial hypercholesterolaemic patients.3-7 In order to characterise further the different articular manifestations of familial hypercholesterolaemia we studied 73 patients with the heterozygous form of this genetic disorder.

Patients and methods

Patients The patients were diagnosed as having heterozygous familial hypercholesterolaemia according to the following criteria: the presence of hypercholesterolaemia (age adjusted) but below 500 mg/dl (13 mmol/l) for LDL cholesterol, and the presence of tendinous xanthomata. In the absence of tendinous xanthoma in a proband hypercholesterolaemia and tendinous xanthomata were considered as essential findings in at least one first-degree relative. Secondary forms were excluded by the appropriate diagnostic procedures.

Seventy-three consecutive patients (45 female, 28 male) seen at the Lipid Clinic of Laval University Hospital Center were interviewed and examined. The questionnaire was standardised and included...
past rheumatological history and present symptoms. A complete articular examination was performed by one of us (GM).

LIPIDS AND LIPOPROTEINS
Total cholesterol and triglyceride levels were determined simultaneously after extraction of plasma with isopropanol and treatment with zeolite mixture on Auto Analyser II (Technicon Instruments Inc., Tarrytown, New York). Very low density lipoproteins (VLDL) were isolated by ultracentrifugation at a density of 1.006 g/ml as described by Havel et al. High density lipoprotein cholesterol was measured in the bottom fraction (density greater than 1.006 g/ml) after precipitation of LDL with heparin (6%) and manganese chloride (0.092 mol/l final concentration) as described previously.9

LDL cholesterol was obtained by the difference in the concentration of cholesterol before and after precipitation of the plasma fraction of density greater than 1.006 g/ml. Total apoproteins A and B, and LDL apoprotein B were measured by rocket immunoelectrophoresis.10

Results

PATIENTS, LIPID AND LIPOPROTEIN LEVELS (Table 1)
The mean age of the 73 patients was 35.3±16.8 years (mean±SD) (range 5 to 68 years). 80% of the patients were 20 years or older. Total cholesterol, LDL cholesterol, total apoprotein B, and LDL apoprotein B were increased respectively at 364.2±66.9 mg/dl (9.43±1.73 mmol/l), 307.5±64.1 mg/dl (7.96±1.66 mmol/l), 2.02±0.54 g/l, and 1.83±0.42 g/l. (These values are given as mean±standard deviation of the mean.)

ARTICULAR SYMPTOMS (Fig. 1)
Twenty-nine patients (40%) had suffered from articular manifestations at some time. These manifestations were of four types: Achilles pain, Achilles tendinitis, oligomonoarthritis, and polyarthritis (rheumatic fever (RF) type). Seven of them reported more than one type of articular or periarticular symptoms, representing a total of 37 manifestations.

The most frequent manifestation was Achilles pain (18% of the patients) in which limping was the only sign and lasted only for a few hours. It recurred frequently.

Tendinitis of the Achilles tendons was frequent (observed in 11% of the subjects) and was characterised by a subacute onset, often associated with a prodrome and always accompanied by inflammation. All patients had a severe limp, and they were frequently bedridden. The duration of each episode was short, averaging from two to three days, but the recurrences were frequent (two or three times a year). The Achilles tendons remained symptom free between attacks, though it was quite often infiltrated at the time of examination. The mean age of onset was 17 years.

7% of the patients had a mono-oligoarticular arthritis, and the affected joints were the knees in six instances, the ankles in three, and the proximal interphalangeal joint in one patient. All patients described the arthritis as very acute and severe enough to necessitate bed rest. Each episode lasted a few days (mean duration 10 days), and the involved joint always returned to normal function.
Although the recurrences were frequent (up to 15 episodes in a period of 18 months in one patient),
the affected joints remained asymptomatic between
episodes. They were normal at the time we ex-
amined them. This type of arthritis usually made its
appearance around the age of 20.

The polyarticular type (rheumatic fever type) was
reported by 4% of the patients. It was characterised
by systemic symptoms with fever, and the patient
was always incapacitated. The polyarthritis was
symmetrical, having an acute onset with severe
clinical signs. In comparison with the mono-
oligoarticular arthritis the illness lasted longer
(mean duration about one month) but never re-
curred. One of the patients reported having been
treated with penicillin and another having had a
'miraculous' recovery with corticosteroid treatment.
After the illness the joints remained symptom free
and were normal at the time of the examination.
The mean age of occurrence for this type of arthritis
was 18 years.

TREATMENT SIGNS
58% of the subjects studied had bilateral Achilles
xanthomata at the time of examination, and they
were present unilaterally only in 2% of the patients.
Patellar tendon and plantar xanthomata were both
found in 8% of patients.

40% of the patients had xanthomata on the
extensor tendons with a mean of 2-3 tendons
infiltrated. Flexor tendon infiltrations were
observed in 71% of patients, with a mean of 2-6
affected tendons per patient.

Discussion

Khachadurian,3 in 1968, was the first to report
migratory polyarthritis in patients with homozygous
familial hypercholesterolaemia. He described the
characteristics of the articular disease and made the
clinical distinction between this type of polyarthritis
and rheumatic fever, which may have similar clinical
and laboratory manifestations such as polyarthritis,
heart murmurs, and an accelerated sedimentation
rate. The same year Glueck and colleagues4 re-
ported on the oligomoarthritis and tendinitis affect-
ing 14 patients with heterozygous familial
hypercholesterolaemia. Later, Shapiro and
colleagues5 described similar articular manifesta-
tions of heterozygous familial hypercholester-
olaemia in children and adolescents. In 1978
Rooney and colleagues2 suggested that the syn-
drome had a periarticular pathogenesis.

In our retrospective study based on symptoms
reported by 73 patients, mostly adults with the
heterozygous form of familial hypercholesterol-
olaemia, we found that 40% had articular manifesta-
tions at some time during their life. The articular
symptoms were of four types: mono-oligoarthritis,
polyarthritis, Achilles tendinitis, and Achilles pain.
The most frequent site of involvement was the
Achilles tendon and the mono-oligoarticular or
polyarticular arthritis were less common. In addition
to tendinous xanthomata, which are characteristic
of familial hypercholesterolaemia and are usually best
observed on the Achilles, patellar, and extensor
tenons of the fingers, we also found infiltrations of
the flexor tendons.

The diagnosis of the hand flexor tenosynovitis was
made according to the following criteria: crepita-
tion, grinding, snapping, or locking on passive or
active movement of the finger. They occurred in a
non-specific fashion in 71% of the population
studied.11 However, they seem to be part of the
disease, as they were associated with xanthomata of
the extensor tendons in 83% of the cases, with no
other medical manifestations apart from the familial
hypercholesterolaemia to explain their high inci-
dence in our population.

The articular manifestations in our heterozygous
population of familial hypercholesterolaemia were
frequent, diverse, recurrent, incapacitating, short
lasting, and transitory. The joints remained symp-
tom free between attacks, and they never pro-
gressed to articular damage or deformity as observed
in the homozygous form. Although tendinous xanth-
omata were present in many of the patients at the
time of examination, they may be absent when the
symptoms occur. In fact, tendinous xanthomata
rarely occur before the age of 20,12 and Achilles
tendon thickness shows a positive correlation with
age in heterozygous familial hypercholesterolaemia.2
Unless the existence of hypercholesterolaemia is
known, the diagnosis may be difficult and articular
symptoms and signs may lead to extensive investiga-
tion to identify the aetiology.

Articular symptoms may be the first clue to the
diagnosis of familial hypercholesterolaemia, long
before the appearance of xanthomata and ischaemic
heart disease. The diagnosis of familial hyper-
cholesterolaemia is important, as its treatment
prevents the development of ischaemic heart
disease13 and may also prevent the recurrence of the
articular symptoms.14

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