Sclerodactyly, CREST syndrome, proximal sclerosis

Sir. In their interesting paper Furst et al.1 define CREST as patients with sclerodactyly and PSS as those with ‘proximal scleroderma’.2

It is surprising that the authors found differences in the internal organs of the two subsets only in the case of lung involvement. It is reasonably well known that patients with limited skin sclerosis (so-called CREST syndrome) have a less severe prognosis compared with patients with ‘diffuse scleroderma’. One possible explanation of this unexpected finding could be that the PSS subset with proximal scleroderma constitutes too broad a group of patients, including also cases in whom skin sclerosis is confined to a few areas of the skin (face, neck). Such cases could be closer to sclerodactyly than to diffuse scleroderma.

Furthermore, the clinical findings in Table 1 of the paper by Furst et al.1 show that not all cases of CREST syndrome presented all five features of CREST, and that other patients with proximal scleroderma also had the features of CREST. What in effect distinguishes the two groups is that the so-called CREST group presents skin sclerosis confined to the fingers, whereas the other group has skin sclerosis also in other areas.

This being so, would it not be better to speak of patients with sclerodactyly rather than CREST?

1st Faculty of Medicine, University of Naples, Via Pansini 5, 80131 Naples, Italy

References

M GIORDANO

Anti-Ro positive rheumatoid arthritis

Sir. The high incidence of side effects in patients with anti-Ro positive rheumatoid arthritis treated with β-penicillamine noted by Moutsopoulos1 will be of interest to clinicians. A 61% incidence of side effects compared with 8.5% in the anti-Ro negative group would question the use of β-penicillamine in anti-Ro positive patients.

Our own observations on a small group of patients with rheumatoid arthritis treated with β-penicillamine have not confirmed this striking difference. A group of 17 rheumatoid arthritis patients, most of whom had developed serious side effects, was studied retrospectively. The results are shown in Table 1. Of the 13 who developed side effects, four had anti-Ro antibodies. A further nine patients had their anti-Ro status determined before commencing β-penicillamine. Two of these have developed side effects, and both were anti-Ro negative. The two patients who were anti-Ro positive have not developed side effects after more than six-months’ treatment.

Of the 15 patients with significant side effects, only four...
Hypothalamic-pituitary-adrenal axis suppression after repeated intra-articular steroid injections

Sir, We read with interest the report of O’Sullivan et al. relating a case of Cushing’s syndrome and hypothalamic-pituitary-adrenal (HPA) axis suppression caused by frequent large doses of intra-articular steroids. Such therapy is certainly unusual, although a survey of 25 rheumatology consultants appointed between 1979 and 1981 carried out by ourselves found that 3 of the 20 consultants replying had inherited patients receiving regular intra-articular corticosteroids (unpublished data). As we had inherited such a group of patients we undertook to test the HPA axis in eight patients with rheumatoid arthritis who had received regular intra-articular injections of methyl prednisolone acetate (160 mg a visit) for periods ranging from one to 11 years at intervals of five to six weeks. Two of the eight patients showed suppression of HPA axis function when tested both by short Synacthen and insulin stress tests five to six weeks after the last injection.

Although none of our patients had clinical evidence of Cushing’s syndrome, our study did show sustained HPA axis suppression after intra-articular injection, as confirmed in the recent study of a single patient by O’Sullivan et al.

Although such suppression is unlikely to have major clinical implications in the majority of patients receiving intra-articular steroids, those rare individuals receiving regular intra-articular steroids should carry steroid warning cards advising precautions, similar to those taken in patients receiving oral corticosteroids, during intercurrent illness. There may also be a risk of an inadequate adrenal response in those patients who develop a serious intercurrent illness soon after a single injection of intra-articular steroid.

Sir, We read with interest the above letter. The discrepancy between our findings and those of Drs Stewart and Ridley may be attributed to the different ethnic background of the two groups tested.

In fact, Greek patients with rheumatoid arthritis (RA) are not associated with any of the HLA-A, -B, and -DR antigens tested.

We agree that a multicentre study is necessary to solve the question of whether anti-Ro antibodies in RA patients can serve as a marker for patients who are likely to develop d-penicillamine side effects.

Department of Medicine, Medical School, University of Ioannina, 453 32 Ioannina, Greece

Reference


References


