Perivascular infiltration in normal skin of patients with rheumatoid arthritis: association with rheumatoid factors and HLA-DR antigens

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SUMMARY The relation between immunohistological findings in biopsy specimens of apparently normal skin, HLA antigens, and rheumatoid factors (RF) was studied in 120 patients with rheumatoid arthritis (RA), selected for treatment with d-penicillamine. Perivascular infiltration (PVI) of more than three mononuclear cells was present in 77 (68%) of 114 patients, accompanied usually by the presence of IgM or C3, or both, in immunofluorescence studies. The number of perivascular cells was associated significantly with the titre of circulating RF. A weak relation of both perivascular cellular infiltration and RF with HLA-DR3 and DR4 did not reach statistical significance. It is concluded that the histological presence of perivascular inflammation is associated mainly with deposition of RF. It is suggested that the first is merely an epiphenomenon of the latter. PVI was not prognostic for the occurrence of the clinical syndrome of rheumatoid vasculitis. For practical purposes skin biopsies do not appear to be useful in the evaluation of individual patients with RA.

Perivascular infiltrates of mononuclear cells, accompanied frequently by deposition of IgM or C3, or both, in immunofluorescence studies, are found in normal appearing skin of 25–65% of patients with rheumatoid arthritis (RA).1–6 In healthy controls and patients with osteoarthritis such abnormalities are absent.3,5,7 The presence of these infiltrates has been associated with extra-articular disease manifestations, seropositivity, and circulating immune complexes, but does not necessarily indicate the clinical syndrome of rheumatoid vasculitis with skin ulcers, nail fold lesions, neuropathy, or gangrene.1,9

The importance of these findings is subject to discussion. Some regard it as an epiphenomenon, whereas others think they play a central part in the pathogenesis of RA.3,9,10 The genetic basis of RA has been demonstrated by the association with HLA-DR4 and also in twin studies.11–12 HLA-DR4 has been associated with manifestations of RA that indicate a more severe disease course: seropositivity, erosions, and extra-articular features like Felty's syndrome and rheumatoid vasculitis.12–21 Studies of a direct relation between HLA antigens and the presence of PVI have to our knowledge not been reported, though an association of PVI with HLA-DR4 has been mentioned.22

We took biopsy specimens of apparently normal skin from patients with RA who entered an open study of effectivity and toxicity of d-penicillamine.23 To evaluate possible associations with side effects HLA typing was performed in most of these patients. These data enabled us to study the relation between histological findings in normal skin, rheumatoid factors (RF), and HLA antigens—subject of the present report.

Patients and methods

One hundred and twenty consecutive patients with classical or definite RA, eligible for treatment with d-penicillamine, were studied. The male/female ratio was 45/75, mean age 58 (range 24–80) years and mean duration of disease 14 (range 1–44) years. Eighty six patients (72%) were seropositive (Rose-
Waaler test titre $\geq 1/16$), the others being seronegative on at least three occasions. Extra-articular features were present in seven patients: a combination of splenomegaly, episcleritis, and lymphadenopathy in one patient, episcleritis alone in two, and pleuritis with lymphadenopathy in one. Leg ulcers were present in two patients and a mild polynuclear neutrophil in one. These patients did not have other manifestations of the clinical syndrome of rheumatoid vasculitis. Skin biopsy was performed in six of these seven patients.

Erythrocyte sedimentation rate (ESR), RF, and antinuclear factors (ANF) were measured with standard methods at the time the skin biopsy specimen was taken, i.e., before treatment with D-penicillamine was started. HLA typing with a standard microlymphocytotoxicity assay was performed in the laboratory of the Blood Transfusion Service, University of Nijmegen (Dr P Reekers) and the central laboratory of the Netherlands Red Cross Blood Transfusion Service (Dr L P de Waal). As the decision to evaluate possible associations with tissue antigens was taken after the beginning of the study HLA-DR typing was not performed on 30 patients.

One hundred and fourteen patients consented to a skin biopsy. Punch biopsy specimens were taken from the medial side of the forearm. One specimen was snap frozen in liquid nitrogen for immunofluorescence studies, another was fixed in 4% formaldehyde and stained with haematoxylin and eosin (H&E). The sections were initially assessed by the routine methods of the pathology department. Direct immunofluorescence was performed with monospecific rabbit antisera against IgG, IgM, IgA, IgE, and C3. Immunoglobulins or C3, or both, were considered present when granular deposits in the subepidermal vessel walls exceeded the intensity of background staining. Previous studies in our laboratory of skin biopsy specimens from non-rheumatoid patients and a few patients who died from traffic accidents did not show deposition of C3, and rarely a slight deposition of IgM. To obtain an objective measure of perivascular infiltration all H&E sections were reassessed using a semiquantitative scale ranging from 0 to 3 as described by others. Less than three mononuclear cells per vessel were scored as 0, with three to six cells the score was 1, 7–10 cells: 2, more than 10 cells: 3. Skin biopsies, examinations of immunofluorescent sections, and the reassessment of H&E sections were performed by one of us (TMV).

Statistical analysis was performed with the $\chi^2$ test with Yates's correction.

**Results**

Characteristics of all patients, patients who had skin biopsies, and those who were HLA typed showed no important differences. Thus the probability of selection bias in these respects is small (Table 1).

Perivascular infiltration of more than three mononuclear cells was present in 77 (68%) of 114 patients and of more than 10 cells in only two patients, both without clinical signs of vasculitis at the time of the biopsy. Immunofluorescence studies showed deposition of IgM, almost invariably together with C3 in 58 (51%) patients. Deposition of IgA was found in one patient. IgE, bound to mast cells, was seen in five patients. As expected the prevalence of HLA-DR4 was significantly higher than in healthy Dutch blood donors (71% vs 20%). This was not the case for HLA-DR3 (16% vs 23%). Results of both HLA typing and a skin biopsy were available from 86 patients.

The number of perivascular cells was significantly increased in patients who also had deposition of IgM or C3, or both, men, seropositive patients, patients with rheumatoid nodules, and patients possessing HLA-DR3 (Table 2). PVI was also more prevalent in patients with ANF or HLA-DR4, but the level of statistical significance was not reached.

The prevalence of serological abnormalities and rheumatoid nodules was increased slightly in patients having either HLA-DR3 or HLA-DR4, but

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All patients</th>
<th>Skin biopsy</th>
<th>HLA typed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>120</td>
<td>114</td>
<td>90</td>
</tr>
<tr>
<td>Women</td>
<td>75 (63)*</td>
<td>71 (62)</td>
<td>58 (64)</td>
</tr>
<tr>
<td>Mean age in years (SD; range)</td>
<td>58 (12; 24–80)</td>
<td>58 (12; 24–80)</td>
<td>57 (12; 24–77)</td>
</tr>
<tr>
<td>Mean duration in years (SD; range)</td>
<td>14 (10; 1–44)</td>
<td>13 (10; 1–44)</td>
<td>14 (9; 1–44)</td>
</tr>
<tr>
<td>Rheumatoid nodules</td>
<td>38 (52)</td>
<td>35 (31)</td>
<td>28 (31)</td>
</tr>
<tr>
<td>Radiological erosions</td>
<td>110 (92)</td>
<td>104 (91)</td>
<td>83 (92)</td>
</tr>
<tr>
<td>Mean ESR in mm/h (SD; range)</td>
<td>52 (28; 6–130)</td>
<td>53 (27; 6–130)</td>
<td>52 (28; 6–130)</td>
</tr>
<tr>
<td>Rose-Waaler test titre $\geq 1/16$</td>
<td>86 (72)</td>
<td>82 (72)</td>
<td>65 (72)</td>
</tr>
<tr>
<td>Antinuclear factors</td>
<td>32 (27)</td>
<td>30 (26)</td>
<td>24 (27)</td>
</tr>
</tbody>
</table>

*Values are Nos (%).
Table 2  Characteristics of 114 patients divided into three groups according to semiquantitative scoring of perivascular mononuclear cells

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>0 (0-2 cells)</th>
<th>1 (3-6 cells)</th>
<th>2/3 (&gt;6 cells)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>37 (32)†</td>
<td>49 (43)</td>
<td>28 (25)</td>
</tr>
<tr>
<td>IgM/C3 deposition</td>
<td>6 (16)</td>
<td>29 (59)</td>
<td>23 (82)**</td>
</tr>
<tr>
<td>Men</td>
<td>11 (30)</td>
<td>17 (35)</td>
<td>15 (34)*</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>61</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>Mean duration (years)</td>
<td>16</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Rheumatoid nodules</td>
<td>6 (16)</td>
<td>16 (33)</td>
<td>13 (46)*</td>
</tr>
<tr>
<td>Other EAF†</td>
<td>1 (3)</td>
<td>4 (8)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Radiological erosions</td>
<td>34 (92)</td>
<td>44 (90)</td>
<td>26 (93)</td>
</tr>
<tr>
<td>Mean ESR (mm/h)</td>
<td>58</td>
<td>47</td>
<td>57</td>
</tr>
<tr>
<td>Rose-Waaler test titre ≥1/16</td>
<td>23 (62)</td>
<td>32 (65)</td>
<td>27 (96)**</td>
</tr>
<tr>
<td>Antinuclear factors</td>
<td>6 (16)</td>
<td>14 (29)</td>
<td>10 (36)</td>
</tr>
<tr>
<td>Number HLA typed</td>
<td>30 (81)</td>
<td>35 (71)</td>
<td>21 (75)</td>
</tr>
<tr>
<td>HLA-DR4 positive</td>
<td>20 (67)</td>
<td>23 (66)</td>
<td>17 (81)</td>
</tr>
<tr>
<td>HLA-DR3 positive</td>
<td>1 (3)</td>
<td>8 (23)</td>
<td>5 (24)*</td>
</tr>
</tbody>
</table>

* **Significantly increased (*p<0.05, **p<0.01; χ² test) if compared with patients with ≤6 cells.
† Values are Nos (%).
‡ EAF=extra-articular features; see text.

Table 3  HLA-DR3 and HLA-DR4 and some disease parameters

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>RF+</th>
<th>ANF+</th>
<th>Nodules</th>
<th>Erosion</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR4+</td>
<td>64</td>
<td>49 (77)*</td>
<td>17 (27)</td>
<td>22 (34)</td>
<td>58 (91)</td>
</tr>
<tr>
<td>DR4-</td>
<td>26</td>
<td>16 (62)</td>
<td>7 (27)</td>
<td>6 (23)</td>
<td>25 (96)</td>
</tr>
<tr>
<td>DR3+</td>
<td>14</td>
<td>12 (86)</td>
<td>6 (43)</td>
<td>4 (29)</td>
<td>13 (93)</td>
</tr>
<tr>
<td>DR3-</td>
<td>76</td>
<td>49 (64)</td>
<td>18 (24)</td>
<td>24 (32)</td>
<td>70 (92)</td>
</tr>
</tbody>
</table>

*Values are Nos (%).
Differences do not reach statistical significance.

Table 4  Relation between titre of the Rose-Waaler test at the time of biopsy and HLA-DR3 and HLA-DR4

<table>
<thead>
<tr>
<th>Rose-Waaler test titre</th>
<th>No</th>
<th>DR3+</th>
<th>DR4+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>21</td>
<td>2 (10)*</td>
<td>15 (71)</td>
</tr>
<tr>
<td>1/8-1/16</td>
<td>13</td>
<td>0 (0)</td>
<td>8 (62)</td>
</tr>
<tr>
<td>1/32-1/64</td>
<td>14</td>
<td>2 (14)</td>
<td>8 (57)</td>
</tr>
<tr>
<td>≥1/128</td>
<td>42</td>
<td>10 (24)</td>
<td>33 (79)</td>
</tr>
</tbody>
</table>

All patients 90 14 (16) 64 (71)

*Values are Nos (%). Differences do not reach statistical significance.

titre of RF as estimated at the time of biopsy (Tables 4 and 5). Deposition of IgM or C3, or both, as well as PVI were significantly associated with high titres of RF. HLA-DR3 and DR4 were somewhat more prevalent in patients with high titres of RF, but the difference did not reach statistical significance.

Discussion

Within the broad spectrum of RA, seropositive disease with extra-articular features has been proposed as a separate disease entity. From many studies the clustering of RF, nodules, Felty's syndrome, and—less pronounced—radiological erosion of para-articular bone has become clear. This concept is further supported by the association of these symptoms with HLA-DR4. It is likely that PVI and deposition of IgM or C3, or both, are also associated with this cluster. In this study PVI of mononuclear cells in normal skin was associated with seropositivity and the presence of rheumatoid
nODULES, CONFIRMING THE ABOVE MENTIONED OBSERVA-
TIONS. A DIRECT RELATION BETWEEN EXTRA-ARTICULAR
DISEASE MANIFESTATIONS COULD NOT BE SHOWN AS THE
LATTER WERE PRESENT IN ONLY SIX OF 114 PATIENTS.
ASSOCIATION OF PVI WITH MALE SEX (TABLE 2) IS LIKELY
to BE SECONDARY TO THE ASSOCIATION WITH RF AND
NODULES, THE LATTER BEING MORE OFTEN PRESENT IN MALE
PATIENTS WITH RA. OUR DATA INDICATE A WEAK RELATION
BETWEEN ANF AND HLA-DR3 AS HAS BEEN REPORTED BY
OTHERS, BOTH BEING WEAKLY ASSOCIATED WITH PVI.15 17
Perhaps these should also be regarded as markers for a more severe form of RA. PVI WAS
PRESENT IN 77/114 (68%) OF OUR PATIENTS WITH RA
SELECTED FOR TREATMENT WITH D-Penicillamine.
COMPA1RED WITH OTHER STUDIES THIS FIGURE IS HIGH,
WHICH MAY REFLECT PARTLY RATHER SERIOUS AND LONG-
STANDING DISEASE IN OUR PATIENTS. MORE IMPORTANT ARE
DIFFERENCES IN THE CRITERIA THAT WERE USED: A CUT OFF
POINT OF SIX CELLS PER VESSEL REDUCES THE FIGURE TO
25%.

The number of perivascular cells correlated with deposition of IgM or C3, or both, in the vessel wall,
as reported in other studies.1-4 Both PVI and IgM/C3 deposition were associated with RF. The increasing number of perivascular cells in patients with high titres of RF (TABLE 4) can be regarded as an argument for a causal relation. Our data indicate a weak association of RF with HLA-DR3 and DR4 (TABLES 3 AND 5), NOT REACHING STATISTICAL SIGNIFICANCE. AS THE CONNECTION BETWEEN HLA-DR4 AND
RF IS IN AGREEMENT WITH OBSERVATIONS OF OTHERS13-17
WE BELIEVE IT IS NOT LIKELY TO HAVE RESULTED FROM
CHANCE. AS HIGHER TITRES OF RF ARE ASSOCIATED WITH
BOTH PVI AND HLA-DR4 AN INCREASED PREVALENCE OF
THIS GENETIC MARKER IN PATIENTS WITH DENSE INFILTRATES
IS EXPECTED. ALTHOUGH NOT REACHING STATISTICAL
SIGNIFICANCE, HLA-DR4 WAS INDEED MORE FREQUENTLY
PRESENT IN PATIENTS WITH INFILTRATES OF MORE THAN SIX
CELLS. HLA-DR3 ALSO APPEARS TO BE ASSOCIATED WITH
PVI, BUT IT IS MORE CORRECT TO STATE THAT THE
PREVALENCE OF HLA-DR3 WAS IN FACT ONLY DECREASED IN
PATIENTS WITH 0-3 CELLS AS THE OVERALL PREVALENCE IN
THE OTHER GROUPS DID NOT EXCEED THAT IN HEALTHY
CONTROLS.

From a pathogenetic point of view as well as from a practical one it is important to address the question of what comes first: RF or vasculitis? Intravenous administration of RF to rats is followed by diapedesis of leucocytes from venules and capilar-
aries and may induce cutaneous inflammation.25 26 When this observation is extended to patients with RA one may propose a hypothesis of circulating (IgM) RF being trapped or deposited in the vessel wall, activating the complement system, and attract-
ing leucocytes.3 The demonstration of IgM or C3, or both, in most patients with PVI (TABLE 2) is in
AGREEMENT WITH THIS HYPOTHESIS BUT DOES NOT PROVE
THAT DEPOSITION OR FORMATION OF IMMUNE COMPLEXES
IN THE VESSEL WALL PRECEDES CELLULAR INFILTRATION.

If HLA-DR4 is a marker for the genetic basis of a more severe disease process, including high titres of RF and PVI, one would expect a stronger association with the primary disease manifestation. Our finding that HLA-DR4 IS MORE PREVALENT IN PATIENTS
WITH RF THAN IN PATIENTS WITH PERIVASCULAR INFILTRA-
TION SUPPORTS THE HYPOTHESIS THAT PVI IS SECONDARY TO
DEPOSITION OF CIRCULATING RF.

In the management of patients with RA information on the presence of PVI will only be helpful if CLEAR ASSOCIATIONS WITH CERTAIN DISEASE MANIFESTATIONS
OR PROGNOSIS CAN BE DEMONSTRATED. WESTEDT ET AL
FOUND CORRELATION OF PVI WITH ACTIVE JOINT INFILTRA-
TION USING THE RITCHIE INDEX.4 7 DISEASE ACTIVITY IN
OUR PATIENTS, AS MEASURED BY THE ESR, WAS NOT
ASSOCIATED WITH THE PRESENCE OR DEGREE OF PERIVAS-
CULAR INFILTRATION. A POSSIBLE PROGNOSTIC SIGNIFICANCE
OF PVI HAS BEEN EVALUATED IN TWO STUDIES.4 6 NEITHER
PVI NOR SKIN VESSEL WALL IMMUNE DEPOSITS WERE
PREDICTIVE OF CHANCE IN ACTIVITY OF JOINT DISEASE OR
DEVELOPMENT OF EXTRA-ARTICULAR MANIFESTATIONS. IN
OUR PATIENT GROUP, AFTER AN AVERAGE FOLLOW UP PERIOD
OF 7 (1-10) YEARS, 2/86 PATIENTS WITH 0-6 PERIVASCULAR
CELLS, AND 3/28 PATIENTS WITH >6 CELLS HAD DEVELOPED
MINOR CLINICAL SIGNS OF VASCULITIS: SKIN ULCERS, COMB-
INED WITH NAIL FOLD LESIONS IN TWO. THESE FIVE
PATIENTS WERE ALL SEROPOSITIVE, TWO HAD ANF, WHILE
HLA-DR4 WAS PRESENT IN 4/4 AND HLA-DR3 IN 0/4.
In our opinion this outcome does not indicate a useful prognostic significance of skin biopsies.

In conclusion, perivascular cellular infiltration in apparently normal skin of patients with RA IS
ASSOCIATED WITH SOME OF THE SYMPTOMS THAT MARK A
MORE SEVERE DISEASE COURSE. HLA-DR4 HAS ALSO
BEEN ASSOCIATED WITH THESE SYMPTOMS, BUT ITS PRE-
VALENCE IS ONLY MARGINALLY INCREASED IN PATIENTS WITH
PERIVASCULAR INFILTRATION. THE PERIVASCULAR INFIL-
TRATES ARE PROBABLY SECONDARY TO THE PRESENCE AND
QUANTITY OF CIRCULATING RF.

It is not likely that skin biopsies will provide a better insight into the prognosis of RA for individual
patients. To identify patients with a more severe disease course or a high risk of developing extra-
ARTICULAR SYMPTOMS OTHER TESTS LIKE RF AND ANF CAN
BE OBTAINED MORE EASILY AND ARE PROBABLY BETTER DISCRIMINATORS.

References
1 Conn D L, Schroeter A L, McDuffie F C. Cutaneous vessel
19: 15-19.
2 Rapoport R J, Kozin F, Mackel S E. Cutaneous vascular
immunofluorescence in rheumatoid arthritis. Correlation with

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