LETTERS TO THE EDITOR

Polyomysitis and cyclosporin A

Sir: Polyomysitis is an inflammatory disease of striated muscle of unknown cause. When it is accompanied by the characteristic skin lesions the disease is called dermatomyositis.1 Although controlled studies have not been carried out, it seems that corticosteroids are beneficial, particularly in acute polymyositis.2,3 Certain patients, however, need very high doses or do not respond to this treatment. Such patients have been treated with a wide spectrum of immunosuppressive agents, alone or combined with steroids, with very variable response.2

4,6 Such arthritis, Raynaud’s phenomenon, proximal dyspnoea, telangiectasia, and proximal sclerosis. Osseopaghal manouevres showed impaired mobility. Antibody anti J1, (1/6400) with a nucleolar pattern. A diagnosis of progressive systemic sclerosis was made. In May 1985 she was readmitted because of severe weakness of both girdles. Electromyographic and histopathological studies showed myositis. Corticosteroid treatment (1 mg/kg/day) was started, without clinical improvement. Treatment with cyclosporin A was then started (120 mg/day), with a rapid strength recovery. This treatment was stopped in January 1987. From then the patient has been asymptomatic.

Polymyositis/dermatomyositis left to its spontaneous evolution has a high mortality, estimated to be more than 60%.6 Most authors agree that steroids are useful in the treatment of acute forms.7 Failure to respond to steroid treatment occurs in 25–50% of patients, however.3 In this ‘tired resistant’ group other immunosuppressant treatments, including cyclosporin A, have been tried, with variable results.2,8

Cyclosporin A is a peptic drug with immunosuppressant effects that interferes with the synthesis and release of lymphokinones from the T helper subset.9 Some authors agree with the usefulness of cyclosporin A in the acute forms of polymyositis/dermatomyositis,2,5 but chronic polymyositis is not clear. Cyclosporin A was given to all three patients because of failure or severe side effects of conventional treatment. A good correlation was found between clinical improvement and cyclosporin A administration in all the patients.

Side effects that might be attributed to cyclosporin A treatment in our patients are hirsutism and tremor in all of them, and mild hypertension with moderate impairment of renal function in patient No 1. All these abnormalities, very common in patients receiving cyclosporin A,10 were reversed after the drug was tapered off. These few cases show that cyclosporin A can be useful in patients with acute forms of polymyositis/dermatomyositis. Suppression of cyclosporin A treatment in polymyositis/dermatomyositis can produce a new bout of the disease, but probably in some patients the cyclosporin A treatment given for an indefinite period might stop the activity of the disease even after withdrawal of the treatment for many months. Thus cyclosporin A may be the treatment of choice when conventional immunosuppressant therapy fails or when adverse effects of this treatment are important. More studies are needed to corroborate these clinical observations.

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Toxic shock syndrome associated arthropathy

Sir: We read with interest the recent paper by Foley-Nolan et al,1 which states ‘the only previous report of a patient with the toxic shock syndrome and associated arthropitis was a 15 year old girl’. We have previously reported arthropathy as a manifestation of toxic shock syndrome2 and would draw this to the attention of the author and your readers.

This recalls a couplet which in apt:

When I am dead, I hope it may be said:
‘His sins were scarlet, but his papers were read.’
(After Hilaire Belloc, On His Book.)

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Destructive arthropathy after successful renal transplantation

Sir: In their recent article Duncan et al reported two patients treated for chronic renal failure, who developed a severe erosive arthropathy at a relatively young age.2 Their series had slightly degenerative changes of both hands after two years of haemodialysis. Eleven years after successful renal transplantation he developed a severe erosive arthropathy. We report here a patient with chronic renal failure who developed her first joint complaints and later a destructive arthropathy after successful renal transplantation.

A 52 year old white woman attended the outpatient clinic of the department of rheumatology in 1983 with a six month history of pain and swelling of the hands. In 1968 she developed renal failure secondary to chronic pylonephritis. She underwent haemodialysis from 1971 to 1976 and then received a renal graft. After initial problems, for which she needed antirejection treatment on four occasions, the graft functioned well (mean creatinine clearance 86 ml/min). There was no family history of osteoarthrosis or psoriasis.

On examination she had a synovitis of the interphalangeal joint of both thumbs, the proximal interphalangeal joint of the right middle finger and left ring finger, and the distal interphalangeal joint of the left index finger. All other joints were unremarkable. Radiographs of her hands showed soft tissue...
Toxic shock syndrome associated arthropathy.

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