Long term evolution of adult onset Still's disease seen in an infectious diseases department

SIR: Adult onset Still's disease was first reported by Bywater\(^1\) in 1971, who stated that the long term articular prognosis was good. Several studies have shown, however, that severe infections do occur and often leave patients with severe sequelae.\(^2\)\(^-\)\(^3\) Cabane et al\(^4\) found that the incidence of hip disease was 50% and that hip replacement was required in seven out of 18 cases. This letter reports the long term outcome of 10 patients with adult onset Still's disease who presented to an infectious diseases department and were followed up for more than three years.

All 10 patients were more than 16 years old (mean 36 years, range 20–56) and fulfilled the American Rheumatism Association criteria for adult onset Still's disease;\(^5\) in eight patients all four major criteria (fever, arthritis, rash, leucocytosis) were present and the diagnosis was confirmed. The age was only probable in two patients because of the absence of the characteristic rash. Arthritis most commonly affected the knees (seven patients), wrists (four), and ankles (two), and was monarticular (six) or pauciarticular (four) in distribution. The patients were followed up for a mean of 8.9 years (range 3–17).

Long term outcome was assessed according to the criteria defined by Cush et al\(^6\) and is reported in the table. Systemic disease activity was the dominant aspect of the illness in eight out of 10 patients in whom articular involvement was mild or absent. Five of these eight patients had only polyserositis with no systemic disease followed by clinical and biological remission. Currently, they have discontinued treatment after a mean duration of 20 months and a mean follow up period of six years. Three of these eight patients had a polycylic systemic disease pattern defined by multiple episodes of systemic disease without severe articular involvement. Chronic articular disease was identified in two other patients with polyserositis which was not controlled by non-insulin dependent intravenously 6 g/day. After three days course of this fluid yielded Nocardia asteroides. Drug treatment was switched to trimethoprim 160 mg-sulphamethoxazole 800 mg every 12 hours orally. The patient's condition showed a rosy colour. No further treatment was necessary.

Septic arthritis due to Nocardia asteroides

SIR: A 75 year old man from a nursing home with past medical history of osteoarthritis, type 2 diabetes mellitus, and hypertension was admitted in October 1988 with loculated left pleural effusion and infiltrates in the lower left lung field. Despite extensive evaluation no definite cause could be suspected. The patient was treated intravenously with antibiotics and was discharged after his condition stabilised. In January 1990, while he was in hospital after peripheral vascular surgery, he developed left knee joint pain. Physical examination at that time showed an elderly, moderately built man with blood pressure 130/70, pulse rate 84/min, temperature 37.5°C. Chest examination showed decreased breath sounds and rales at the left base. There was a grade II/VI systolic ejection murmur at the right upper sternal border with regular heart rhythm. Examination of the left knee showed heat, marked tenderness, decreased range of motion, and moderate synovial effusion. The aspirated joint fluid was purulent and had a rosy colour. The white blood cell count showed 415×10\(^3\) cells/l, of which 93% were neutrophils. Empirical treatment was non-insulin dependent intravenously 6 g/day. After three days course of this fluid yielded Nocardia asteroides. Drug treatment was switched to trimethoprim 160 mg-sulphamethoxazole 800 mg every 12 hours orally. The patient's condition showed a rosy colour. No further treatment was necessary. The patient was discharged after his condition stabilised. A 75 year old man from a nursing home with past medical history of osteoarthritis, type 2 diabetes mellitus, and hypertension was admitted in October 1988 with loculated left pleural effusion and infiltrates in the lower left lung field. Despite extensive evaluation no definite cause could be suspected. The patient was treated intravenously with antibiotics and was discharged after his condition stabilised. In January 1990, while he was in hospital after peripheral vascular surgery, he developed left knee joint pain. Physical examination at that time showed an elderly, moderately built man with blood pressure 130/70, pulse rate 84/min, temperature 37.5°C. Chest examination showed decreased breath sounds and rales at the left base. There was a grade II/VI systolic ejection murmur at the right upper sternal border with regular heart rhythm. Examination of the left knee showed heat, marked tenderness, decreased range of motion, and moderate synovial effusion. The aspirated joint fluid was purulent and had a rosy colour. The white blood cell count showed 415×10\(^3\) cells/l, of which 93% were neutrophils. Empirical treatment was non-insulin dependent intravenously 6 g/day. After three days course of this fluid yielded Nocardia asteroides. Drug treatment was switched to trimethoprim 160 mg-sulphamethoxazole 800 mg every 12 hours orally. The patient's condition showed a rosy colour. No further treatment was necessary. The patient was discharged after his condition stabilised. A 75 year old man from a nursing home with past medical history of osteoarthritis, type 2 diabetes mellitus, and hypertension was admitted in October 1988 with loculated left pleural effusion and infiltrates in the lower left lung field. Despite extensive evaluation no definite cause could be suspected. The patient was treated intravenously with antibiotics and was discharged after his condition stabilised. In January 1990, while he was in hospital after peripheral vascular surgery, he developed left knee joint pain. Physical examination at that time showed an elderly, moderately built man with blood pressure 130/70, pulse rate 84/min, temperature 37.5°C. Chest examination showed decreased breath sounds and rales at the left base. There was a grade II/VI systolic ejection murmur at the right upper sternal border with regular heart rhythm. Examination of the left knee showed heat, marked tenderness, decreased range of motion, and moderate synovial effusion. The aspirated joint fluid was purulent and had a rosy colour. The white blood cell count showed 415×10\(^3\) cells/l, of which 93% were neutrophils. Empirical treatment was non-insulin dependent intravenously 6 g/day. After three days course of this fluid yielded Nocardia asteroides. Drug treatment was switched to trimethoprim 160 mg-sulphamethoxazole 800 mg every 12 hours orally. The patient's condition showed a rosy colour. No further treatment was necessary. The patient was discharged after his condition stabilised.

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