Further studies are needed to clarify the biological significance of the soluble form of interleukin-2 receptor in systemic sclerosis and, by longitudinal follow up of several patients, its possible use for monitoring the progression of the disease.


Nature of the osseous joints and their involvement in rheumatoid arthritis

Sir: I read with interest the paper published recently in the Annals1 but must disagree with the description of the osseous joints as synovial with diarthroidal articular discs. I note the use of the paper by Reiter et al2 as a reference for this statement, but examination of his paper shows that his assertion is not based on referenced pathological or anatomical fact. In 1981 the osseous joints were described by Anson as 'diarthrodial joints surrounded by a thin capsular ligament. From the inner surface of the capsular ligament a wedge-shaped circular rim projects into the joint cavity and incompletely divides it.'3 There was no mention of synovium or a cartilaginous disc. Modern understanding of the physiology of sound conduction through the middle ear emphasises the importance of the ossicles acting only as a piston without significant rotation about the joints.4 In man the incudo-malleal joint seems to have no function apart from binding the two bones together as there is no movement at the joint. Indeed in many rodents there is no joint and the malleus and incus are one bone. The most important factor changing the low pressure, high displacement vibrations of air into low displacement vibrations suitable for driving cochlear fluids is the ratio of the areas of the tympanic membrane and the stapes footplate.

Therefore, their joining should participate in the rheumatoid process seems far less likely. Interestingly, however, this study and those of Reiter and Moffat4 all showed altered stiffness of the middle ear conducting mechanism. Goodwill, who examined the ossicles remained at necropsy from three rheumatoid patients, did not find nodules or erosive joint changes but instead fibrous tissue replacement of the long process of the incus.5 This finding is not uncommon in chronic otitis media and is thought to result from the fact that the long process of the incus has the most tenuous blood supply of all the osseous elements and thus is most at risk of endarteritis obliterans secondary to infection with subsequent resorption of bone and replacement by fibrosis. Probably, the middle ear changes in rheumatoid arthritis are secondary to the associated vasculitis, which is already known to account for most of the other extra-articular manifestations.

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Ankylosing spondylitis and selective IgA deficiency

Sir: We read with interest the account from Dr Herrera-Beaumont and colleagues of a patient with selective IgA deficiency and severe spondyloarthropathy.1 We report a further case of IgA deficiency in ankylosing spondylitis that is associated with an exceptionally poor patient outcome.

A 40-year-old woman was referred to the rheumatology clinic with severe lower back pain and stiffness of 10 years duration. Initially, treatment with anti-inflammatory drugs, analgesics, and exercise had been successful. However, following a brief period of remission, the symptoms returned and the patient subsequently developed a significant degree of structural damage to the axial skeleton. Despite aggressive medical therapy, including cyclosporin A, the patient opted for surgical intervention, including total hip replacement and anterior fusion of the lumbar spine.

The patient's family history was negative for ankylosing spondylitis. She was HLA-B27 positive. There was no past or family history of uveitis, psoriasis, or other associated disease, and serological tests for nucleic acid antibodies and rheumatoid factor were consistently negative. Treatment consisted of non-steroidal anti-inflammatory drugs, analgesics, and exercise.

The course of her disease was unremarkable and did not feature the destructive peripheral arthropathy noted in the previous reports. At her final assessment her disease activity was subjectively moderate, with no morning stiffness and with lower back pain rated as 26% on maximum on a visual analogue scale. The most striking feature was the absence of any peripheral arthritis.

Further studies are needed to clarify the biological significance of the soluble form of interleukin-2 receptor in systemic sclerosis and, by longitudinal follow up of several patients, its possible use for monitoring the progression of the disease.

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Although selective IgA deficiency has been associated with recurrent mucosal infection and allergy, and with an increased incidence of several autoimmune disorders, most patients are asymptomatic.1 IgA deficiency affects about 0.2% of the adult white population,2 and ankylosing spondylitis up to 1%.3 By chance alone the two disorders will therefore occur together in 0.002% (one in 50 000 people), suggesting that there are around 1000 such patients in the United Kingdom. Unlike the four previously reported cases our patient did not have 'severe' ankylosing spondylitis, and we argue against interpreting IgA deficiency as a poor prognostic factor in ankylosing spondylitis until more evidence has been accumulated.

At a mechanistic level the existence of such cases indicates that an intact IgA response is not essential to the pathogenesis of ankylosing spondylitis.
Ankylosing spondylitis and selective IgA deficiency.

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