controls. Each point in the graph shows the mean of four observations.

**Plasma von Willebrand factor antigen concentrations.** Each point represents one patient or control. The bar is the median value.

of a higher von Willebrand factor antigen in patients with diffuse disease suggests endothelial cell damage may be more extensive and active in this group. The extent of vascular injury as shown by von Willebrand factor antigen concentrations may be regarded as a prognostic marker in these disorders.

A D BLANN
Department of Surgery
Research and Teaching Unit
University Hospital of South Manchester
Nell Lane, Didsbury
Manchester M20 8LR, UK

KAREN J ILLINGWORTH
M I V JAYSON
University of Manchester Rheumatism Disease Centre
Clinical Sciences Building
Hope Hospital
Eccles Old Road
Salford, Manchester M6 8HD, UK


**Anticardiolipin antibodies in drug addicted patients with AIDS**

Sir: The presence of anticardiolipin antibodies and lupus anticoagulant has been noted in up to 90% of homosexual patients with AIDS.

To determine the presence of anticardiolipin antibodies with *Pneumocystis carinii* infection, but other opportunistic infections, and with neoplasm, but up to the present, anticardiolipin antibodies in patients with AIDS have only been associated with a poor outcome of the illness. In these patients anticardiolipin antibodies do not have the same clinical significance as they have in systemic lupus erythematosus.

As drug addicted patients with AIDS have a different spectrum of rheumatic manifestations, with less reactive arthritis, Reiter's syndrome, and HIV related arthritis, and more septic arthritis than homosexual patients with AIDS (Montesquido I et al, unpublished data), we studied the presence of anticardiolipin antibody in drug addicted patients with AIDS and its relation with clinical manifestations.

Anticardiolipin antibody was determined (Cheshire Diagnostic QCA enzyme linked immunosorbent assay (ELISA) kit) in 55 drug addicted patients. Forty three of these had been admitted to hospital because of acute problems related to AIDS (mainly infections) and the remaining 12, with no acute problems, were seen at the outpatient AIDS clinic in the hospital. Anticardiolipin antibodies were positive in 42 (76%)—31/43 (72%) of the patients and 11/12 (92%) of the outpatients. Clinical problems in the hospital patients were diverse, and we found no significant relation between infection and the presence of anticardiolipin antibodies. Additionally, there was no relation between anticardiolipin antibodies and the antecedent and kind of infection in these patients. Of the 55 patients, 43 were in stage IV AIDS, with 34 (79%) being positive for anticardiolipin antibodies. The remainder were in other stages and anticardiolipin antibodies were found in 10/12 (83%).

Our results show that the presence of anticardiolipin antibodies in drug addicted patients with AIDS is similar to that found in homosexual patients with AIDS. We found no relation between anticardiolipin antibodies and clinical manifestations (mainly infections) nor pathological antecedents in these patients. Similarly, there were no differences between outpatients and hospital patients. As with homosexual patients with AIDS, we found no correlation between anticardiolipin antibodies and recurrent thrombosis and thrombopenia. Probably, anticardiolipin antibodies are associated with HIV infection itself or with an abnormal immune response which is not yet well defined.

JAVIER RIVERA
INDALECIO MONTEAGUDO
JAVIER LOPEZ-LONGO
EDUARDO MALDONADO
LUIS CARRENO
Servicio de Reumatología
Hospital General Gregorio Maranon
Madrid, Spain

Correspondence to: Dr J Rivera, Servicio de Reumatología, Hospital Gregorio Maranón, Doctor Esquerdo 46, 28007 Madrid, Spain.


**Disabling ossification of the patellar tendon**

Sir: A 42 year old lorry driver without any medical or traumatic history had had for two years pains in the right knee when walking. They had appeared simultaneously with the use of a new truck, in which the accelerator pedal was particularly stiff. After some months of limping clinical examination showed that the right patellar tendon was diffusely thickened and tender; a bulge sign was found, as was a marked reduction of the knee flexion. Erythrocite sedimentation rate was 1 mm/1st h; fasting blood sugar, calcium, phosphorus, and alkaline phosphatase were normal. Synovial fluid contained 0.1×10^6 leucocytes/ml without crystals.

Lateral plain radiographs and tomograms (without signs of patella alta: length of the patellar tendon equal to the diagonal length of the patella) showed ossification of the tendon, which did not affect its distal third (fig 1).

Sonography showed that ossification was mostly in the lateral part and that the non-ossified distal third was thickened in comparison with the tendon on the left side (antero-posterior thickness 9 mm v 6 mm). Radiographs and computed tomography also showed irregular enesthesic osteophytes of the origin of patellar tendon, with some involvement of the distal part, a femoral and tibial osteopetrosis. Radiographs of cervical, thoracic, and lumbar spine showed no abnormalities.

Arthroscopic examination showed the joint capsule was normal. During operation, an orthopaedic surgeon found that the right patellar tendon was wider than normal. The ossified mass was not adherent to the adjacent patella or tibia and could be easily dissected and removed. The patient recovered slowly and was able to resume his work three months later.

Pathological examination showed compact remodelled lamellar bone. In the mass of the bone, and on the proximal end, strips of fibrous cartilage were seen, which might be considered as an abnormal metaplasia of the tendon (figs 2A and B). Despite its distance from any insertion site this intermingling of bone and fibrous cartilage resembles that seen in enthesopathic hyperostosis—that is, in a location in which fibrocartilaginous bundles are normally found. On the distal end tendinous bundles intermingled with scar tissue associated with some degree of scar.

**Figure 1 (A) Plain radiograph; (B) tomogram.**
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J Rivera, I Monteagudo, J Lopez-Longo, E Maldonado and L Carreño

Ann Rheum Dis 1991 50: 338
doi: 10.1136/ard.50.5.338-a

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