The relationship between rheumatoid arthritis and bronchiectasis

We studied the recent article by McMahon et al which attempted to rationalize the relationship between rheumatoid arthritis (RA) and bronchiectasis. There is now good evidence that bronchiectasis is associated with RA and this paper brought the important hints that obstruction in patients with bronchiectasis and RA may be more pronounced than in those with bronchiectasis alone. The reason for this remains unclear but the suggestion that it may be mediated by the presence of secondary Sjögren syndrome was novel. However, we would like to provide two items of evidence which appear to make this theory less tenable.

In neither physiological nor pathological studies of the Airways of patients with primary Sjögren syndrome (PSS) have we found evidence of bronchiectasis, although high resolution computed tomography (HRCT) demonstrated bronchiolar infiltrates in 30% of PSS patients complaining of dyspnoea. Of more direct relevance we have recently completed a HRCT study of 40 patients with RA, 10 of whom had evidence of bronchiectasis. Schirmer’s tear tests were measured in all patients and abnormal results were found in 60%. Using the same criteria as McMahon et al we found 18 of 30 patients with RA without bronchiectasis and 10 of 10 RA patients with bronchiectasis to have 5 mm or less wetting from either eye over five minutes.

Thus we have been unable either to demonstrate the presence of bronchiectasis in patients with PSS, or to show a relationship between Schirmer’s tear test results and the presence of bronchiectasis in RA patients. The difference between our results and those of McMahon et al may be explained by the relatively low percentage of RA patients without bronchiectasis (controls) with an abnormal Schirmer’s tear test in their study (22%). This is lower than our experience in our patients with pure bronchiectasis and may represent an underestimate of the true value. We conclude that the case for Sjögren syndrome contributing to the development of bronchiectasis in patients with RA remains at best unproven.

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AUTHOR’S REPLY: We thank Drs Kelly and Gardiner for their interest in our paper and for their informed comments on our hypothesis that elements of Sjögren syndrome may account for the link between RA and bronchiectasis. We acknowledge the limitations of inferring a diagnosis of Sjögren syndrome from a Schirmer’s test and that the small numbers of patients involved made confident...
Matters arising

However, the significance of our findings is heightened by the close matching of our rheumatoid alone (RA) and rheumatoid and bronchiectasis (RABR) groups and we suspect that Kelly and Gardiner's groups were not so matched. Clearly the point concerning the relative frequency of Sjögrens syndrome in RA and RABR will not be settled until it has been examined with more rigour and sufficient numbers of subjects. Secondly, there are clinical, genetic and serological differences between primary and secondary Sjögrens syndrome, and if bronchiectasis is associated with secondary Sjögrens syndrome, it does not necessarily follow that a similar relationship will be found with primary Sjögrens syndrome.

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