Table 1: The comparison of anti-HCV between the general population and patients with SLE

<table>
<thead>
<tr>
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<th>Total (n)</th>
<th>anti-HCV (+) (n)</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>5257</td>
<td>77</td>
<td>1.4</td>
</tr>
<tr>
<td>Patients with SLE</td>
<td>38</td>
<td>1</td>
<td>2.6*</td>
</tr>
</tbody>
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* p > 0.05.
Gouty arthritis in the manubriosternal joint

Gouty arthritis rarely involves arthropod joints such as the manubriosternal joint. We report a case of recurrent manubriosternal joint (MSJ) pain in a patient with idiopathic, tophaceous chronic gouty arthritis.

A 52 year old man consulted for recurrent swelling of ankles, wrists, knees, and feet during the previous 12 years. His family doctor had previously made a diagnosis of gout, and intermittent colchicicine and allopurinol 100 mg/day were prescribed. Despite treatment, however, he experience episodes of gout three to four times a year and he stopped treatment. Alcohol intake was about 100 g/day. During the previous two years he was admitted twice to the emergency unit for intense, acute, anterior thoracic pain located on the sternum that lasted two or three days and was ameliorated by analgesics. Electrocardiograms and chest roentgenograms were reported to be normal.

Physical examination on the first visit showed that he was 15 kg overweight, tophi were present in both olecranon bursae, and limitation of the mobility of mid-feet, ankles, and wrists was present. Aspiration from tophi showed monosodium urate crystals under polarisation microscopy examination. Roentgenograms demonstrated chronic gouty arthropathy in mid-foot. Plasmatic uric acid was 9.1 mg/dl, clearance of urate 5.48 ml/min/1.73 m², clearance of creatinine 123 ml/min/1.73 m², urinary urate 726 mg/day. Liver function tests and blood cell count were within normal limits. A hypocaloric (2000 kcal/day) alcohol free diet was prescribed, together with allopurinol 300 mg/day and diolcenac 50 mg/day.

Three weeks later he suffered acute gastroenteritis and a polyarticular gouty attack involving elbows, wrists, knees, and ankles and was admitted into hospital. Pain was also present on MSJ, and local soft tissue swelling was observed. A chest radiograph showed degenerative signs on the MSJ (fig 1). Aspiration of MSJ yielded a few drops of bloody fluid. Urate crystals were observed in a wet preparation under polarisation examination, and in samples obtained from a knee. No microorganism was recovered from blood, stools or synovial fluid samples. Prednisone 20 mg/day was prescribed with complete recovering in eight days. Then prednisone was gradually tapered (5 mg each five days). After a five year follow up, the patient is asymptomatic, tophi resolved, and plasma uric acid is 4.1 mg/dl with allopurinol 300 mg/day. No chest pain episodes have occurred during follow up.

Gouty arthritis most commonly locates in peripheral synovial joints. Involvement of spine, sacroiliac joints, symphysis pubis or thoracic wall is rare. The opposing osseous surfaces of the manubrium and the body of the sternum are covered by hyaline cartilage and separated by fibrocartilage; in one third of persons, this fibrocartilage cavitates and in 15% it may osify and form a synostosis. Gout involvement of MSJ seems to be extremely uncommon: only two cases have been reported in the medical literature (MEDLINE search) in the past 10 years. The rarity of MSJ involvement may be because of several reasons: firstly, only 30% of adults with chronic gout would show cavitation of MSJ that may predispose to urate crystal deposition; secondly, the more centrally a joint is located, the most uncommon is gouty involvement; thirdly, pain over the sternum in patients with chronic gout may be interpreted as chest pain related to other causes and disappear with treatment for gout. In this case, as in both previously reported, urate crystals were observed in fluid aspirated from the MSJ. The patient observed by Shrewing and Carvell suffered recurrences despite appropriate treatment and underwent MSJ arthrodesis. Severe, progressive involvement of MSJ has also been reported in patients with pustulosis palmoplantaris and surgical treatment may be considered in such cases, but the present case also illustrates that some patients with poor control of serum urate concentrations may suffer from gouty attacks until proper treatment is started. Indeed, this patient was free of symptoms after weight control, alcohol withdrawal, and achieving urate concentrations of under 6 mg/dl.

Figure 1 Lateral radiograph of the MSJ (close up photograph), showing joint irregularities and prominent anterior and posterior osteophytes that suggest chronic arthropathy.
Prevalence of hepatitis C virus antibody in patients with systemic lupus erythematosus

YÜKSEL KARAKOÇ, KAMIL DILEK, MUSTAFA GÜLLÜLÜ, MAHmut YAVUZ, ALPAŞLAN ERSOY, HALİS AKALÝN and MUSTAFA YURTKURAN

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