LETTERS

Fatal vascular occlusion in juvenile dermatomyositis

Juvenile dermatomyositis (JDM) is a relatively rare disease characterised by vasculopathy. Involvement of the gastrointestinal tract may occur in some subjects and is often life threatening. We describe here a case of fatal JDM with gastrointestinal perforation. Immunohistochemical examination by antibody against factor VIII seems to be useful for evaluating the pathological basis of vasculopathy in JDM.

A 13-year-old Japanese girl was admitted in April 1994 with high fever, muscle pain, and muscle weakness. She noticed a facial rash for two months before admission. Physical examinations were: blood pressure 135/90 mm Hg, temperature 38°C, and weight 50 kg. She presented with an erythematous rash on her face, neck and arms, heliotropic eruption, Gottron’s sign, and nail fold telangiectasia. Proximal muscular weakness and pain were prominent. Laboratory findings were as follows; stool occult blood negative, leucocyte count 5800/mm$^3$, thrombocyte count 109 × 10$^9$/mm$^3$, and serum C reactive protein value normal. Muscle enzyme examination showed; glutamic oxaloacetic transaminase 294 IU/l, creatinine phosphokinase 5960 IU/l, and lactate dehydrogenase 1469 IU/l. Rheumatoid factor, antinuclear antibody and other autoantibodies were all negative. Electromyogram findings showed short and small motor units. Muscle biopsy specimen showed variation in fibre size and perivascular inflammatory cell infiltration in the connective tissue. JDM was diagnosed according to the criteria of Bohan and Peter. No features of other connective tissue diseases or malignant neoplasms were present.

Intravenous prednisolone (60 mg/day) was started. However, dysphagia occurred and thrombocytopenia (41 × 10$^3$/mm$^3$) with increase in platelet associated IgG (268 ng/10$^9$ platelet) was apparent. Three courses of methylprednisolone pulse therapy (1000 mg/day for three days) and two courses of high dose intravenous immunoglobulin (20 g/day for five days) were prescribed followed by intravenous methotrexate (100 mg/day every two weeks). Although thrombocytopenia and the increase in serum muscle enzyme had improved, abdominal pain, haematemesis, and melaena resulting from multiple gastrointestinal ulcers were noted. Cyclophosphamide pulse therapy (750 mg/day, every two weeks) and plasma exchange were not effective and oesophageal and bowel perforation occurred. After the resection of perforated lesions, peritonitis occurred and she died of massive abdominal haemorrhage seven months after admission (fig 1).

Surgical findings showed three perforated areas (lower oesophagus, ileocaecal region, and gastric antrum). Pathological examination of these lesions showed occlusion of both arteries and veins. The internal elastic lamina of arteries were intact (fig 2A). Intimal hyperplasia was seen in some vessels and some other vessels were occluded by fibrin thrombi with proliferation of the endothelial cells, characterised by positive staining for factor VIII (fig 2B and C). Some vessels showed infiltration of lymphocytes and foamy macrophages to the adventitia and media.

In JDM, an autoimmune connective tissue disease, the microvasculature is thought to be the fundamental site of pathology. Banker and Victor reported that the earliest pathological changes of vessels were perivascular collections of inflammatory cells, followed by intimal hyperplasia of arteries and veins. Vessel lumen may be occluded by thrombi, fibrin or swollen endothelial cells.

In our case the occluded vessels consisted of intimal hyperplasia and fibrin thrombi with proliferated cells, which were stained with anti-factor VIII antibody, an endothelial cell marker. Although the level of factor VIII related antigen was not measured in this case, a high level of factor VIII related antigen in JDM has been previously reported by some authors. Our immunohistochemical findings suggest the endothelial cell dysfunction in the vasculopathy of JDM and also suggest that anti-factor VIII antibody is useful for evaluating the pathological basis of vasculopathy in JDM.

Thrombocytopenia seen in our case was accompanied by an increase in platelet associated IgG, and improved after treatment with prednisolone and intravenous immunoglobulin. This suggested that her thrombocytopenia resulted from autoimmune thrombocytopenia associated with dermatomyositis, which has been reported in only two adult cases. This is the first report of autoimmune thrombocytopenia in JDM.

We thank Dr H Kobayashi, for advice on dermatology; M Obara for helpful comments.

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Figure 1 Clinical course. PSL=prednisolone; m-PSL=methylprednisolone; MTX= methotrexate; IVIG=intravenous immunoglobulin, CY=cyclophosphamide pulse therapy; PE=plasma exchange; Pr=platelet.

Figure 2 (A) Vascular lesion at the oesophageal perforation. Both the artery (left) and vein (right) were occluded. The internal elastic lamina of the artery was intact, elastica Van Gieson stain. (B). The serial section of figure 2A. Deep blue fibrin obliterates the lumen of the vein, PTAH stain. (C) The serial section of figure 2A and 2B. Endothelial cells were stained with anti-factor VIII antibody (F8/86, mouse IgG1, Dako), immunohistochemical stain for factor VIII. Bar=0.5 mm.
Polyarteritis nodosa associated with precore mutant hepatitis B virus infection

Currently there is a trend to support the use of antiviral therapy as the first line treatment of polyarteritis nodosa (PAN) associated with hepatitis B virus (HBV) infection.\(^1\) A combination of a short course of corticosteroids, plasma exchange, and interferon \(\alpha\) (INF) has been proposed. However, we have doubts about this approach in all cases and circumstances of PAN related to HBV infection. One of these circumstances would be precore mutant HBV infection. A 37 year old man was diagnosed with PAN. The initial clinical manifestations were: fever, leukocytosis (50 000 WBC, 80% neutrophils), serum aspartate aminotransferase: 1244 U/l, increased erythrocyte sedimentation rate (90 mm/h) and complement consumption (C4 0.6 g/dl), abdominal pain, and prolonged platelet consumption. Treatment with cyclophosphamide pulses. Six months later the %EF was 45%, and the patient was discharged with oral prednisolone1 g/day, for three days; plasma exchange were stopped. Two weeks later the patient achieved clinical remission. We are cautious to recommend antiviral treatment as first line treatment in polyarteritis associated with HBV. The experience with INF in the treatment of polyarteritis is still limited. To our knowledge, this is the first case report of a patient with a precore mutant strain of HBV incapable of synthesising HBe antigen; therefore, there is no previous experience with INF. The precore defective HBV is present in one third of patients in the Mediterranean with chronic HBV infection.\(^6\) It has been speculated that the absence of HBe Ag in the hepatocyte membrane prevents the elimination of infected cells by immune system stimulated by INF. It is considered a viral infection with few trends to spontaneous remission and more progressive in comparison with the infection caused by the wild type virus. In general, the treatment with INF in the chronic hepatitis produced by this variant is unfavourable. The rates of relapses are very high in patients who have precore mutant compared with wild type HBV infection (40–90% compared with 13%)\(^7\); and it is recommended to include these patients in multicentric and controlled trials. On the other hand, HBV mutant infection has been associated with fatal liver failure after immunosuppressive therapy.\(^8\) Precore mutant HBV associated PAN should be considered as an individual entity whose therapeutic approach is complex and not defined at present. It is necessary to perform prospective studies to evaluate the exact role of immunosuppressive and antiviral therapy, including new antiviral agents.

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Table 1 Demographic and clinical details of patients

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Dry eyes*</th>
<th>Xerostomia†</th>
<th>PMR Duration</th>
<th>ESR on presentation</th>
<th>RF</th>
<th>ANF</th>
<th>Ro</th>
<th>La</th>
<th>Protein electrophoresis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>54</td>
<td>F</td>
<td>+</td>
<td>+</td>
<td>2 years</td>
<td>65</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>polyclonal increase in γ globulins</td>
</tr>
<tr>
<td>Patient 2</td>
<td>52</td>
<td>F</td>
<td>+</td>
<td>+</td>
<td>1 year</td>
<td>60</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>polyclonal increase in γ globulins</td>
</tr>
<tr>
<td>Patient 3</td>
<td>52</td>
<td>F</td>
<td>–</td>
<td>+</td>
<td>6 months</td>
<td>58</td>
<td>+</td>
<td>–</td>
<td>+</td>
<td>NK</td>
</tr>
</tbody>
</table>

*Both subjective and objective with impaired tear production (Schirmer’s test reading <5 mm at 5 minutes).†Both subjective and objective (lack of saliva pool under tongue). NK, not known.


Polymyalgic presentation of Sjögren’s syndrome: a report of three patients

We report on three patients who presented with polymyalgia but on subsequent clinical and laboratory assessment fulfilled criteria consistent with primary Sjögren’s syndrome. Clinical, immunological, and genetic differences exist now to classify Sjögren’s syndrome (SS) more clearly into primary and secondary SS than in the past. In primary SS patients can present with a plethora of symptoms although most patients present with sicca complaints, lathargy or arthralgia. Polymyalgia, as presenting complaints of primary SS, has not been reported previously.

Our patients presented during a two year period with proximal aching and stiffness associated with a raised erythrocyte sedimentation rate (ESR) and all three responded characteristically as in polymyalgia rheumatica (PMR) patients to oral prednisolone therapy. Subsequent investigations and clinical evaluations (table 1) however raised the possibility of primary SS as the underlying condition, confirmed by the usual immunological parameters and all three patients showed some features of the sicca syndrome, although none had a history of swelling of the salivary gland.\(^1\)

Follow up over at least a two year period showed that patients were relieved of their PMR symptoms but other clinical and laboratory features persisted, except for normalisation of the ESR. None, however, has yet been able to stop taking prednisolone altogether.

PMR in itself is a distinct syndrome characterised by proximal aching and stiffness, associated with raised ESR and characteristically responding to adequate prednisolone therapy in a week or 10 days with a significant reduction in the ESR in that time period. All three patients in this report responded in a similar manner, although they continued to have dry eyes or xerostomia, or both; Ro and La antibodies persisted. Note-worthy in this series of polymyalgia patients is the occurrence of this syndrome at a somewhat younger age than the average PMR patient.\(^1\) Primary SS is a distinct entity with mainly sicca complaints but with a plethora of manifestations including arthralgia or arthritis without actual joint destruction.\(^1, 2\) We are not aware of any previous report of PMR as a presenting manifestation in this condition. PMR-like presentations have been reported in other rheumatic disorders such as rheumatoid arthritis, lupus or in association with a malignancy.\(^7\) To our knowledge, it has not been reported either as a presenting manifestation or as a complaint in established primary SS, although inflammatory arthritis or arthralgia without joint erosions occur commonly.

It is conceivable that the diagnosis of primary SS would have been missed in these patients if their sicca complaints were not prominent, but our index of suspicion for this disorder is high as a result of our clinical and research interests. Moreover, some patients with this disorder are never diagnosed, wrongly diagnosed or diagnosed after a long delay.\(^7\) Given our patients’ circumstances and both their clinical and laboratory features we did not feel it was justifiable or even necessary to undertake an invasive test such as biopsy to prove that they do have primary SS.\(^7\)

In view of our experience perhaps primary SS should be added to the list of polymyalgia-like syndromes. Longer term follow-up of such patients may be of interest to further study their clinical and laboratory progression. In particular it would be important to continue to note these patients with regard to the sicca component of the condition. Although around 90% of patients with primary SS have dry eyes or mouth, or both, practitioners should be aware that an occasional patient may have the condition without these features as we reported in the past.\(^5\) Whether some patients with typical PMR have subclinical or unrecognised SS is not known but we have started evaluating such patients with a view to screening for the presence of SS both on clinical and laboratory grounds.

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Table 1 Clinical characteristic of responders to MTX treatment compared with non-responders

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Responders</th>
<th>Non-responders</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>12.7 (5.9)</td>
<td>9.4 (4.1)</td>
<td>NS</td>
</tr>
<tr>
<td>ESR ratio</td>
<td>2.3</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>Disease duration (y)</td>
<td>4.7 (4.5)</td>
<td>3.4 (2.5)</td>
<td>0.001</td>
</tr>
<tr>
<td>Polyclonal type (%)</td>
<td>8 (80)</td>
<td>5 (70)</td>
<td>NS</td>
</tr>
<tr>
<td>Total corticosteroid dose at entry (mg/day)</td>
<td>1 (1.7)</td>
<td>9.3 (1.2)</td>
<td>0.001</td>
</tr>
<tr>
<td>Number of active joints at entry</td>
<td>12.5 (9)</td>
<td>12.4 (10.1)</td>
<td>NS</td>
</tr>
<tr>
<td>Duration of morning stiffness (min)</td>
<td>15.5 (20.1)</td>
<td>34.3 (20.7)</td>
<td>0.004</td>
</tr>
</tbody>
</table>

Data shown as mean (SD).
In view of the limited numbers of patients who have been studied so far, further prospective controlled studies are necessary to confirm the the value of MTX in the treatment of refractory RA.

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4 Kavanaugh AF, Betsdorff E, Bemish MA, Balis SG. Methotrexate in systemic lupus erythematosus (SLE) patients. Although the numbers of patients in this pilot study were comparatively small, significant and dose dependent decreases in TC, TC/HDL ratio, and LDL/HDL ratio were noted in this double blind, placebo controlled study. As is the case for RA, accelerated ASCVD is an important contributor to morbidity and mortality among SLE patients.

Recently, another factor has been described that underlines the relevance of dyslipidaemia among patients with rheumatic diseases. Studies detailing the frequency of atherosclerotic complications among patients with homocystinuria have helped establish that increased concentrations of homocysteine are an important, independent risk factor for ASCVD. It has been estimated that increments in total plasma homocysteine as small as 5 µmol/l confer as much additional risk for ASCVD as increases in cholesterol of 0.5 mmol/l. Other than genetic background, one of the most important factors causing an increase in homocysteine is folate deficiency. This is of particular relevance to patients with rheumatic diseases, many of whom are older, and a number of whom have suboptimal dietary intake. Moreover, many patients are treated with agents that directly oppose the activity of folate, particularly methotrexate.

Increased concentrations of homocysteine may thus represent a common risk factor for ASCVD among rheumatology patients, which at present is largely unrecognised. Because the presence of multiple ASCVD risk factors leads to a synergistic increase in disease, control of dyslipidaemia may be all the more important in the care of patients with rheumatic diseases.

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In an accompanying editorial, Situnayake and Kita investigated the value of MTX in the treatment of refractory RA.

Letters, Matters arising

Lipid profiles in patients with rheumatoid arthritis

Munro et al have demonstrated a salubrious effect of hydroxychloroquine (HCQ) on lipid profiles in patients with rheumatic arthritis (RA).

1 In an accompanying editorial, Situnayake and Kita investigated the potential importance of dyslipidaemia in RA. We concur with the relevance of this problem, and would like to call attention to some additional data that supports the authors’ points.

In an earlier study, we reported on the serum lipoprotein profiles of 60 men with RA. According to National Cholesterol Education Program guidelines, 18% of the patients had dyslipidemia, in so much as they would be considered at “high risk” of developing atherosclerotic cardiovascular disease (ASCVD) (that is, total cholesterol (TC) > 6.21 mmol/l, LDL-cholesterol > 4.14 mmol/l). An additional 13% had “borderline” increases in lipids (TC ≥ 5.17 mmol/l or LDL ≥ 3.36 mmol/l), which would be significant and merit treatment in the setting of other risk factors for ASCVD. Also, 50% of patients had depressed concentrations of HDL-cholesterol, another risk factor for ASCVD. In all, 68% of this particular group of RA patients had significant dyslipidaemia. While this was a skewed subset of RA patients (that is, older, men), the results are notable.

In agreement with the findings of Munro et al, we demonstrated cholesterol lowering effects of HCQ in systemic lupus erythematosus (SLE) patients. Although the numbers of patients in this pilot study were comparatively small, significant and dose dependent decreases in TC, TC/HDL ratio, and LDL/HDL ratio were noted in this double blind, placebo controlled study. As is the case for RA, accelerated ASCVD is an important contributor to morbidity and mortality among SLE patients.

We herein present a correlation between increased serum homocysteine and homocystinuria in systemic lupus erythematosus. Moreover, increased homocysteine levels in lupus patients may be related to decreased availability of vitamin B12, folic acid, and/or reduced methylation of DNA.


Smoking, rheumatoid factors, and rheumatoid arthritis

Saag et al reported that smokers were more often rheumatoid factor (RF) positive, had more often rheumatoid nodules and more radiographic erosions compared with nonsmokers. Their report questions whether smoking stimulates RF production and thus affects the disease progression in RA. Their findings relate to previous reports that smoking increases the risk of RA, although not all studies agree. As raised RF, in particular Iga RF, is associated with poor prognosis in RA, we report a positive correlation between smoking and Iga RF.

We studied 59 RA patients participating in a prospective study on RA. They comprised

<p>| Table 1 Associations between smoking and clinical and laboratory findings in patients with RA (n=59) |</p>
<table>
<thead>
<tr>
<th>Study cohort</th>
<th>Non-smokers (n=47)</th>
<th>Smokers (n=12)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>59 (46–69)</td>
<td>62 (53–67)</td>
<td>NS</td>
</tr>
<tr>
<td>Disease duration (y)</td>
<td>10 (5–16)</td>
<td>4 (2–15)</td>
<td>NS</td>
</tr>
<tr>
<td>Laboratory findings</td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>RF by nephelometry (IU/ml)</td>
<td>78 (31–161)</td>
<td>358 (177–555)</td>
<td>p=0.023</td>
</tr>
<tr>
<td>Iga RF by ELISA (AU/ml)</td>
<td>11 (6–31)</td>
<td>73 (23–165)</td>
<td>p=0.017</td>
</tr>
<tr>
<td>Igm RF by ELISA (AU/ml)</td>
<td>11 (9–41)</td>
<td>62 (15–135)</td>
<td>NS</td>
</tr>
<tr>
<td>CRP (mg/l)</td>
<td>8 (2–17)</td>
<td>11 (6–26)</td>
<td>NS</td>
</tr>
<tr>
<td>Clinical findings</td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>HAQ score*</td>
<td>0.8 (0.4–1.9)</td>
<td>0.4 (0.1–1.2)</td>
<td>NS</td>
</tr>
<tr>
<td>DAS score†</td>
<td>4.3 (3.1–5.4)</td>
<td>4.5 (3.8–4.8)</td>
<td>NS</td>
</tr>
<tr>
<td>Larsen score</td>
<td>39 (24–70)</td>
<td>45 (31–70)</td>
<td>NS</td>
</tr>
<tr>
<td>Rheumatoid nodules</td>
<td>11%</td>
<td>17%</td>
<td>NS</td>
</tr>
</tbody>
</table>

*HAQ: Health Assessment Questionnaire. †DAS: Disease Activity Score.
47 female patients and 12 male patients of mean age 57.0 years and mean disease duration 12 years. They were attending the rheumatology clinic at King's College Hospital, London and fulfilled the 1987 ACR criteria for RA. Forty six patients (78%) were taking one or more disease modifying drugs (DMARDs), most often methotrexate, gold or salazopyrine. RA was assessed by Disease Activity Score (DAS) using 28 tender and swollen joints, health assessment questionnaire (HAQ), Larsen score for erosions, and C reactive protein (CRP). RF was measured by nephelometry and IgA RF and IgM RF by enzyme linked immunosorbent assay (ELISA). The results are presented as medians (25th and 75th centiles). Findings were evaluated with the Mann-Whitney U test and Fisher's exact test when appropriate. The level of significance was set at 5%.

Only 12 (20%) patients were active smokers at the time of study. They had significantly higher RF levels by nephelometry (p=0.023) and higher IgA RF by ELISA (p=0.017) compared with non-smokers (table 1). IgM RF also tended to be higher among smokers (p=0.073). Of the smokers 67% had an increase in both IgA RF and IgM RF compared with only 26% of the non-smokers (p=0.014). DAS, HAQ, Larsen score, and rheumatoid nodules were similar between groups.

Our findings that smoking has a strongest association with IgA RF supports the findings of Saag et al. They used a latex fixation test to measure RF, which will preferentially detect IgM RF and does not discriminate between RF isotypes.

Although we found no significant differences between smokers and non-smokers regarding clinical features and this contrasts with the results of Saag et al., the prevalence of smoking in our study was low (20%) and the study cohort was also heterogeneous in respect to both age and disease duration. Therefore, negative results must be treated with caution.

The association of smoking with IgA RF is interesting as IgA antibodies are important for mucosal immunity. Thus, it is tempting to speculate that smoking may activate or stimulate the mucosal immune system of the respiratory tract leading to increased production of IgA RF. A similar mechanism has previously been suggested for other diseases where mucosal immunity is important and IgA RF is occasionally raised, such as dermatitis herpetiformis and coeliac disease.11

We recommend that larger studies are established to evaluate the association between smoking, RF, and disease progression in RA as stopping smoking may have important advantages for RA patients.

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Fatal vascular occlusion in juvenile dermatomyositis

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