Prevalence of the antiphospholipid syndrome in primary systemic vasculitis

J D Rees, S Lança, P V Marques, J A Gómez-Puerta, R Moco, C Oliveri, M A Khamashta, G R V Hughes, D P D’Cruz

Methods: All case notes of patients attending the vasculitis clinic at St Thomas’ Hospital over the 12 month period October 2001–October 2002 were reviewed. We also included all inpatients admitted under our care during this time. The case notes were reviewed and only those patients with a definite diagnosis of PSV were included. Patients in whom a diagnosis of systemic lupus erythematosus was suspected were excluded. The 144 patients were classified according to American College of Rheumatology (ACR) criteria and for those with microscopic polyangiitis according to the Chapel Hill consensus definition. Patients not meeting these criteria were designated unclassified systemic vasculitis.

All patients were tested for anticardiolipin antibodies (aCL) and lupus anticoagulant (LA) on at least one occasion. Positive aCL and/or LA tests were classified according to the significance of these results. Those who met the international consensus criteria were classified as having definite APS. Those who had clinical features of APS with positive aCL or LA serology but not fulfilling the international criteria were classified as possible APS. Those who had clinical features of APS with a positive aPL but not enough to fulfill the Sapporo criteria were classified as having unclassified APS. Twelve had only positive aPL.

Results: Of 144 patients with PSV, 25 had positive aCL or LA on at least one occasion, representing a point prevalence of 17%. Of these, nine had definite APS (classified by the Sapporo criteria) and a further four patients had clinical and serological features of APS, although insufficient to satisfy the Sapporo criteria. Twelve had only positive aPL.

Conclusion: The antiphospholipid syndrome, aCL, and the LA may occur in association with PSV.
patients), mesenteric vasculitis (2 patients), cryoglobulinaemic vasculitis (2 patients), relapsing polychondritis (1 patient), and retinal vasculitis (1 patient). A further 36 patients with vasculitis remained unclassified.

The average age at diagnosis was 45 and the average treatment duration was 8 years. Vasculitis Damage Index (VDI) scores were available for 135/144 patients. The mean (SD) VDI at diagnosis was 2.13 (1.71) and at the last follow up was 2.72 (2.18). Of the 42 patients with Wegener’s granulomatosis, half had localised and half generalised disease. Of the Wegener’s group overall, 34 required treatment with cyclophosphamide at presentation while a further 3 required cyclophosphamide subsequently.

Of these 144 patients, 25 (17%) had some features of the APS: 9 (6%) had classical APS by Sapporo criteria while 4 had features of APS with positive serology but not enough for the Sapporo criteria (probable or possible APS). A further 12 had positive aPL serology with no significant clinical features; the remaining 119 were completely negative for aPL. Table 1 summarises the patients with definite APS. The 12 patients with positive aPL but without clinical features of APS, one had positive serology for both aCL and LA, four were positive for aCL alone, and the remaining seven were LA positive. Of the seven positive for LA alone, four were positive on multiple occasions.

DISCUSSION
Our results show a prevalence of definite APS of 6% (9/144) in our population of patients with PSV. A further 3% (4/144) have features of both clinical and serological of APS and we have classified these as possible APS. Additionally, 8% (12/144) have positive serology for aCL or LA, or both.

As this series is retrospective it is subject to possible left censorship bias in that some patients may have died during the 12 month collection period. We made every effort to include patients who had died and although two patients did die during this period, (definite APS patient 5 and a further patient who was aPL and LA negative) this did not significantly affect our results. The nine patients with definite APS demonstrate that the APS may occur in association with a PSV, complicating clinical management for these cases. Six of the 12 patients with serological features of APS had persistently positive serology. Of note, although Behçet’s disease was included in our cohort of patients with vasculitis, none of these patients had a thrombosis or positive serology at any time. It has been suggested that aPL are associated with acute vascular inflammation, and their temporary presence in the serum is a reflection of polyclonal globulin secretion. Thus, their presence in vasculitis may simply represent a secondary response. Another hypothesis is that the endothelial cell disruption which occurs in vasculitis reveals cryptic antigens and stimulates antiendothelial cell antibodies that may be part of the spectrum of aPL. In this case, aPL might just be an epiphenomenon of endothelial phospholipid exposure due to vascular inflammation, as proposed by Manna et al. Some authors found positive aPL in patients with acute infections such as mycoplasma, adenovirus, rubella, chicken pox, and mumps. The levels often declined when the infection resolved, were often low, and not associated with thrombosis. This possibility might explain the presence of aPL in some of our patients; particularly the patients with only one weak positive result. However, many of our patients had high titre positive antibody levels which were consistently present over time. Only one patient (patient No 5 with definite APS) had a demonstrated infection at the time of aPL testing.

Our series of patients highlight the fact that some patients appear to have highly pathogenic LA or aCL and thrombosis while other patients, often with high antibody titre levels, do not. Possibly, the pathogenicity of the antibodies is influenced by host genetic factors, antibody isotype, and underlying vessel wall integrity, as proposed by Norden et al.

In conclusion, our data suggest that aPL can be present in patients with PSV and may influence its clinical course and management. Studies are in progress to assess the possible impact of aPL on morbidity in these patients.

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REFERENCES

Table 1 Summary of patients with systemic vasculitis who also had a definite (Sapporo criteria) diagnosis of antiphospholipid syndrome

<table>
<thead>
<tr>
<th>No</th>
<th>Sex</th>
<th>Diagnosis</th>
<th>aCL</th>
<th>LA</th>
<th>DVT</th>
<th>PE</th>
<th>CVA</th>
<th>Other</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>Polyarteritis nodosa</td>
<td>160</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>Relapsing polychondritis</td>
<td>16</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>Wegener’s granulomatosis</td>
<td>70</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>Churg-Strauss syndrome</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>Unclassified systemic disease</td>
<td>2</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Giant cell arteritis</td>
<td>2</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>Churg-Strauss syndrome</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>Limited Wegener’s granulomatosis</td>
<td>17</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>Takayasu’s disease</td>
<td>10</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DVT, deep vein thrombosis; CVA, cardiovascular accident; PE, pulmonary embolism.


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