Gold in psoriatic arthropathy

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SUMMARY It has been suggested that gold is not effective in psoriatic arthropathy. We did not agree and therefore did a retrospective study of 98 patients. Gold had been given to 27 and was effective in 22, 14 of whom are still receiving it. The incidence of side effects was low and comparable to those in rheumatoid arthritis.

Recently it was stated that gold is of no proved value in psoriatic arthritis (PA) (*British Medical Journal*, 1978). We therefore decided to look back over the treatment records of the past 10 years.

Patients and methods

Ninety-eight case records of patients with psoriatic arthritis were examined. We subdivided our patients into 4 clinical patterns: (1) rheumatoid pattern (including oligoarticular group); (2) distal interphalangeal joint pattern (DIP); (3) spondylitic group; (4) mutilans pattern. There was overlap of 2 or 3 patterns in some patients.

Results

Twenty-two of the 27 patients with the rheumatoid pattern had a very good response to gold. These patients had active progressive disease poorly controlled or not controlled with non-steroidal anti-inflammatory drugs. Patients were started on sodium aurothiomalate (Myocrisin) 30 mg weekly until clinical response was obtained or to a dose of 1 g and thereafter maintained on 30 mg monthly. The mean total dose of myocrisin was 1589 mg. In addition to a rheumatoid-like pattern 12 had DIP joint involvement and 4 spondylitis. The clinical response was well documented at follow-up visits in all patients. Fourteen patients (52% of those started on gold) remain well on long-term maintenance gold therapy. Gold was discontinued in 9 patients because of adverse effects. There were no clinical relapses in patients on gold in contrast to a recent study (Dorwart *et al.*, 1978). In 1 patient gold was discontinued because of lack of efficacy, and 1 patient defaulted from follow-up but was considered well controlled on gold at the last clinical visit.

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ADVERSE EFFECTS

Four patients developed a rash on gold. In 3 of these gold was restarted at a lower dose, with no recurrence of the rash. Five patients had a possible exacerbation of their psoriasis. In no case was there exfoliative dermatitis.

Two patients developed proteinuria, 1 transiently and 1 more persistently. One patient had nausea, vomiting, and diarrhoea, thought by a gastroenterologist to be due to diverticulitis, after 400 mg in toto. The total number of adverse effects was 14 in 13 patients. The incidence of all reactions was 44%, but only 1 patient had a severe toxic reaction, namely, persistent proteinuria.

Discussion

Our results provide further evidence (Wright, 1959, 1961; Dorwart *et al.*, 1978) that gold therapy is effective in severe PA and that toxic reactions are no more frequent than in rheumatoid arthritis (RA) (Dorwart *et al.*, 1978). The incidence in RA of these reactions varies between 4 and 55% (Freyberg, 1972) and was 32% in a large series. In a standard textbook of rheumatology (Sigler, 1972) it is suggested that gold is less effective in PA than RA, with an increased incidence of toxicity. A recent report (Dorwart *et al.*, 1978) compares gold therapy in 14 patients with PA with a comparable group of 42 patients with RA. There was a higher remission rate with less severe toxic reactions in patients with PA; their psoriasis was not affected by gold therapy.

Gold is of proved benefit in RA, and it is striking that all of our patients with PA on chrysotherapy had a rheumatoid-like pattern with in addition DIP joint involvement in 12. Seven of the 12 patients had a good response with gold. Four of the 27 patients on gold had spondylitis and 1 was HLA B27 positive; this patient's peripheral arthritis responded to gold.

We believe that chrysotherapy has a definite place in the management of severe PA. The incidence of severe toxic reactions is low.

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