multisystem vasculitic disorder in which thrombosis is a well recognised feature.[3] However, unlike the case for patients with SLE, serological markers such as antinuclear and rheumatoid factors are rare in BS.[3 4]

We therefore studied 25 patients (14 male, 11 female) with BS and thrombophlebitis for evidence of anticardiolipin antibodies. All patients had at least three of the four major criteria for the diagnosis of BS.[5] The thrombophlebitis involved the leg or arm vessels, or both, and was accompanied by major vessel venous thrombosis (e.g., deep veins of leg or venae cavae) in 15 (60%) of the patients. At least five patients had clinical and arteriographic evidence of pulmonary arterial occlusions, and two of these had pulmonary hypertension confirmed by catheter studies. All but three of the 25 patients were taking corticosteroids or other immunosuppressive drugs, or both. Patients were not known to have autoantibodies, and in particular, none had antinuclear factor, rheumatoid factor, or a false positive reaction for syphilis. Anticardiolipin antibody levels of immunoglobulin classes G and M were determined by a modified radioimmunoassay method,[1] and an abnormal level was taken as being three standard deviations above the mean for normal controls.[3]

Raised anticardiolipin antibody levels were detected in only two (8%) of the 25 patients, both of whom had IgM antibodies alone. Clinically these two patients were similar to those without raised anticardiolipin antibody levels, and both had orogenital ulceration, uveitis, and arthritis. Neither had evidence of cerebral, pulmonary, or retinal vascular disease, or deep vein thrombosis, features previously associated with the presence of anticardiolipin antibodies in SLE.[1]

These results in a group of patients with a high incidence of thrombotic problems and pulmonary vascular disease (admittedly taking corticosteroids and/or other immunosuppressive therapy) suggest that anticardiolipin antibodies do not have a major pathogenetic role in the vascular complications of BS. This contrasts with the results of a recent study of BS from three countries, in which anticardiolipin antibodies were found in 13 of 70 (18·6%) patients, with a particular association being found with retinal vascular disease.[6] The cause for this disparity is not clear, particularly as the patients in both studies were apparently diagnosed using the same standard criteria and the anticardiolipin antibody levels measured in the same way.

It is suggested that, as in all studies of this heterogeneous group of patients, a wider and international serological study of BS should be undertaken, with particular emphasis on the vascular complications of the disease and antiphospholipid antibodies.

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Notes

Immunogenetics and rheumatoid arthritis

A two-day workshop on this subject will be held at The London Hospital on Thursday and Friday, 14 and 15 November 1985. Enquiries to: Administrative Officer, Postgraduate Teaching Centre, London Hospital Medical College, 47 Turner Street, London E1 2AD.

VIth Eular workshop on rheumatology research

The VIth Eular workshop will be held in Montpellier, France on 13–14 March 1986. The main topics will be: immunopathology of arthritides, immunomodulating drugs, Gougerot-Sjögren's syndrome, bone remodelling and its evaluation, pathology of cartilage, miscellaneous. Abstracts should be submitted before 31 December 1985. Correspondence to Professeur J Sany, Secretary of the VIe Eular Workshop on Rheumatology Research, Service d'Immuno-Rhumatologie et Réadaptation Fonctionnelle, Centre Gui-de-Chauliac, 34059 Montpellier Cedex, France.