Subungual splinter haemorrhages: A new sign of the antiphospholipid coagulopathy?

Sir: We recently reported two patients with valve lesions and transient ischaemic attacks, including amaurosis fugax, both of whom showed other features associated with the 'antiphospholipid syndrome'.1 One of these patients, in addition to claubbing, showed florid subungual splinter haemorrhages with nail fold telangiectasia.2 Treatment of culture negative infective endocarditis in addition to anticoagulation, nevertheless, resulted in clinical improvement.

A recent paper has drawn attention to the presence of subungual splinter haemorrhages in four patients with amaurosis fugax and antiphospholipid antibodies,3 and a similar patient with amaurosis fugax, who was also found to have aortic incompetence, was reported by Kleiner et al.4

We have recently encountered two further patients with splinter haemorrhages and antiphospholipid antibodies. The first also developed splinter haemorrhages in association with amaurosis fugax in the absence of valve lesions or vasculitis. The patient, a 43 year old white woman, suffered a right sided cerebral thrombosis in August 1988. This had been preceded by seven months of amaurosis fugax, which accompanied by subungual splinter haemorrhages. These episodes lasted for approximately 20 minutes at a time, and affected the vision of the left eye predominantly. After discharge from hospital she continued to have episodes of amaurosis fugax accompanied by splinter haemorrhages despite the administration of salicylates (aspirin 300 mg daily).

She had had one spontaneous abortion during the second trimester some 10 years previously. There was no family history of other thrombotic events, nor was she thrombocytopenic. She was referred to St Thomas's Hospital in November 1988 because of the development of telangiectases to cardiogalin. There was no evidence clinically of systemic lupus erythematous; she showed a positive test for antinuclear antibodies 1/160, but other antibodies, including those to double stranded DNA, and extractable nuclear antigens were absent. She has remained well on a combination of aspirin (300 mg daily) and anticoagulation with warfarin and has had no further episodes.

She was regarded as suffering from a 'primary' antiphospholipid syndrome.

The second patient, a 31 year old Israeli woman, had already been reported.4 She had developed a hepatic infarction in association with a lupus anticoagulant, the only such case reported to date. She stated that at the age of 22 years after only one tablet of oral contraceptive (Microgynon), subungual splinter haemorrhages developed in the nail area of the fingers and toes. About one month later the same preparation was again tried with a similar result. Nine years later on becoming pregnant, they again reappeared, lasted for one month, and then disappeared spontaneously. She subsequently aborted at 20 weeks. There was no valve lesion detectable.

In our first patient the splinter haemorrhages coincided with episodes of amaurosis fugax, as reported in the other patients. In the second, however, there was a clear relation with hormonal influences (oral contraceptives, pregnancy). In neither of these two was any valve lesion present.

Splinter haemorrhages in systemic lupus erythematous were first reported in 1966 by Fraga and Mintz2 and were the subject of a recent review by Young et al.6 Although larger vascular oculations are more commonly associated with antiphospholipid antibodies, smaller size vessels, such as the retinal7 or digital or pedal vasculature, with the resultant complications of infarctions and gangrene, have been reported.9 These lesions have been unassociated with vasculitis.

The presence of subungual splinter haemorrhages may similarly represent evidence of platelet thrombi in the smaller vessels to the nail bed in patients with the 'antiphospholipid syndrome'. A similar mechanism may be causing the transient ischaemic attacks. We wish to bring this to the attention of our readers and to emphasise the importance of careful examination of this group of patients in order to increase its detection.

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Iron chelation in rheumatoid arthritis: clinical and laboratory evaluation

SIR: Chronic inflammatory processes cause a significant change in iron metabolism with a drop in serum iron and an increase in iron to the activated reticuloendothelial system. In patients with rheumatoid arthritis (RA) iron accumulates in the synovial membrane, an extension of the reticuloendothelial system, and in synovial fluid.4 It has been suggested that iron may play an important part in acute and chronic phases of the arthritic inflammatory process.5 Iron may catalyse free radical reactions, leading to lipoperoxidation and membrane disruption.6 An abnormal accumulation of iron may promote an infiltration of lymphocytes and macrophages into the synovium of affected joints.7 Serum measurements of $\beta$ microglobulin, a low molecular weight protein (11 815 daltons) associated with the light chains of cellular membrane HLA antigens, have been significantly correlated with the clinical activity of RA and other rheumatic diseases.8 It seems to be a global marker of the number of lymphocytes implicated in the autoimmune processes and of the alteration in the various lymphocytes subsets.

We evaluated serum ferritin and $\beta$ microglobulin concentrations and other laboratory and clinical indices in patients with RA treated with desferrioxamine, a metal chelating agent with a very high affinity for iron,9 to assess the usefulness of iron chelation in reducing chronic inflammation.

Eighteen female patients, aged 23 to 64 years, with RA according to the 1987 revised American Rheumatism Association diagnostic criteria, were treated with desferrioxamine (0-5 g twice a day) by subcutaneous injections into the lower anterior abdominal wall for 14 days in the 1987 to 1988 period. All patients were receiving non-steroidal anti-inflammatory drugs (diclofenac 100 to 200 mg daily). Active disease was defined by the following criteria: morning stiffness of at least 30 minutes’ duration, six or more tender joints, three or more swollen joints, and an erythrocyte sedimentation rate of 50 mm 1st h. Eleven patients (group A) had two or three of the four preceding criteria and seven (group B) had all four criteria.

Haematological, biochemical, and immunological measurements and clinical indices were evaluated before the start of treatment, at the 14th day, and at the 28th day.

Serum concentrations of ferritin and $\beta$ microglobulin were determined by radioimmunoassays.

Statistical analysis was performed using Student’s t test. The table shows the laboratory and clinical results.

<table>
<thead>
<tr>
<th>Group</th>
<th>Patients had low or normal serum ferritin concentrations (range 10-4-76-5 μg/l) in contrast with group B patients who had high serum ferritin values (range from 119-7 to 1075-1 μg/l).</th>
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<tr>
<td>A</td>
<td>No significant differences in serum iron, transferrin, and binding capacity between the two groups at the beginning of the study, though serum iron was lower in group A and transferrin and iron binding capacity higher than in group B. Excessively decreased reticuloendothelial $\beta$ microglobulin were significantly higher in group B (p &lt; 0.05). There were no significant differences in morning stiffness, grip strength, and Ritchie index between groups A and B, though they were slightly worse in group B. A notable increase in IgG concentrations was seen in both groups at the 14th day and 28th day.</td>
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<tr>
<td>B</td>
<td>$\beta$ Microglobulin concentrations increased at the 14th day in both groups A and B (p &lt; 0.01), showed no variation at the 28th day in group A, but had decreased significantly by the 28th day in group B compared with the 14th day and with the initial value. At the end of the study significant improvements of morning stiffness, grip strength, and Ritchie index were seen in both groups of patients (p &lt; 0.01).</td>
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No statistical differences were noted in erythrocyte sedimentation rate, haemoglobin, serum iron, transferrin, iron binding capacity, and complement concentrations compared with the 14th day.

An ophthalmological examination was normal in all patients studied. Electro-ocular tests were not performed because of the short period of desferrioxamine administration.

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Desferrioxamine, a metal chelating agent with high affinity for iron, has been found to suppress tissue injury in animal models of inflammation. A few studies have been performed in humans, and these have given conflicting results. Giordano et al showed an improvement in clinical status and a significant increase of serum iron and haemoglobin with a marked progressive decrease of serum ferritin in patients with RA with hyposideremic anaemia in a short desferrioxamine treatment. 4 Federman et al by intramuscular administration of desferrioxamine noted predominantly systemic effects with decreased serum ferritin and decreased serum concentrations of lipid peroxidation products. There are no data on patients with RA with larger doses of desferrioxamine and found serious side effects consisting of loss of consciousness and of pigmentary retinopathy. 11 Pall et al observed ocular toxicity after a low dose of desferrioxamine. 12 Polton et al found no significant changes in rheumatological indices or in immunological markers of disease activity of patients with RA after 6 months. 13

Recent studies have shown that desferrioxamine affects lymphocyte function. It can inhibit proliferation of human lymphocytes, probably by blocking auto-oxidative processes and decreasing DNA synthesis. 14 It is found that desferrioxamine treatment impairs the expression of interleukin 2 binding receptors on lymphoid cells in response to mitogen and markedly reduces interleukin 2 production by mitogen stimulated cells. 15

In this study we noted a statistically significant improvement of clinical indices in the patients with RA at the 28th day. Patients had no side effects. A notable increase of serum ferritin and microglobulin concentrations was noted in all patients at the 14th day followed by a statistically significant decrease at the 28th day in patients with more active disease. This increase in ferritin microglobulin at the end of desferrioxamine administration (14th day) without a worsening in clinical indices has not been explained. It may be due to a polyclonal B lymphocyte response. In these patients determined by desferrioxamine displacement of iron or other metals. Polyclonal B lymphocyte activators are mitogens that non-specifically stimulate lymphocytes to secrete immunoglobulins, and both groups of patients had significantly increased concentrations of immunoglobulins after desferrioxamine treatment.

High serum ferritin concentrations seem to correlate with the severity of arthritic involvement. In this study patients with more active RA had higher serum ferritin concentrations than patients with less active disease. On the other hand, low serum ferritin concentrations may be connected with iron deficiency and in this study patients with RA and low serum ferritin concentrations had lower serum iron and higher transferrin and iron binding capacity than patients with higher serum ferritin.

In patients with severe active RA the association of raised concentrations of ferritin and microglobulin suggests that conspicuous iron deposits may play a part in the stimulation of lymphoid cells. Desferrioxamine seems to reduce lymphocyte activation and function, probably by inhibiting DNA synthesis and interleukin 2 action in these patients. In patients with less active RA and low or normal serum ferritin concentrations the desferrioxamine effects do not seem to influence lymphocyte activity.

Aspirin was added for pain relief when necessary. The course of their disease has been quite satisfactory with a minimum of discomfort and they have led a fairly active life. The treatment has not prevented the appearance of classical bone deformities, however.

During the past two years, four of our six patients, whose ages range from 60 to 83 years, developed skin lesions on hands and feet, which were diagnosed as warts. To confirm this diagnosis one patient was biopsied. The anatomical diagnosis was "hyperkeratotic seborrhoeic wart" (Professor La Chapelle, University of Louvain).

Hyperkeratotic warts are fairly common among old people. It is impossible to draw any conclusion from a group of six patients but we wonder if the high incidence of warts among our azathoprine treated patients is related to their treatment.