Drugs and the elderly

Sir: I was interested to read the article by Bird on drugs and the elderly. I agree that a substantial proportion of doctors will not understand pharmacokinetics. Unfortunately, their level of understanding will not be helped by some of the errors that have crept into this article.

For drugs which display first order kinetics the plasma half life and clearance are constant irrespective of the amount of drug available in the body for elimination. This is in contrast with a drug which displays zero order kinetics, where the clearance falls with increasing concentration as the elimination process becomes saturated. The definition of the volume of distribution of a drug is not, as stated in this paper, the amount of drug in the body available for elimination, but is the theoretical volume of fluid in which the drug is distributed if it existed in the same concentration elsewhere as it does in the plasma. This would be given by dividing the total amount of drug in the body by the plasma concentration. It is also incorrect to state that if the volume of distribution is reduced the peak plasma concentration will increase. This will be the case if the distribution process is rapid, but another major determinant of peak plasma concentration is the rate of absorption, and for a drug which is rapidly absorbed but slowly distributed, such as digoxin, volume of distribution will have a negligible effect on peak plasma concentration.

Finally, I find the term ‘accumulation’, as used here, confusing. Accumulation is not a phenomenon that depends upon the property of a drug, nor are there drugs which accumulate and drugs which do not accumulate. It depends upon the relation between the half life of the drug and the dosing interval and, by definition, accumulation occurs if the drug is given at a dosage interval of less than 1/2 half lives. This occurs in young patients, accumulation of piroxicam will occur and we are speaking about in elderly subjects is relatively greater accumulation. It must also be stated that accumulation is not, in itself, a bad thing but is in fact necessary to produce fairly stable plasma concentrations.

T PULLAR
Clinical Pharmacology and Rheumatology
Department of Medicine
General Infirmary
Leeds LS1 3EX


Cryptosporidial enteritis complicated by conjunctivitis

Sir: Shepherd et al recently reported two children with cryptosporidial enteritis complicated by reactive arthritis.1 A 13 year old girl with a past history of epilepsy, asthma, and hypothyroidism presented with a two week history of profuse watery diarrhoea, colicky lower abdominal pains, lethargy, nausea, vomiting, scattered arthralgic and myalgic pains. She also had conjunctivitis in both eyes. The child was admitted and stool examination showed oocysts of Cryptosporidia spp. No other pathogens were uncovered, and she eventually made a spontaneous recovery; her conjunctivitis settled.

Reiter’s syndrome may follow urethral infection or gastroenteritis, and the clinical features of the condition—namely, arthritis, conjunctivitis and urethritis, or gastroenteritis, are well known. Shepherd et al described two female paediatric cases (and referred to one adult male case described by others) where cryptosporidiosis was complicated by reactive arthritis; all these subjects were evidently immunocompetent. In addition, two potentially relevant cases positive for antibody to HIV have been described, one being a 27 year old homosexual man with diarrhoea, urethritis, conjunctivitis, arthritis, and cryptosporidiosis,2 and the other a 4 year old child (sex unknown) with cryptosporidiosis who developed conjunctivitis as part of a more profound systemic illness which was subsequently diagnosed as measles.3

Our patient had a long history and scattered arthralgic and myalgic pains associated with her gastroenteritic illness; accordingly, although the pathogenesis of cryptosporidial enteritis in immunocompetent subjects remains poorly understood, it is feasible that Reiter’s syndrome may represent a potential clinical consequence of the condition. It may be pertinent to note that unlike the almost total male exclusivity of Reiter’s syndrome associated with urethritis, among cases of Reiter’s syndrome associated with gastroenteritidis (of whatever underlying cause) a much larger proportion occur in women.4 In addition, the syndrome has been reported occurring in sexually inactive children.5

STEPHEN T GREEN
SHELDON SCOTT
JAMES McMENAMIN
DAVID J GOLDBERG
W CAMPBELL LOVE

Departments of Infection and Tropical Medicine and the Communicable Diseases (Scotland) Unit
Ruchill Hospital
Glasgow G20 9NB


LETTERS TO
THE EDITOR

Drug concentrations of endotelin1 in systemic lupus erythematous

Sir: Endothelin-1 is a newly described vasoconstricor peptide produced and secreted by vascular endothelial cells. It has potent and longlasting vasoconstrictive action and is involved in the pathogenesis of hypertension and vascular spasm.

High plasma concentrations of endothelin-1 have been reported in acute and chronic renal failure,6 in subarachnoid haemorrhage with vasospasm,7 and in myocardial infarction.8 9

Systemic lupus erythematous is commonly associated with nephritis, hypertension, peripher al vasculitis, and vasospastic diseases like Kawasaki disease and Raynaud’s phenomenon.

In this study we measured venous plasma concentrations of endothelin-1 in 28 young female patients with systemic lupus erythematous. All patients met at least four of the American Rheumatism Association’s criteria10 for systemic lupus erythematous and were randomly chosen from a cohort of patients with systemic lupus erythematous interviewed about their obstetric histories. Control subjects were healthy young, randomly selected female laboratory personnel. Plasma endothelin-1 concentrations were measured by a specific radioimmunoassay.9 The endothelin-1 antiserum used showed less than 0.1% cross reaction with big endothelin-1: 1–38 and its fragment 22–38, and fragment 171–201 of preproendothelin-1. It cross reacted 100% with endothelin-2 and -3. Plasma endothelin-1, when analysed by high performance liquid chromatography,8 10 and endothelin-1 in plasma, cerebrospinal fluid, and urine of patients, coeluted with synthetic endothelin-1. No other peaks of immunoreactivity were detected. The small amount of endothelin-1 in plasma did not allow testing for bioactivity. The findings in this study were not correlated with the clinical picture of systemic lupus erythematous. We also measured anti-cardiolipin antibodies by an enzyme linked immunosorvent assay (ELISA). Lupus nephritis was verified by biopsy in 13 of the 15 patients, who at some time of their disease had proteinuria of more than 0.5 g/day. The distribution of biopsy findings according to WHO classification was as follows: type II thrombocytopathy, type IV focal glomerulonephritis, and type V one patient. Biopsy was not done in two patients. Statistical analysis was by the χ2 method.

Plasma concentrations of endothelin-1 were raised in 23 of 28 patients with systemic lupus erythematous as compared with the normal range (mean 2 (SD)) in 66 healthy subjects (table). Raised plasma endothelin-1 concentrations correlated with severity of nephritis (p<0.05) but did not correlate significantly with hypertension, Raynaud’s phenomenon (present in 8/28 (29%) of patients), migraine (present in 6/28 (21%)), thrombocytic events, lower plasma creatinine, or clinically evident peripheral vasculitis. Nine patients (32%) had positive anti-cardiolipin antibodies and eight of them had increased endothelin-1. This distribution did
Mean (SD) plasma endothelin-1 concentration in 28 patients with systemic lupus erythematosus: correlating factors (results given as number of patients)

<table>
<thead>
<tr>
<th>Group</th>
<th>Endothelin-1 plasma concentration (pg/ml)</th>
<th>Nephritid</th>
<th>Raynaud's phenomenon</th>
<th>Anticardiolipin antibodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (n=28)</td>
<td>10.8 (5.0)***</td>
<td>15</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Normal endothelin-1 concentrations (n=5)</td>
<td>3.2 (2.0)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>High endothelin-1 concentrations (n=23)</td>
<td>12.4 (3.8)</td>
<td>14*</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Healthy subjects (n=66)</td>
<td>2.9 (1.2)</td>
<td>0</td>
<td>0</td>
<td>Not done</td>
</tr>
</tbody>
</table>

*p<0.05 vs patients with systemic lupus erythematosus with normal endothelin-1 concentrations; **p<0.001 vs healthy controls.

M, proteinuria >0.5 g/day during some period of the disease. Biopsy done in 13 patients (see text).

Plasma endothelin-1 concentration <5 pg/ml.

Plasma endothelin-1 concentration >5 pg/ml.

not reach statistical significance, but is interesting. Anticardiolipin antibodies are directed against platelets and endothelial cells and may contribute to endothelin-1 production.

The increase of plasma endothelin-1 in patients with systemic lupus erythematosus found in this study suggests that endothelin-1 may play a part in the pathophysiology of systemic lupus erythematosus. The association with nephritis is intriguing, but needs further evaluation.

HEIKKI JULKUNEN
OHTI SAIJONMAA
CAROLA GRÖNHAGEN-RISKA
ANNA-MAJA TEPPO
PREF PYHÖYRIST
Fourth Department of Medicine
Helsinki University Central Hospital
Uniohosmat 38
SF-00170 Helsinki, Finland


Myocplasmas and human arthritis

Sir: The recent recovery of Mycoplasma incognitus1,2 and mycoplasmas from HIV infected patients draws attention again to the possible role of mycoplasmas in human disease.

The veterinarians have long known that animal mycoplasmas are a cause of joint symptoms, which sometime develop into a chronic stage.1 At least 13 mycoplasma species have been implicated.

In man, also, Mycoplasma hominis,3-5 M. salivarium,6 M. pneumoniae,7-10 and Ureaplasma urealyticum11,12 have been found in the joint fluid specimens from patients, some of them with hypogammaglobulinaemia. In one case ciprofloxacin and doxycycline seemed to be equally effective in producing a clinical response.13

M. arthritidis strain Campo, previously called M. hominis type 2, was first isolated by Dienes in 1948 when he was studying urethral specimens from patients with polyarthritis.16 It was also found by Bartholomew in a synovial fluid specimen16 and by Brown et al in pleural effusion of rheumatoid arthritis.19 In Finland this same mycoplasma species was found in synovial fluid and tissue specimens of several arthritic patients, whereas control specimens from traumatic joint lesions were negative.20-22

In the polycrylamide gel electrophoresis performed in our laboratory we found that the isolated strain, earliest, 20-20, had a protein pattern similar to that of the M. arthritidis strain PG 6 and, especially, strain Campo.

The possibility that mycoplasmas are actiological triggers in human arthritis remains unresolved.

ELLJ JANSSON
KATI HAKKARAINEN
ARI MIETTINEN
KARI KAITALIA
MATTI KARPPEL
University of Tampere
Department of Biomedical Sciences
Post Box 607
33101 Tampere
Finland


Bartholomew L E. Characterization of mycoplasma strains and antibody studies from patients with rheumatoid arthritis. Ann NY Acad Sci 1967; 143: 522-34.


