MATTERS ARISING

Management of knee osteoarthritis

I read with great interest Dr Jawad's letter and the authors' reply about the EULAR recommendations for the management of knee osteoarthritis (OA).1

Although most points of criticism were answered by M Dougados and M Doherty it seems to me that treatment of knee OA with symptomatic slow acting drugs in osteoarthritis (SYSADOA) and cyclo-oxygenase-2 (COX-2) inhibitors needs to be discussed in a different light in the way of recent publications.

With respect to SYSADOA, the statement that these substances may modify structure seems to have been strengthened by the publication of Regnster et al, in which glucosamine sulphate (GS) treatment was proved to exert a significant decrease in joint space narrowing compared with placebo during a three year period, indicating the disease modifying effect of GS for the first time.2 Moreover, symptomatic efficacy was shown using the WOMAC index as an outcome measure.

As a number of studies dealing with possible disease modifying properties of hyaluronic acid are well known,3 and trials investigating the same issue for chondroitin sulphate (CS) are currently underway. Two meta-analyses4 as well as controlled trials have provided evidence for the symptomatic efficacy of GS and CS and proved their overall excellent tolerability, when compared with treatment with nonsteroidal anti-inflammatory drugs (NSAIDs).5

With respect to COX-2 inhibitors, to my knowledge no publication exists to show that these substances may modify structure of knee OA, however, at the time they were written seemed to summarise all the recommendations developed by the group of European experts.6

Most points of criticism were answered by Dr Jawad and to give further arguments for the accuracy of the recommendations developed by the group of European experts.7

Regarding the EULAR recommendations need to be revised in the near future.

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Author's reply

I thank Dr Leeb for his interest in my recent letter about the EULAR recommendations.1 The recent large, randomised, placebo-controlled, double-blind, long-term perspective trial had shown that glucosamine sulphate (GS) treatment resulted in significantly less medial joint space narrowing of the knee, in addition to significant improvement in pain and disability, which were sustained for the three year duration of the study. However, the general correlation between symptoms and structural changes was poor.8 The symptoms of patients with severe joint space narrowing receiving GS did improve, but this was not associated with slowing down of radiographic structure impairment. Further studies with longer follow up are needed to assess whether these changes are predictive of further clinical progression of osteoarthritis. The year 2000 meta-analysis of the six best designed trials of GS for osteoarthritis reported two possible limitations among the analysed studies. Firstly, only one study had adequately assured randomised allocation.9 The second limitation was that authors were often affiliated with the manufacturers of the product tested. Among the six studies analysed, the one associated with the highest quality score reported the smallest effect.10

A meta-analysis of seven randomised controlled trials of chondroitin sulphate (CS) in osteoarthritis had shown better pain relief with CS than with placebo at six months; however, no dose effect was noted (for example, 2000 and 800 mg/day were similarly effective).11 A large long term, double blind, randomised controlled trial is needed to confirm the symptomatic benefit of CS in osteoarthritis.

The main advantage of GS and CS is their safety, and they are certainly more safe than non-selective, non-steroidal anti-inflammatory drugs (NSAIDs), especially in their effect on the gastrointestinal tract.

With regards to COX-1 sparing NSAIDs, I agree with Dr Leeb, that there is no evidence for any important differences in efficacy between them and non-selective NSAIDs.12 Systematic reviews have also found no important differences in efficacy between different NSAIDs, but found differences in side effects related to increased doses of NSAIDs and the nature of the NSAID itself.13

The principal benefit of COX-1 sparing NSAIDs is that they produce analgesia and anti-inflammatory effects comparable with those of the non-selective NSAIDs but cause fewer symptomatic gastric and duodenal ulcers and fewer gastrointestinal symptoms.14 The EULAR recommendations need to be revised in the near future.

4 Noack W, Fischer M, Forster KK, Rovatic LC, Setnikar I. Glucosamine sulphate in osteoarthri-

LETTERS TO THE EDITOR

Fenofibrate: a new treatment for hyperuricaemia and gout?

Allopurinol is the most commonly used drug in the prevention of gout owing to its efficacy and good tolerability. However, some patients still experience hyperuricaemia or gout, or...
both, despite allopurinol treatment. Fenofibrate is an established treatment for many common lipid disorders and is unique amongst the fibric acid derivatives because of its ability to lower serum urate by increasing renal uric acid clearance. This urate lowering property has been demonstrated in healthy volunteers and in diabetic and non-diabetic patients with hyperlipidaemia. To date, no studies have specifically evaluated the urate-lowering effect of fenofibrate in patients with hyperuricaemia receiving established treatment with allopurinol. We report three cases in which micronised fenofibrate, a single dose formulation of the drug, was initiated in patients who had established gout and hyperuricaemia, with and without coexisting hyperlipidaemia. Two of these patients were already receiving established allopurinol treatment.

**PATIENT 1**
A 74 year old Chinese man had recurrent attacks of gout affecting the metatarsophalangeal joints every two to three months for the preceding three years. He had treated hyper- 

tension and polygenic hypercholesterolaemia and had been taking allopurinol 300 mg daily for three months, which produced a serum urate range between 0.40 and 0.44 mmol/l. The 24 hour urine uric acid clearance was 6.4 ml/min (reference range 6–11). Treatment was started with micronised fenofibrate 200 mg daily, and three weeks later his urate had fallen by 35% to 0.26 mmol/l, with the 24 hour uric acid clearance rising to 11.5 mmol/l (table 1). Alkaline phosphatase activity fell from 77 to 44 U/l, confirming compliance with the fibrate treatment. A temporary withdrawal of fenofibrate treatment for three weeks resulted in an increase in urate to 0.39 mmol/l. Fenofibrate was restarted and he continues to take it in combination with allopurinol. No acute attacks of gout have occurred since fenofibrate was started.

**PATIENT 2**
A 49 year old white man had recurrent episodes of gout affecting the metatarsophalangeal and knee joints despite having adhered to a low purine diet. His serum urate was 0.58 mmol/l, and when determined three weeks later it was 0.61 mmol/l with a corresponding 24 hour uric acid clearance of 8.0 ml/min. Micronised fenofibrate 200 mg daily was added to the allopurinol treatment and three weeks later the serum urate had been reduced by 39% to 0.37 mmol/l, with an associated doubling in uric acid clearance (table 1). Additionally, serum lipids were reduced, together with a reduction in alkaline phosphatase activity. Fenofibrate was temporarily discontinued and the serum urate returned to a higher level. It has been restarted and no further attacks of gout have occurred in 12 months of follow up.

**PATIENT 3**
A 43 year old white man was referred with recurrent episodes of acute gout affecting the ankle and toe interphalangeal joints every four to six weeks. There was no other medical history of note, but there was a family history of gout. During his most recent attack of gout, the serum urate was 0.35 mmol/l. When repeated after one month the urate was 0.48 mmol/l and 1.5 mmol/l respectively, and the uric acid clearance rose from 5.8 to 11.2 ml/min. Alkaline phosphatase activity fell from 82 to 72 U/l. He continues to receive micronised fenofibrate 200 mg daily, and further attacks of acute gout have not recurred over a six month follow up period. We have reported three cases of hyperuricaemia in association with recurrent episodes of gout, in which micronised fenofibrate was effective in further lowering serum urate and in reducing the frequency of gouty attacks. Importantly, two of these patients were already being treated with allopurinol. Total urate effect has been previously shown in patients with hyperlipidaemia treated with fenofibrate, but this report demonstrates its efficacy specifically in patients with hyperuricaemia. The reductions in urate shown in these three patients treated with fenofibrate were of similar magnitude to those seen in patients given the drug who had hyperlipidaemia with or without type 2 diabetes and who were not receiving allopurinol treatment. The doubling in uric acid clearance, which was reversed in two of the patients when fenofibrate was withdrawn, indicates a drug-specific renal effect. The particularly large reduction in serum urate in the second patient was perhaps a little surprising, but we are certain that this was largely a fenofibrate effect because a rise in uric acid clearance was seen, together with reductions in alkaline phosphatase activity and serum lipids. Furthermore, he denied any significant lifestyle changes during this period. Importantly, none of these patients has had any adverse effect, in particular a flare of gout, while taking fenofibrate. Only the second patient wished to take a prophylactic drug against this. Each was advised to increase their fluid intake at the time, though uric acid urolithiasis has not been reported previously with fenofibrate. There has been no evidence of an adverse interaction between allopurinol and fenofibrate in the first two patients, who both continue to take this combination. Although specific renal adverse reactions and interactions should be borne in mind when fenofibrate is prescribed for patients with hyperuricaemia, and measures taken to prevent them considered.

Severe urate is often raised in hyperlipidaemic patients, particularly those with hypertriglyceridaemia. The mechanism for the relationship is not clearly defined, though the association may arise associated with environmental and genetic risk factors shared by hyperuricaemia and hypertriglyceridaemia, such as obesity and excessive alcohol consumption, or through a primary metabolic defect. In contrast, hypertriglyceridaemia has been reported to occur in up to 60% of patients with gout. Hyperlipidaemia is common in the UK population and is a major risk factor for cardiovascular disease. The relationship between ischaemic heart disease and serum urate is controversial. It has recently been shown that hyperuricaemia may be an independent risk factor for ischaemic heart disease, though other studies have not supported this observation. A reduction in both hyperlipidaemia and serum urate might therefore be desirable in order to reduce cardiovascular risk. Fenofibrate may offer a useful dual effect in this respect, so potentially reducing the need for multiple drug treatments. This specific role for the drug is an important area in need of further study.

We have confirmed in our three cases that fenofibrate effectively lowers serum urate by a uricosuric effect. Expected reductions in lipids were also seen, suggesting a specific clinical role of this drug in the treatment of the common metabolic abnormality of coexisting hyperuricaemia and hyperlipidaemia. Further, it may be considered in combination with allopurinol in patients with hyperuricaemia who still experience gout despite a low urate in their serum urate. We would encourage further studies to be performed to evaluate the role of fenofibrate alone or in combination with allopurinol in the treatment of gout and hyperuricaemia. Gout remains a common problem in the community—fenofibrate appears to be a long awaited agent with great potential for use in this condition.

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Table 1

<table>
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<th></th>
<th>Allapourin (alone)</th>
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<td>Serum urate (mmol/l)</td>
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<td>Uric acid clearance (ml/min)</td>
<td>6.4</td>
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<td>Total cholesterol (mmol/l)</td>
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<tr>
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<td></td>
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<td>0.61</td>
<td>0.37</td>
<td>0.46</td>
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<tr>
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<td>16.4</td>
<td>9.0</td>
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<tr>
<td>Total cholesterol (mmol/l)</td>
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</tr>
<tr>
<td>Serum triglyceride (mmol/l)</td>
<td>2.3</td>
<td>2.1</td>
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Effect of leeches therapy (Hirudo medicinalis) in painful osteoarthritis of the knee: a pilot study

Leeches therapy was a mainstay in conventional treatment of pain and inflammatory diseases throughout antiquity until the 20th century. There is now renewed interest in leech therapy in the field of complementary medicine. Sales of the four principal German traders have increased continuously throughout the past few years and led to an estimated 70 000 treatments (330 000 leeches sold, year four to five for each single treatment) yearly in Germany (Roth M, unpublished data). The majority of these treatments aim at pain reduction in regional pain syndromes, mostly for knee osteoarthritis. 1 With the exception of its application in plastic surgery to maintain blood flow in congested skin flaps, 2 treatment with leeches has, however, never been evaluated in clinical studies. We, therefore, undertook a non-randomised controlled pilot study to assess the onset of action and the impact of leech therapy as an adjunctive treatment in knee osteoarthritis.

From inpatients whose main diagnosis was severe chronic knee back pain, we recruited over a period of three months 16 consecutive patients with primary knee osteoarthritis. All patients had persistent knee pain for more than six months and had definite radiographic signs of knee osteoarthritis without previous injury. Major exclusion criteria were treatment with anticoagulants, secondary osteoarthritis, substantial comorbidity, and intra-articular corticosteroids in the three preceding months. All patients had an in-hospital period of 14 days and received a health education programme, with focus on exercise, physiotherapy, relaxation techniques, and diet. Regular use of non-steroidal anti-inflammatory drugs was stopped during leeching which might explain the observed rapid treatment effect as remarkable; treatment with leeches reduced pain significantly after three days and up to four weeks. The efficacy and safety of this traditional treatment in knee osteoarthritis should therefore be tested in larger randomised controlled trials.

The study was supported by Karl and Veronika Carstens Foundation, Germany.

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Clinical features of several connective tissue diseases with anti-Golgi antibody

Rodriguez et al were the first to report autoantibodies directed against the Golgi complex identified in the serum of a patient with Sjögren’s syndrome (SS). Since then, several isolated reports have described the

Figure 1 Treatment with four leeches at typical periarthritis sites of the knee joint.

Table 1 Pain ratings (VAS, 0 = no pain, 10 = extremely painful) in patients with leech treatment and in controls; mean score and 95% confidence interval (x ± 1.96 SEM)

<table>
<thead>
<tr>
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<th>Baseline</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 10</th>
<th>Day 28</th>
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<td>Leeches (n=10)</td>
<td>7.4 (6.3 to 8.5)</td>
<td>7.2 (6.2 to 8.2)</td>
<td>4.1 (2.8 to 5.4)</td>
<td>2.4 (1.0 to 3.4)*</td>
<td>1.0 (0.5 to 2.8)*</td>
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<td>Controls (n=6)</td>
<td>6.3 (4.8 to 7.8)</td>
<td>5.8 (4.4 to 7.3)</td>
<td>5.2 (3.6 to 6.7)</td>
<td>5.2 (3.8 to 6.5)</td>
<td>4.8 (3.8 to 5.9)</td>
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</table>

Days 1–3: Pretreatment observation period. First rating after leeches treatment on day 4. Further ratings at days 6, 10, and 28.

*p<0.05 between group differences.
The presence of anti-Golgi antibodies (AGAs) in several connective tissue diseases (CTDs). In addition, immunoblotting and immunoprecipitation studies have suggested that there are at least 14 different Golgi complex autoantigens, and their molecular masses range from 35 to 260 kDa. However, few reports describe the association between the clinical features of CTDs and AGAs. In this letter, we present a case of rheumatoid arthritis (RA) associated with AGAs and review several reported cases.

The patient was a woman born in 1939 who developed seropositive RA in 1990. She was admitted to our hospital in March 1998 because of high grade fever, cough, sore throat, chest pain, and severe arthralgia. Systemic laboratory examination disclosed no antinuclear antibody, anti-DNA antibody, or anti-Jo-1 antibody. Anti-SS-A antibody was positive. Chest computed tomography showed interstitial pneumonia with fine reticular shadow and honeycomb in both lower lobes. Physical examination showed fine crackles in both lung fields. A laboratory examination showed raised C reactive protein (78 mg/l), serum aspartate aminotransferase (62 U/l), lactate dehydrogenase (527 U/l), IgA (5.6 g/l), and IgG (26.2 g/l). Mild interstitial lymphocytic infiltration was demonstrated in a muscle biopsy specimen. Therefore, a clinical diagnosis of RA, polyomysitis complicated with interstitial pneumonia was made, in addition to a suspicion of SS.

Indirect immunofluorescence stained by the patient’s serum (fig 1) showed crescent-shaped cytoplasmic organella that surrounded the nuclear membrane of Hep-2 cells, and these were considered to be Golgi apparatus. Linear-shaped cytoplasmic filaments were also seen and considered to be cytokeratins. Western blotting analysis against human liver cell line (HLE) showed that proteins of 58 kDa, 54 kDa, and 50 kDa were stained by the patient’s serum. The 58 and 50 kDa proteins were considered to be Golgi antigens, and the 54 kDa protein was considered to be cytokeratin 8. Table 1 outlines the clinical features of the 15 patients with AGA reported. The patients comprised 11 women, three men, and in one case the sex of the patient was not given. Western immunoblot analyses disclosed several antigens with molecular weights ranging from 50 to 230 kDa.

To date, several possible clinical correlations have been identified in patients with AGA. However, the clinical associations are different; in Blaschek’s report, the incidence of an association with SS was shown to be significantly higher than in patients with other CTDs, whereas Fritzler’s report suggested a strong association with systemic lupus erythematosus (SLE). Our present letter also showed that AGA was detected in patients with SS, SLE, and RA. As clinical features, our patient had mild liver dysfunction as indicated by raised liver enzymes and interstitial pneumonia. Fritzier et al have also reported that 5/8 patients with AGA had liver dysfunction. In addition, several patients had cardiopulmonary diseases, including pulmonary fibrosis as shown in our case. Because we have shown the existence of antigens in type II epithelial cells (AT549) as well as in hepatoma cell lines (HLE), it was speculated that the existence of AGA might be related to liver dysfunction and the onset of interstitial pneumonia. Furthermore, detection of AGA in a patient with RA might also have potential pathogenic implications, because the Golgi apparatus participates in terminal protein glycosylation whereas high levels of agalacto-siGal occurred in RA and correlate with disease activity.

In conclusion, our case and those of previous reports suggest that although antigens of AGA have diversity and heterogeneity, AGA might be pathogenically related to some clinical features of CTDs.

Table 1

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Age and sex</th>
<th>Background*</th>
<th>Rheumatoid factor</th>
<th>Antinuclear antibody</th>
<th>Arthritis</th>
<th>Cardiopulmonary†</th>
<th>Liver dysfunction</th>
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<td>Rodriguez 1982</td>
<td>56F</td>
<td>SS + lymphoma</td>
<td>ND</td>
<td>+</td>
<td>+</td>
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<td>+</td>
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<td>ND</td>
<td>+</td>
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<td>73F</td>
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<td>+</td>
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<td>Yang 2001</td>
<td>61F</td>
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<td>+</td>
<td>+</td>
<td>+</td>
<td>ND</td>
<td>8/13 (62%)</td>
<td>58, 50</td>
<td>This study</td>
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*SS = Sjögren’s syndrome; SLE = systemic lupus erythematosus; RA = rheumatoid arthritis; PM = polymyositis. †Cardiopulmonary parameters included pericarditis, pleuritis, and/or pulmonary fibrosis. §ND = not described.

Figure 1. Indirect immunofluorescence staining of anti-Golgi antibodies just outside the nuclear membrane of Hep-2 cells with the patient’s serum. Crescent-shaped cytoplasmic organella that surround the nuclear membrane of Hep-2 cells are clearly shown, and considered to be Golgi apparatus. Linear-shaped cytoplasmic filaments are also seen and considered to be cytokeratins.

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Serum procalcitonin measurement for detection of intercurrent infection in febrile patients with SLE

It is sometimes difficult to distinguish infection from disease flare in febrile patients with systemic lupus erythematosus (SLE). Chills, leukocytosis, and increased C reactive protein (CRP) are known to be markers favouring infection. Procalcitonin (PCT) is the precursor of calcitonin and is synthesized in the parafollicular C cells of the thyroid. Serum PCT increases in severe bacterial or fungal infection but does not increase, or increases only slightly, in viral infections. The purpose of this study was to evaluate the usefulness of serum PCT in febrile episodes of patients with SLE to distinguish infection from disease flare.

We prospectively enrolled 19 patients with SLE with fever who were admitted to Seoul National University Hospital between October 1998 and April 1999. Fever was defined as an axillary temperature over 38°C. Eleven patients with inactive SLE were enrolled as controls. Blood of the febrile lupus patients was withdrawn three times: on the day of the hospital visit, and after 24 hours and 48 hours. Another sample was withdrawn two weeks after defervescence to control infection or because of a decrease in lupus activity. At the time of fever, blood cultures and other necessary cultures were performed with complete blood count, Westernerg erythrocyte sedimentation rate (ESR), CRP, serum anti-dsDNA, complements (C3, C4), urine analysis, serum creatinine, and chest x ray examination.

The patients were divided into groups on the basis of viral infection, non-viral infection, and lupus flare. Lupus flare was defined by the Systemic Lupus Erythematosus Disease Activity Index (SLEDAI) as an increase of more than three points compared with the SLEDAI of the patient one month before the febrile period. Serum PCT was measured by an immunoluminometric assay (LUMTest, Brahms Diagnostika, Berlin). Twelve lupus patients were shown to have infection (nine non-viral, three viral infections) and seven patients had lupus flare. Non-viral infections consisted of urinary tract infection (n=3), sinusitus (n=1), tuberculiosis (n=1), scrub typhus (n=1), pseudomembranous colitis (n=1), aspergillosis (n=1), and nocardiosis (n=1). Viral infections were upper respiratory infection (n=2) and gastroenteritis (n=1). The white cell count was higher in the group with non-viral infection than in the group with lupus flare (p=0.015, table 1). Westernerg ESR increased in 89% of the groups with viral and non-viral infection and in all members of the group with lupus flare. There was no difference between the Westernerg ESRs of the groups with viral and non-viral infection and lupus flare during the early febrile period (p=0.32). CRP increased in 92% of the group with infection and 89% of the group with lupus flare. CRP tended to be higher in the group with non-viral infection than in the groups with viral infection or lupus flare, but this did not reach significance (p=0.98).

Serum PCT in the group with non-viral infection tended to increase continuously or rise gradually in the early febrile period (fig 1). Serum PCT levels in the early febrile period were significantly higher in the group with non-viral infection (mean (SD), 0.98 (0.12) ng/ml) than in the group with viral infection (0.13 (0.04) ng/ml, p<0.01), the group with lupus flare (0.24 (0.18) ng/ml, p<0.01), and the controls (0.12 (0.03) ng/ml, p<0.01). There was no statistical difference in the PCT levels of the groups with viral infection or lupus flare and the control group (p=0.12). After defervescence the serum PCT level was 0.21 (0.18), 0.13 (0.04), 0.14 (0.08) ng/ml in the group with non-viral infection, the group with viral infection, and the group with lupus flare, respectively. None of the values were significantly different from the control group (p=0.86, 0.49, 0.58, respectively).

New serological markers to distinguish lupus flare from infection have been investigated in an attempt to differentiate infection with lupus flare. Serum PCT is normally almost undetectable (<0.1 ng/ml) and not influenced by kidney function. Dandonila et al found that after injecting endotoxin intravenously, PCT increased suddenly at six hours and maintained a plateau for more than 24 hours. Recently, the stimulation of peripheral blood mononuclear cells with lipopolysaccharide was found to increase PCT mRNA transcription. PCT levels in autoimmune disease were first studied by Eberhard et al, who showed that the PCT increased in vasculitic patients with infection (1.93 (1.19) ng/ml) and decreased after control of the infection (0.63 (0.62) ng/ml). PCT did not increase in patients with Wegener’s granulomatosis upon disease aggravation but increased with combined infection.

Our study is the first to observe serum PCT changes in lupus patients with fever and defervescence prospectively. In our study lupus patients with bacterial or fungal infection had higher serum PCT levels than those with viral infections and a higher level than the controls. We tried to determine the serum PCT changes during the febrile period by measuring serum samples. Serum PCT in the group with non-viral infection tended to increase continuously or rise gradually in the early febrile period (fig 1). The PCT values varied among the non-viral group and serious infections, such as aspergillosis pneumonia, showed higher values than urinary infection or sinusitus (data not shown). The pitfalls of PCT as a marker for infection are that it may not increase or increase only slightly in viral infection. Our study showed that there was no difference between the serum PCT of the group with viral infection and the control group.

CRP is useful for detecting and differentiating infections in lupus. CRP rises earlier and is more sensitive than ESR. In this study, CRP tended to increase in the case of non-viral infection, compared with viral infection or lupus flare, but this did not reach statistical significance. Our results indicate that during the early febrile period, serum PCT increased significantly in patients with SLE with non-viral infection compared with patients with lupus flare. Serum PCT decreased after defervescence. These results suggest that serum PCT helps in detecting bacterial or fungal infections during the early febrile period in SLE.

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References


Effect of daily corticosteroid treatment on CRP response to hip or knee replacement in patients with RA

Serum C-reactive protein (CRP) is an acute phase reactant which may be continuously increased in patients with persistently active rheumatoid arthritis (RA), or raised only temporarily to a high concentration for a few days as a normal response to uncomplicated hip or knee replacement in patients with osteoarthritis or RA. CRP usually decreases in patients with RA when inflammatory activity is treated with daily low dose corticosteroid. This prompts the question whether the CRP response to hip or knee replacement is decreased in patients with RA taking a daily low dose of oral corticosteroid compared with those not taking corticosteroid. This is an important issue because CRP is used as an index to indicate postoperative complications. In this letter we compare the CRP response to hip or knee replacement in two groups of patients with RA: those taking and those not taking oral low dose corticosteroid.

Sixty patients (47 women, 13 men) fulfilling the American Rheumatism Association 1987 criteria for RA, treated at the Rheumatism Foundation Hospital, Heinola, in 1999, underwent hip or knee replacement. Fifty two patients were seropositive. The group receiving prednisolone comprised 44 patients, mean age 62 (SD 8.5) years. The prednisolone doses were as follows: four patients received <5 mg daily, 37 had 5–10 mg daily, and three had 12.5–30 mg daily. The patient group not receiving prednisolone comprised 16 patients, mean age 59 (13.4) years.

The CRP concentration was measured by the Randox, United Kingdom, immunoradiometric assay. The magnitude of the CRP response was measured by assessing the difference between measurements taken preoperatively and during the first one to two days postoperatively (the time of the peak CRP level) in both patient groups. The CRP responses in the respective groups were compared and statistically evaluated with the Mann-Whitney U test. In the group not receiving prednisolone the preoperative CRP level was 12 (interquartile range [IQR] 5–26) mg/l, and at day 1 or 2 postoperatively the median CRP had risen to 80 (IQR 53–112) mg/l. In the group in which patients were taking prednisolone the preoperative median was 14 (IQR 6–38) mg/l, the postoperative median 62 (IQR 41–100) mg/l. The difference in CRP response to the operation between the groups was not significant, p=0.15 (fig 1). None of the patients had bacterial infection or substantial haematomata after the operation.

The rise in CRP concentration in response to hip or knee replacement was slightly, but not significantly, smaller in patients with RA receiving than in those not receiving prednisolone. Increased CRP concentration was a normal phenomenon in the first few days after hip or knee replacement in these patients with RA and was not altered by low dose prednisolone treatment. This study affords no information as to the CRP response in the presence of postoperative complications, because no such case was encountered. However, we recommend further measures if the CRP concentration remains raised for several days postoperatively and does not decrease steadily.

Lumbar spondylodiscitis secondary to Enterobacter cloacae sepsicaemia after extracorporeal shock wave lithotripsy

Infections of the lumbar spine may affect either the intervertebral disc or the vertebral body. Most infections of the intervertebral disc occur as an extension of vertebral osteomyelitis or direct inoculations during diagnostic or surgical procedures, or as a result of iatrogenic tract infections and sepsicaemia. This paper reports a case of L5–S1 spondylodiscitis secondary to Enterobacter cloacae sepsicaemia after extracorporeal shock wave lithotripsy (ESWL).

A 52 year old man presented with side pain, pollakiuria, haematuria, and nocturia. He had been treated with ciprofloxacin for acute pyelonephritis and nephrolithiasis as an outpatient. One week later, the patient was admitted to hospital by the urology department with symptoms of left side pain, fever, chills, shaking, and dysuria. Right renal and right ureter distal lithiasis and right hydronephrosis due to the lithiasis were diagnosed. One week after ESWL the patient was sent to the physical medicine and rehabilitation clinic with chills, shaking, high fever, and low back pain complaints. Lumbar movements were found to be restricted. There was an increase in severe pain at rest. The patient could not stand or walk. No neurological deficit was present. Body temperature was 39°C, pulse 110 beats/min, blood pressure 130/70 mm Hg, breathing 20 breaths/min.

Laboratory findings were as follows: haemoglobin 133 g/l, packed cell volume 0.31, white blood cells 18×10⁹/l, platelets 316×10⁹/l, erythrocyte sedimentation rate 110 mm/1st h, antistreptolysin O 25 IU, C reactive protein 12.5 mg/l, rheumatoid factor negative. Lactate dehydrogenase was 145 U/l, creatinine 170 µmol/l. Glucose and electrolytes were normal and serum aspartate aminotransferase was 80 U/l, serum alanine aminotransferase 44 U/l, lactate dehydrogenase 321 U/l, total bilirubin 22 µmol/l, direct bilirubin 10 µmol/l. A considerable number of leucocytes and erythrocytes were noticed in urine microscopy. Enterobacter cloacae was isolated from blood and urine. The isolated pathogen was sensitive to ceftriaxone and amikacin.
Figure 1 shows magnetic resonance imaging (MRI) pictures obtained two weeks after the septicemia.

Amikacin (1500 mg/day) and indometacin (150 mg/day) were given, but amikacin was stopped because nephrotoxicity developed after seven days of treatment. Later, ceftriaxone 2 g twice a day was given for one week, and then stopped at 1 g/day for three months. The patient used a lumbosacral support.

The clinical and laboratory findings of the patient improved and pain was relieved after a two month rehabilitation programme. The control MRI findings obtained 27 months later showed degeneration of the L5-S1 intervertebral disc and adjacent vertebral corpus end plates. Grade 1 spondylolysis is the sequel to the infection. Lumbar spondylodiscitis has not recovered after two years’ follow up.

Staphylococcus aureus is reported as the major agent of spondylodiscitis. Streptococcus viridans, Streptococcus pyogenes, Salmonella spp, Enterococcus spp, Pseudomonas aeruginosa, and Brucella spp are other possible causative agents. In most cases, isolation of an agent is difficult. In a limited number of cases an agent may be isolated in biopsy materials or in blood.6

We found two reported cases of spondylodiscitis caused by Enterobacter cloacae.7 8 Generally, S. aureus is the causative agent. However, Salmonella enteritidis,9 Candida albicans, Streptococcus spp, and Enterococcus spp are rare isolated pathogens. In our case, acute pyelonephritis was diagnosed before spondylodiscitis. Furthermore, worsening of the symptoms after ESWL seems important. Haematoma, contusion, petechial haemorrhage, and spinal epidural space causing neuronal compression or irritation, or both. (C) Contrast enhanced mid-sagittal slice shows enhancement in the L5-S1 intervertebral disc, adjacent vertebral corpus medullary bone, and inflammatory soft tissue component.

Rheumatic pneumonia

Rheumatic pneumonia (RP) is a well described and poorly understood complication of acute rheumatic fever (ARF). It has been reported for more than a century and it has been traditionally associated with a high mortality rate. However, the existence and specificity of primary pulmonary lesions has remained controversial, because similar features may be seen in ARF with complicating congestive failure or uraemia.10 We report a case of RP that was successfully treated with steroids.

An 18 year old man was admitted to our hospital because of a 10 day history of fever, malaise, and dry cough. The patient had had ARF with carditis at age 7, which resolved without sequelae. A tonsillectomy was performed three years later. Since then, he had received a benzathine penicillin G injection monthly until three years before his actual admission. On admission, physical examination disclosed a temperature of 38.5°C, respiratory rate of 26/min, and rales were heard at the left lower lung. The rest of the examination was unremarkable.

Laboratory values were white blood cells 14.3x10⁹/l, with 80% neutrophils and 9% band cells, haemoglobin 132 g/l, and platelets 410x10⁹/l. The erythrocyte sedimentation rate was 90 mm/1st h. Urine analysis, coagulation studies, renal and hepatic function tests, and arterial blood gas value analysis during room air breathing were normal. A chest x-ray examination showed an ill-defined and non-homogeneous area of consolidation at the left lower lobe with a normal cardiac silhouette. As there was a clinical suspicion of pneumonia, acquired in the community, intravenous cefuroxime (750 mg three times a day) and oral roxithromycin (150 twice daily) were given.

On the fourth day after admission to hospital, fever and tachypnoea persisted. Consolidation of the air space in the posterior segment of the left lower lobe and pleural effusion were seen on chest x-ray examination and thoracic computed tomography (fig 1).

Thoracentesis yielded a serous fluid containing 1.2x10⁷ leucocytes/l, with 70% neutrophils, glucose 1.4 mmol/l, protein 27 g/l,
and lactate dehydrogenase 477 IU. Doppler echocardiography showed a posterior pericardial effusion without any other abnormality. Bronchoscopic examination showed inflammation in left lower bronchi. There were no neoplastic cells in bronchoalveolar lavage specimens. Repeated serological tests for Mycoplasma pneumoniae, Chlamydia pneumoniae, Legionella species, cytomegalovirus, and Epstein-Barr virus were negative. Tests for antineutrophil cytoplasmic antibodies, rheumatoid factor, and antinuclear antibodies were negative, and the serum level of angiotensin converting enzyme was normal.

On the 14th day after admission to hospital the patient developed arthritis at the left knee and the right wrist. Arthrocentesis showed a turbid fluid which contained 15,2×10^6 leucocytes/l and glucose 1.3 g/l; no crystals were seen. Titres of antistreptolysin O and C reactive protein were 400 Todd units (normal <200) and 1.20 g/l, respectively. Blood, sputum, pleural fluid, bronchoalveolar lavage, and joint effusion repeated cultures were negative, and no acid fast bacilli were seen. The antibiotic treatment was discontinued and acetylsalicylic acid (1.5 g four times a day) was started. A dramatic improvement in fever and arthritis occurred, though the radiological lesion remained unchanged. A histological lung specimen obtained by thoracoscopy showed inflammatory changes with thickness and fibrosis of alveolar septa, and nodular aggregates of mature lymphocytes. No micro-organism was seen or cultured in tissue specimens. Prednisone 60 mg daily was substituted for aspirin. The radiological lesion improved progressively, and antistreptolysin O and C reactive protein normalized. Concomitant treatment was tapered over two months without any further relapse, and prophyaxis with benzathine penicillin G monthly was resumed. In a 24 month follow up period the patient remained asymptomatic.

For unknown reasons, in the past decades there has been a decline in the incidence and severity of rheumatic fever in developed countries.1 Thus unusual complications, such as RP, are a challenging diagnosis for clinicians without experience of this illness.2 To the best of our knowledge, only six isolated case reports have been reported in English or Spanish over the past 20 years (table 1).5 Pulmonary disease may occur in both the first and recurrent attacks of ARF, either as part of the rheumatic process, or secondary to the cardiac lesion, congestive heart failure, uraemia or intercurrent infection.6 The incidence of pulmonary disease in ARF has greatly varied (2–60%) depending on the rigidity of the criteria used and the nature of the series.1 The clinical spectrum of RP varies from a mild to a fulminant course. Dyspnoea and non-productive cough are the most commonly reported symptoms.1 Multiple radiological patterns have been described, including consolidation, diffuse bilateral and migrating infiltrates, pleural effusion, and confluent nodular lesions.1 4 A pathological examination shows no unique lung lesions in ARF, and the most commonly reported pulmonary findings have been vascular haemorrhage, acute bronchopneumonia, organising fibrinous oedema, interstitial inflammatory exudates, inflammation and necrosis of septa, arteriolitis, and globular tufts of intra-alveolar fibrous tissue, so-called Masson bodies.8 It may be difficult to separate the contribution of the heart failure or uraemia to the RP by itself.9 10 Because of the lack of specific criteria, RP remains an exclusion diagnosis.11

Our patient satisfied the updated Jones criteria for the diagnosis of ARF.12 The absence of response to antimicrobial treatment, the histological findings, and the response to anti-inflammatory treatment favoured a diagnosis of RP. Despite the fact that salicylates have been advocated in the management of RP,8 13 steroids seem to be the most suitable treatment. None the less, deaths have occurred despite the use of this treatment.14

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Table 1 Summary of cases reports of rheumatic pneumonia over the past two decades

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age/sex</th>
<th>Previous ARF</th>
<th>Major criteria</th>
<th>Cardiac failure</th>
<th>Treatment</th>
<th>Outcome</th>
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Referrals to an “early synovitis clinic”: are they appropriate?

There is mounting evidence that early disease modifying treatment improves the outcome in patients with rheumatoid arthritis (RA)1 and that treatment should begin before the disease is established and irreversible damage has occurred.2 This evidence has led to the development of “early synovitis clinics” in many rheumatology units to fast track appropriate patients. Early referral for specialist advice has been shown to be associated with improved health and physical function, with the concept of early treatment of RA shortening observation periods before referral in general practice.3 A shortened observation time is important as Irvine et al showed that 73% of patients waiting more than one year from the onset of symptoms already had radiological evidence of erosive change.1

Despite the improved observation times, there are few published data showing whether referrals to early synovitis clinics are appropriate.4 We reviewed all referrals (n=156) to our early synovitis clinic at the Royal Victoria Hospital, Belfast, which was established in January 1999, to determine the proportion which were appropriate. Referrals were considered appropriate if they could be classified within a broad based category of inflammatory arthritis. We felt a broad based approach was necessary to identify patients with RA early in the disease course. Referral guidelines to the early synovitis clinic were circulated to all general practitioners in the catchment area of the hospital (population 600 000) every three months. The information was also communicated, in both medical press and by presentations at general practitioner meetings.

Fifty four per cent (n=84) of the 156 patients were classified as having inflammatory arthritis. Of these patients, 33 were diagnosed as RA and disease modifying treatment was started. The other diagnoses within the inflammatory arthritis group included psoriatic arthritis, reactive arthritis, ankylosing spondylitis, seronegative arthritis, systemic lupus erythematosus, primary Sjögren’s syndrome, and crystal arthritis. Despite the educational strategies outlined above, a large percentage of referrals were inappropriate. Forty six per cent (n=72) of patients did not have inflammatory arthritis. Of these patients, 35 had fibromyalgia, 28 had osteoarthritis, and nine had another diagnosis within the category of soft tissue rheumatism.

The median time from symptom onset to referral was eight weeks and the median time from arrival of the referral letter to attendance at the early arthritis clinic was four weeks. These results suggest that although the message about early referral appears to have been successful there were a large number of inappropriate referrals.
Factors contributing to inappropriate referrals include:
- The low priority of musculoskeletal disorders in undergraduate training, resulting in poor skills in recognising signs and symptoms of inflammatory arthritis.
- The opportunity for faster access to a specialty with long waiting lists.
- The broad based referral guidelines which were designed to obtain maximum sensitivity for patients with early RA.

To maximise valuable clinic time for patients with early RA and improve the proportion of appropriate referrals we suggest that increased emphasis should be given to the importance of recognition of inflammatory arthritis in undergraduate and postgraduate medical education. The exploration of new methods of triage in primary care groups by general practitioners with a special interest in rheumatology, or by specialist rheumatology nurses, may also help to improve referrals.

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Anti-dsDNA antibodies associated with acute EBV infection in Sjögren’s syndrome

The role of viral infection in the pathogenesis of autoimmune diseases is not clear. Some authors have suggested a role for herpes viruses and retroviruses in the pathogenesis of systemic rheumatic diseases, whereas others have produced evidence against this idea. In this report we present a case in which an association was found between Epstein-Barr virus (EBV) infection and anti-dsDNA antibodies in a patient with Sjögren’s syndrome.

A 28 year old woman was diagnosed with Sjögren’s syndrome. The clinical presentation included diffuse myalgias, tiredness, and intermittent respiratory complaints. Electrolytes showed polyclonal hypergammaglobulinaemia. Antinuclear antibody testing by indirect immunofluorescence on HEp-2 cells (Immunoconcepts, Sacramento, CA) showed a fine speckled nuclear pattern. The antibodies were identified as anti-Ro/SS-A antibodies by counterimmunoelectrophoresis. No anti-double stranded DNA (anti-dsDNA) antibodies were present (Cristible luicae assay; Immunoconcepts). Four years after the diagnosis of Sjögren’s syndrome, the patient had an acute EBV infection with persistent tiredness, icterus, and hepatosplenomegaly. The EBV infection was documented by positive heterophile antibodies and the presence of IgM (titre 1/32) and IgG (titre 1/256) antibodies to EBV viral capsid antigen. The antibodies to early antigens were negative (<1/8). The patient did not have IgM rheumatoid factor, which excluded the possibility of a false positive IgM-viral capsid antigen test induced by the presence of rheumatoid factor. Neither antiviral capsid anti-globulinaemia. Antinuclear antibody testing antibodies nor anti-early antigen antibodies had been found one year before the patient presented with the EBV infection. The Cristible luicae test was negative two months before the EBV infection. Three months and eight months after the acute infection, respectively, the Farr assay (Ortho Clinical Diagnostics, Amersham, UK) and the Cristible luicae assay disclosed anti-dsDNA antibodies. The patients showed no progressive disease and did not develop signs of systemic lupus erythematosus.

The association between EBV and anti-dsDNA antibodies in the case presented here indicates a possible role of the virus in the generation of anti-dsDNA antibodies. The formation of anti-dsDNA autoantibodies may result from the activation of specific B lymphocyte clones or from an imbalance in the regulation of the immune system due to EBV infection. This is consistent with the finding that EBV transformed B cells can produce IgG antibodies with specificity for dsDNA, and with the suggestion that EBV infection may be a causative factor in lupus.