

LETTERS

Successful treatment of severe rheumatoid vasculitis by infliximab

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Rheumatoid vasculitis (RV) is a severe complication of rheumatoid arthritis (RA), which like a primary necrotising vasculitis can affect any organ but characteristically presents with painful cutaneous ulcers and systemic inflammation.^{1,2} Usually patients with refractory RA are affected who, therefore, had already undergone extensive immunosuppressive treatment. The prognosis is poor and most patients die from infectious complications, cardiac failure, or cerebral insult.^{3–6} Cyclophosphamide (CYC) is the preferred treatment but is often not well tolerated and does not contain the synovitis.³ We report the cases of three patients with RV who could not sufficiently be treated by CYC and steroids but responded very well to infliximab infusion therapy.

CASE REPORTS

Case 1

A 48 year old male patient with longlasting RA was admitted because of general malaise, dyspnoea, oedema, pleural and pericardial effusions, increased creatinine and liver enzymes, leucocytopenia, thrombocytopenia, decreased C4 and CH₅₀ and increased levels of circulating immune complexes. The diagnosis of RV was established. The patient's condition did not sufficiently improve after treatment with steroid pulses, high dose CYC, or even plasmapheresis. He developed a life threatening heart failure caused by a "swinging heart" due to the pericardial effusion, which required immediate and repeated drainage (fig 1). As a last resort we decided to start



Figure 1 Case 1: chest computed tomographic scan showing the pericardial effusion due to RV.

infliximab treatment at 3 mg/kg. After the first infusion his condition improved rapidly and the pericardial effusion, in particular, disappeared within two weeks. All laboratory findings returned to normal. He continues to receive infliximab every eight weeks and is in good clinical condition. Even the activity of his RA, previously not sufficiently controlled by methotrexate alone, has decreased significantly.

Case 2

A 60 year old woman with a history of aggressive seropositive RA for 36 years suddenly developed painful ulcers on her left leg. The diagnosis of RV was established by biopsy from the ulcer rim. CYC bolus therapy was started and steroids also had to be increased. She responded partially to CYC, but the ulcers did not heal completely. Because of infections and leucopenia the dose and interval of the infusions often had to be adjusted. After 17 boli within 22 months the CYC therapy was stopped because of severe leucopenia. The lesions worsened after an ineffective trial of cyclosporin A (fig 2A). Infliximab was given at 3 mg/kg in weeks 0, 2, and 6 and thereafter every eight

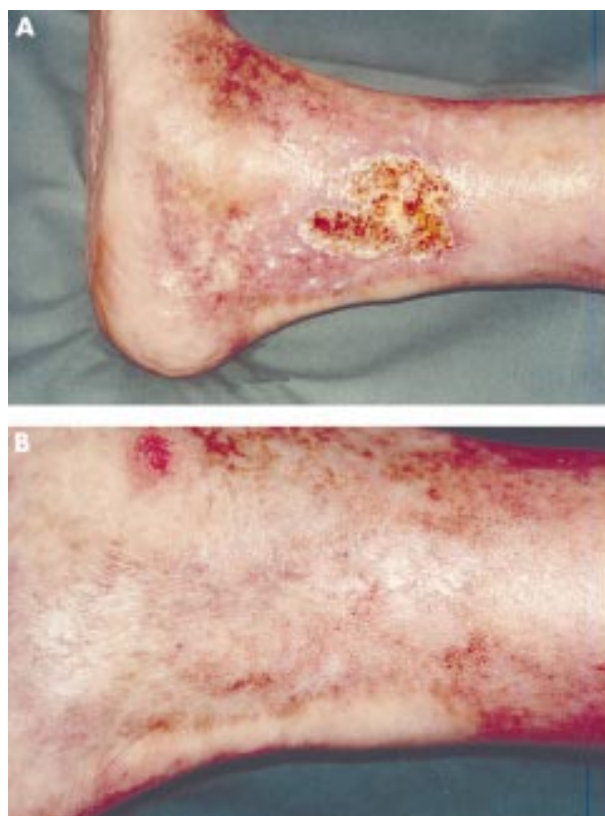


Figure 2 Case 2: leg ulcer before infliximab treatment was started (A) and the same lesion after seven infliximab infusions (B).

weeks. The ulcers improved soon after the second infusion and were completely healed after nine months (fig 2B). Her RA activity also improved greatly.

Case 3

A 64 year old male patient with RA was admitted to our hospital with a fistula between the colon and the urine bladder, which required immediate surgery because of imminent perforation. After surgery the wound did not heal. In addition, painful ulcers appeared on both legs, the scrotum, and other skin areas. All biopsies including that from the fistula, revealed necrotising vasculitis. CYC bolus therapy was started. The scrotal ulcer healed and the belly wound gradually improved, but the leg ulcers remained unchanged and his RA activity increased sharply. CYC had to be stopped because of leucopenia. Infliximab was started at 3 mg/kg at weeks 0, 2, and 6, and thereafter every eight weeks. The treatment was immediately effective for his synovitis and after a while the belly wound and the leg ulcers healed also.

CONCLUSION

These cases demonstrate a very rapid and sustained improvement not only of the vasculitic symptoms but also of the inflammatory joint activity, suggesting that infliximab may be a valuable alternative to standard CYC/steroid therapy for severe RV.

Low dose methotrexate osteopathy in a patient with polyarticular juvenile idiopathic arthritis

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Low dose methotrexate (MTX) is widely used in the treatment of rheumatoid arthritis (RA) and various rheumatic disorders, including juvenile idiopathic arthritis (JIA). MTX is a folate antagonist, and its main adverse effects, which include haematological and hepatic toxicities, are well known. Used in high dosages in paediatric oncology, MTX has been associated with an osteopathy which is characterised by bone pain, osteoporosis, and insufficiency fractures of the legs.¹ The occurrence of MTX osteopathy in patients treated with low dose MTX has been reported but is still debated.^{2–4}

CASE REPORT

A 36 year old woman presented with severe polyarthralgias lasting for the past two months. She had a 27 year history of polyarticular type JIA, and had received prednisone up to 10 mg/day for the past 25 years. She had no history of osteoporotic or insufficiency fractures. Physical examination showed multiple synovitis of hands, wrists, knees, and ankles. Laboratory investigations showed a slight increase of C reactive protein of 20 mg/l, and a strongly positive rheumatoid factor. Low dose oral MTX was started at an initial weekly dose of 7.5 mg (weight 56 kg, height 156 cm, albumin 42 g/l, serum creatinine 60 µmol/l).

In the absence of significant improvement, two months later, the weekly dose of MTX was increased to 10 mg. One month later, while she had a persistent active polyarthritis, and after having received a cumulative dose of 97.5 mg of MTX, she complained of sudden and spontaneous onset of

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right groin pain that was relieved by rest. Standard radiographs showed a fracture of both inferior and superior right pubic ramus. Serum calcium and 25-hydroxycholecalciferol levels were normal. Pain resolved with rest in a few weeks. Treatment with MTX was maintained.

Two months later, the patient presented with bilateral leg pain increased by weight bearing and relieved by rest. At that time, she received cumulative dose of MTX was 137.5 mg. Standard radiographs were normal but bone scanning with technetium-99m disclosed multiple areas of increased uptake (superior and inferior right pubic ramus, pubic symphysis, left hip, bilateral femoral condyles, right calcaneum) characteristic of multiple new insufficiency fractures (fig 1). MTX osteopathy was suspected and the treatment was discontinued.

DISCUSSION

MTX osteopathy was initially reported in children with acute leukaemia treated with a high dose of MTX.¹ Patients present with severe leg pain, osteopenia, and insufficiency fractures. Several reports have also suggested that the occurrence of spontaneous insufficiency fractures is more common than expected in patients with inflammatory rheumatism treated with low dose MTX.^{3–6} The effect of MTX on bone mineral density has been rarely studied. In patients with RA, low dose MTX treatment was not associated with increased bone loss in the lumbar spine or the femoral neck at three years.⁷ However, among the patients who were also receiving prednisone (≥5 mg/day), MTX use was associated with greater bone loss

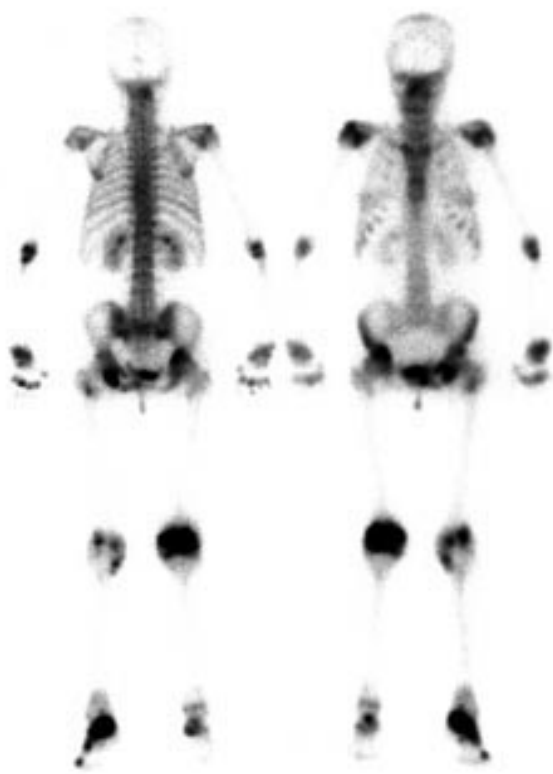


Figure 1 Technetium-99m bone scan (anterior and posterior views, late images) showing multiple zones of enhanced uptake in the superior and inferior right pubic ramus, pubic symphysis, left hip, bilateral femoral condyles, and right calcaneum.

in the lumbar spine, suggesting that the addition of MTX to prednisone may cause more bone loss than would be expected from corticosteroid treatment alone.⁷ Recently, Uehara *et al* have shown in vitro that MTX impairs bone formation by inhibiting the differentiation of osteoblast precursors.⁸

In patients with inflammatory arthritis receiving corticosteroids, MTX treatment should be considered as an additional risk factor for stress fractures. As far as we know this is the first reported case of MTX osteopathy in a patient with JIA. Rheumatologists should be aware of this complication as it may be easily confused with synovitis. Involvement of the leg articular or periarticular area should raise diagnostic clinical awareness. A bone scan is particularly useful for the diagnosis.³

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More on anticardiolipin and anti- β_2 glycoprotein I in systemic sclerosis

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Patients with systemic sclerosis (SSc) may have arterial and venous thrombosis and, according to the limited and controversial data available, may have an increased incidence of pregnancy losses.¹ These observations preceded the definition of antiphospholipid syndrome (APS) as the association of thrombosis and pregnancy loss with antiphospholipid antibodies (aPL), and did not focus on patients with SSc. However, the association of thrombosis and aPL, detected as lupus anticoagulant (LAC) and/or anticardiolipin antibodies (aCL), although rare, was described in SSc,² supporting the possible existence of a "secondary" APS in SSc.³

In view of the fact that most aCL are directed to β_2 glycoprotein I (a β_2 GPI),⁴ the possibility that patients with APS

may be negative for aCL, but positive for a β_2 GPI,⁵ and considering the scarcity of data examining this issue in SSc, we read with great interest the recent study by Schoenroth *et al*,⁶ who examined the frequency of a β_2 GPI in SSc. The authors found IgM a β_2 GPI in 2/26 (8%) patients and IgG in none. This finding did not seem to be related to any clinical or laboratory features. In another report, 80 patients with SSc were studied using an enzyme linked immunosorbent assay (ELISA) detecting the complex cardiolipin/ β_2 GPI. A similar prevalence of aCL/ β_2 GPI (10% IgG and 6% IgM), was found and a significant correlation between the presence of aCL/ β_2 GPI IgG and isolated pulmonary hypertension.⁷

Looking retrospectively at our cohort of 115 patients with SSc fulfilling the American College of Rheumatology criteria,

Table 1 Clinical and laboratory features of 18 patients with SSc aCL+ and/or a β_2 GPI+

Sex, age, subset of SSc	a β_2 GPI*		aCL*		Thromboses	Pregnancy loss	Other clinical and laboratory features	Antithrombotic treatment
	IgG (OD)	IgM (OD)	IgG (GPL)	IgM (MPL)				
F, 37, I	1.68	0.36	67	35	No	No	Overlap SLE, LAC-	Aspirin
F, 55, d	0.38	Neg	Neg	Neg	No	No		Aspirin
F, 57, I	Neg	2.11	Neg	Neg	DVT	2 Miscarriages	Livedo reticularis, LAC-	Warfarin
F, 61, I	Neg	0.84	Neg	Neg	No	No	PBC, LAC-	Aspirin
F, 54, I	Neg	0.66	Neg	Neg	No	1 Miscarriage, 1 intrauterine death		Aspirin
F, 64, I	Neg	0.58	Neg	Neg	No	No	LAC-	Aspirin
M, 65, I	Neg	0.53	13	Neg	Subclavian artery		Non-erosive arthritis, LAC-	Ticlopidine
F, 76, I	Neg	0.43	Neg	15	Recurrent DVT in leg	No		Aspirin
F, 59, I	Neg	0.42	Neg	15	No	No	Pulmonary hypertension	Warfarin + iloprost
F, 63, I	Neg	0.38	Neg	Neg	No	No	Superficial phlebitis	Aspirin
F, 78, I	Neg	0.35	Neg	Neg	No	No		Aspirin
F, 43, I	Neg	0.32	Neg	Neg	No	No		Aspirin
F, 59, I	Neg	0.31	Neg	Neg	No	No	Overlap PM/SLE, LAC-	Aspirin
F, 60, I	Neg	0.30	Neg	Neg	No	No		No
F, 65, I	Neg	Neg	30	Neg	Myocardial infarction	No	Pulmonary hypertension, encephalopathy, LAC+	Warfarin + iloprost
F, 37, d	Neg	Neg	18	Neg	Saphenous vein thrombosis	No	Overlap SLE	Aspirin
F, 54, I	Neg	Neg	20	Neg	No	No		Aspirin
F, 52, d	Neg	Neg	Neg	10.7	No	No		Aspirin

*Normal values: a β_2 GPI IgG <0.13, IgM <0.28; aCL IgG <10, IgM <10. SLE, systemic lupus erythematosus; LAC, lupus anticoagulant; DVT, deep vein thrombosis; PBC, primary biliary cirrhosis; PM, polymyositis.

we found that, where clinically indicated, both aCL and a β_2 GPI had been routinely evaluated in 60 patients (four male, 56 female; mean age 57 years; mean disease duration 13 years, range 1–42). These patients were classified, according to Le Roy (1988), as having limited (lSSc; n=48) or diffuse SSc (dSSc; n=12). Twenty seven patients were anticentromere positive and 16 anti-Scl-70+. Anticardiolipin antibodies were evaluated by a routine standardised method,⁸ and a β_2 GPI as described by Balestrieri *et al*;⁹ values higher than the 99th centile of 100 healthy blood donors were regarded as positive.

Positive tests for aCL were found in 8/60 (13%) patients and for a β_2 GPI in 14/60 (23%) (table 1). The prevalence of a β_2 GPI was higher than in previous studies, probably because we performed the test only where clinically indicated; therefore, the prevalence in patients with SSc overall may differ.

Among 60 patients, eight had a history of documented venous (four) or arterial (four) thromboses: two were aCL+ a β_2 GPI+, two aCL+ a β_2 GPI-, one aCL- a β_2 GPI+, and three aCL- a β_2 GPI-; aCL and anamnestic thrombosis were significantly related ($p < 0.01$; χ^2 with Yates's correction). Two patients had "primary" (that is, not secondary to lung fibrosis) pulmonary hypertension. One patient was aCL+ a β_2 GPI+, whereas the other one was aCL+ and LAC+, but a β_2 GPI-; aCL and pulmonary hypertension were significantly related ($p = 0.02$). According to the Sapporo criteria¹⁰ three patients had a significant history of pregnancy loss without thromboses: one was aCL- a β_2 GPI+, but two were aCL- a β_2 GPI-.

In our experience, the presence of aCL in patients with SSc was significantly associated with a history of thrombosis and with pulmonary hypertension. Anti- β_2 GPI seemed to be less specific, but allowed the identification of a woman with deep vein thrombosis, two miscarriages, and livedo reticularis. Although these events can be related to other thrombophilic conditions, none of these conditions was found in this patient. The association with a β_2 GPI suggests that she might be defined as having "aCL-, a β_2 GPI + APS" or "equivocal APS".⁵

In conclusion, in patients with SSc and APS related symptoms, the evaluation of a β_2 GPI can help to define the clinical picture and the specific treatment required.

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