Pachymeningitis is a rare illness which can be shown by magnetic resonance imaging (MRI) to be a thickening of the intracranial dura mater, when associated with an infectious, malignant, or rheumatic systemic disease.1–6 "Idiopathic hypertrophic cranial pachymeningitis" is also noticeable and is based on a process of chronic inflammation whose cause is unclear.2 Typical symptoms are chronic headaches, facial pain, cerebella ataxia, cranial nerve failure, neuro-ophthalmic complications, including papilloedema.

We report on a 64 year old woman who presented with monthly progressive cephalgia, subfebrile temperatures, loss of weight, Raynaud’s phenomenon, proximal myasthenia, arthritis, photosensitivity, and prickling paraesthesia. From this we diagnosed a mixed connective tissue disease, fulfilling at least three American College of Rheumatology (ACR) criteria, with a secondary vasculitis (pachymeningitis and polyneuropathy) and pulmonary disease (neutrophilic alveolitis).

A cerebral MRI scan showed initially and after 3 months clear thickening and enrichment of contrast dye in all meningeal structures (pachymeningitis), as well as widened ventricles I–III, with periventricular capping in the form of a
hydrocephalus (fig 1). Because of the hydrocephalus, it was neurologically advisable not to perform a cerebospinal fluid puncture. There was no indication of tuberculosis (chest x ray examination, tuberculin test, sputum culture) or any other infection. The neoplasia investigation was also negative. An anamnestic investigation showed that there was no need to use ibuprofen or sulindac.

When the situation became life threatening we initiated immunosuppressive treatment with cyclophosphamide (100 mg/day), as well as intravenous steroids (100 mg) initially. The initial intravenous cortisone treatment relieved the headache symptoms. Follow up examinations for up to 1 year (every 3 months) showed remission of clinical and MRI findings with this treatment (fig 2). Stable partial remission occurred after 8 months, and oral administration of cyclophosphamide was stopped. Treatment to preserve remission was changed to azathioprine (100 mg). The prednisone dose was finally reduced to 5 mg.

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A Bossink, S Thijsen, A J van Houte

**REFERENCES**


Superficial collections of fluid tophaceous material as clinical presentation of anorexia nervosa

C Garcia-Porrua, C Canedo, R Argueso, M A Gonzalez-Gay


A 38 year old female owner of a fashion shop presented at the rheumatology outpatient clinic because of intense pain and nodular lesions in her hands (fig 1A). She had a 1 year history of pain and multiple small intradermal deposits, with drainage of white chalky material. She had been initially considered to have an infection owing to the presence of a pyogenic pustule. Because of this, she had been treated with several courses of antibiotics (oral cloxacillin for 2 weeks and then oral amoxicillin plus clavulanic acid for another 2 weeks) draining a thick material, but not frank pus. At the outpatient clinic a needle aspiration obtained a thick white matter. Cultures were sterile and the material contained numerous monosodium urate crystals. She was diagnosed as having intradermal tophaceous gout.

Tophaceous gout is an unusual feature in a young woman.1,2 In these cases a careful search for secondary conditions needs to be carried out. Our patient had a 3 year history of intense fear of gaining weight or becoming fat, subjective disturbance in her body shape “feeling fat”, and 1 year before diagnosis she had amenorrhoea and constipation. She also admitted excessive ingestion of laxatives and diuretic abuse. At diagnosis her body fat was undetectable, and the bones protruded through the skin. Her height was 163 cm and her weight 55 kg (body mass index was 20.7). Our patient had a medical history consistent with anorexia nervosa.

Laboratory determinations disclosed anaemia (haemoglobin 99 mg/l), leucocytosis (17×10⁹/l), and 402×10⁹ platelets/l. A routine blood biochemistry profile yielded glucose 5.9 mmol/l, creatinine 90 µmol/l, urca nitrogen 16.0 mmol/l, sodium 138 mmol/l, potassium 2.2 mmol/l, and uric acid 456 µmol/l. The 24 hour urate clearance was clearly low (3.2 ml/min) and the 24 hour uric acid excretion was 1.6 mmol/day. Thyroid stimulating hormone and thyroxine (T4) levels were normal. Follicle stimulating hormone (14.8 U/l), luteinising hormone (8.2 U/l), and 17 β-estradiol (150 pmol/l) were within normal ranges. Purine enzyme studies, including hypoxanthine guanine phosphoribosyl transferase, adenine phosphoribosyl transferase, and phosphoribosyl pyrophosphate synthetase, were normal. Evaluation showed glucose-6-phosphatase deficiency was also normal. There was no history of exposure to lead. Treatment with allopurinol was started and 9 months later total resolution of the intradermal tophi was achieved (fig 1B).

A number of unusual cutaneous manifestations of chronic gout have been reported.3 As observed in our patient, deposition of urate crystals in the skin can take the form of intradermal, superficial collections of white tophaceous material resembling pus. Aspiration of the nodular collection demonstrating monosodium urate is the preferred technique to achieve a precise diagnosis.1,2,3

In cases such as our patient, once a diagnosis of chronic tophaceous gout is made, a secondary condition must be excluded.1,2,4 Premenopausal gout is commonly associated with obesity, renal insufficiency, and hypertension. However, Hayem et al report three cases of tophaceous gout affecting premenopausal women and the only precipitating factor was...
the overuse of furosemide. In their cases, the authors highlighted the importance of a careful search for hidden diuretic abuse. Uric acid is primarily excreted by the kidney, and certain drugs including diuretic agents can reduce the excretion of uric acid. No specific tests exist for a diagnosis of anorexia nervosa. Cultural issues, occupation, and body image are important factors in this condition. In our case a dysmorphophobia led to inadequate nutrition and an excessive consumption of diuretics. With this case we would like to emphasise that in Western countries, where culture and body image play an important role in eating disorders, the diagnosis of tophaceous gout in a young woman should require a psychological evaluation to exclude a medical history consistent with anorexia nervosa.

**A colour version of fig 1 can be found at http://www.annrheumdis.com/supplemental**

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Treatment of chronic plantar fasciitis with botulinum toxin A: an open case series with a 1 year follow up

R Placzek, G Deuretzbacher, F Buttgereit, A L Meiss

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Plantar fasciitis, a special type of a soft tissue rheumatic syndrome, is a common painful condition which often becomes chronic. Its aetiopathology is not completely understood. Being over weight and standing work are regarded as predisposing factors. Microtrauma, nerve entrapment (Baxter’s nerve), or limited ankle dorsiflexion are thought to be responsible. Most patients can be treated with physical therapy, local glucocorticoid injections, insoles, acupuncture, and extra-corporeal shock wave therapy. However, this treatment cannot improve the pain in all cases and can require a lot of time on the part of both patient and therapist. Surgery is controversial and should be restricted to patients who do not respond to conservative treatment.

It is not yet clear whether treatment of chronic plantar fasciitis with botulinum toxin A (Btx-A) works by causing muscle paresis or by analgesic/anti-inflammatory effects, or both. A combined effect may occur—namely, (a) induction of paresis of the muscles originating at the medial calcaneal process and (b) occurrence of direct analgesia owing to its anti-nociceptive and anti-inflammatory properties.

In this pilot study here the effect of a single injection of Btx-A was studied in an open case series.

Nine patients with chronic plantar fasciitis (five women, four men, mean (SD) age 55 (9.5) years) were treated with Btx-A. The average disease period was 14 months (range 2–10). Patients were selected according to the inclusion and exclusion criteria of an already planned multicentre study (table 1).

Btx-A (500 units; Dysport, IPSEN Pharma, Ettingen, Germany) was dissolved in 5.0 ml injection solution (0.9% saline), and 2.0 ml (200 units) were injected subfasically in four different directions through one injection puncture into the painful area at the origin of the plantar fascia. The procedure was always performed by the first author.

The following measurements were recorded at weeks 2, 6, 10, 14, 26, 39, and 52:

- Greatest pain during the past 48 hours using a visual analogue scale (VAS), 0–10
- Pain at rest during the past 48 hours using a VAS, 0–10
- Measurement of muscle force using Brunner’s method, scale 0–5, for
  - Extension and flexion of the great toe
  - Extension and flexion of the foot
  - Pronation and supination of the foot
- Pain progression stage using Gerbershagen’s score (Mainz Pain Staging System) at first visit (injection) and final examination (week 52).

Statistical analysis was performed using Wilcoxon’s test. Two weeks after injection a pronounced and statistically significant reduction of pain at rest during the past 48 hours was observed using a VAS (fig 1). The maximum pain during the past 48 hours was reduced to the same extent (p<0.015).

The recorded Mainz Pain Staging System (1–3) at injection and at week 52 showed a decrease from an average stage of 1.56 to 1.00. It is certainly not a specific tool for staging chronicity in plantar fasciitis, but we aimed at making a general statement on the course of the disease. Undesirable effects such as muscle weakness or systemic reactions were not seen. Our patients were satisfied not only by the pain
relief but also that only one injection was needed. The treatment is cost effective compared with repeated physical treatment, acupuncture, or extracorporeal shock wave therapy.

Our results thus suggest that a single injection of 200 units Btx-A (Dysport) may be a possible treatment for patients with chronic plantar fasciitis. This level IV study may yield the database for a power analysis of a double blind, placebo controlled multicentre study (in preparation).

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G Deuretzbacher, A L Meiss, University Hospital, Hamburg-Eppendorf, Germany

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### Table 1  Main inclusion and exclusion criteria of a planned multicentre study which were relevant for the selection of our nine patients

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written informed consent to participate in the study</td>
<td>Participation in a clinical trial within the past 3 months</td>
</tr>
<tr>
<td>Age: at least 18 years</td>
<td>Simultaneous participation in another clinical trial</td>
</tr>
<tr>
<td>Chronic plantar fasciitis (duration of the disease at least 4 months*)</td>
<td>Prior treatment with Btx-A (that is only de novo patients)</td>
</tr>
<tr>
<td>At least two unsuccessful conservative treatments</td>
<td>Surgical pretreatment in the affected area of the foot</td>
</tr>
<tr>
<td>At least four points on a VAS (0–10) for maximum pain during the past 48 hours</td>
<td>Known allergy or antibodies to Btx-A</td>
</tr>
<tr>
<td>On physical examination no evidence of other musculoskeletal diseases</td>
<td>Presence of a rheumatoid disease</td>
</tr>
<tr>
<td>Diagnostic imaging within the previous 6 months (plain radiography, CT, MRI)</td>
<td>Known muscle diseases or disturbance of neuromuscular transmission</td>
</tr>
<tr>
<td>No treatment with aminoglycoside antibiotics during the first 3 months of follow up</td>
<td>Treatment with caumarin or hereditary disturbance of coagulation</td>
</tr>
<tr>
<td></td>
<td>Pregnancy or lactation</td>
</tr>
<tr>
<td></td>
<td>Women of childbearing age without adequate contraceptive protection</td>
</tr>
<tr>
<td></td>
<td>Serious accompanying diseases, particularly of the heart, liver, kidneys, and systemic diseases</td>
</tr>
<tr>
<td></td>
<td>Abuse of alcohol or drugs</td>
</tr>
<tr>
<td></td>
<td>Concomitant prohibited drugs (particularly drugs for pain)</td>
</tr>
<tr>
<td></td>
<td>Concomitant prohibited treatment: local injections in the 2 weeks before and during the study</td>
</tr>
<tr>
<td></td>
<td>Depression (also ingestion of antidepressants)</td>
</tr>
<tr>
<td></td>
<td>Current inability to work having lasted for more than 3 months owing to plantar fasciitis</td>
</tr>
<tr>
<td></td>
<td>Current compensation claims because of plantar fasciitis</td>
</tr>
<tr>
<td></td>
<td>Current application for a pension or desire for a pension</td>
</tr>
</tbody>
</table>

*In one patient a duration of the disease of only 2 months was accepted.

VAS, visual analogue scale; CT, computed tomography; MRI, magnetic resonance imaging.

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![Figure 1](visual-analogue-scale-0-10.png)  

Figure 1  Pain at rest during the previous 48 hours on a VAS, 0–10. The significance level (p value) is shown in the table (top right).
Bilateral hydropneumothoraces in a patient with pulmonary rheumatoid nodules during treatment with methotrexate

N Steeghs, T W J Huizinga, H Dik

Extra-articular manifestations in rheumatoid arthritis (RA), in particular rheumatoid nodules, are common. The most common pulmonary manifestations are pleural abnormalities and interstitial lung disease. Nodules observed on a chest x-ray examination are a well-known diagnostic dilemma in patients with RA, given the differential diagnosis of malignancy and rheumatoid nodules. Spontaneous pneumothorax secondary to pulmonary rheumatoid nodules is an uncommon complication of RA. A 73 year old female patient was admitted for cough, fever, and dyspnoea. She had had seropositive RA for 15 years, and had a history of chronic bronchitis, heart failure, diabetes mellitus, and hypothyroidism. She had been treated for 1 year with prednisone 7.5 mg/day and methotrexate (MTX), for active arthritis. The MTX dose was raised to 12.5 mg/week a month before presentation.

On admission, the patient was dyspnoeic and had a temperature of 39.3°C. She had clinical features of a right sided pneumothorax and destructive joint disease. No evidence of active arthritis or subcutaneous rheumatoid nodules was seen. The erythrocyte sedimentation rate was 73 mm/1st h and the white blood cell count 20.3 x 10^9/L. A chest x-ray examination demonstrated a hydropneumothorax of the right lung.

Drainage by a chest tube produced chylous fluid and air leakage. Antibiotic treatment was started and the temperature normalised. Microbiological cultures and extensive examinations to locate an infection were all negative. A computed tomographic scan (CT scan) showed bilateral hydropneumothoraces with subpleural nodes and thickened pleura visceralis on the right side (fig 1). Ten days after admission the MTX was discontinued and steroid treatment was increased (30 mg/day) to control extra-articular disease (the nodulosis). The bilateral hydropneumothorax persisted. A week later a vigorous subcutaneous emphysema developed. A larger diameter chest tube was placed in the right pleural space. Continuing air leakage persisted. Thoracotomy was considered not to be an option in her condition. Ulcers and necrosis of the foot necessitated partial amputation of her right foot. Secondary infections occurred. Two months after admission the patient died.

Postmortem analysis showed bilateral hydropneumothoraces, with multiple subpleural nodules on both sides. The largest nodule, 2 cm, was located in the right lower lobe and had disrupted the pleura visceralis at that place.

The causes of pleural effusion are various, but combination with a pneumothorax narrows the differential diagnosis. In patients with RA who develop bilateral hydropneumothoraces, extra-articular disease (for example, rheumatoid nodules) should be considered as the cause.

Pleural effusions develop as an inflammatory response to the presence of subpleural nodules. Pneumothoraces occur as a result of cavitation of necrobiotic nodules that rupture to the pleural space, as in our patient, and are rare complications of RA. The incidence of pulmonary nodules is <1% on chest x-ray examination, and about 25% on high resolution CT scan. They are associated, in most cases, with longstanding seropositive RA, the male sex, and subcutaneous rheumatoid nodules.

Previous reports suggest that MTX might be involved in exacerbating extra-articular manifestations of RA. These
Seasonal pattern in the onset of polymyalgia rheumatica

F Perfetto, A Moggi-Pignone, A Becucci, F Cantini, M Di Natale, R Livi, A Tempestini, M Matucci-Cerinic

The aetiology of polymyalgia rheumatica (PMR) is unknown, but its sudden onset and the wide variation in incidence reported from various parts of the world suggest the existence of an environmental agent or genetic factors, or both.1–2 Interestingly, epidemiological studies showed a regular cyclical pattern of incidence of PMR,1–3 whereas others failed to confirm any seasonal trend.4–6

To evaluate the seasonal distribution in the onset of symptoms of PMR, this retrospective study considered 201 patients (mean age 72.6 years; 126 women, 75 men) with a diagnosis of PMR,7 seen by rheumatology units of the Prato (125 patients) and Florence Hospitals (76 patients), Italy, from January 1992 to December 2002. All patients were identified by searching hospital (74 patients) or ambulatory records (127 patients). In 21 patients, PMR was associated with giant cell arteritis (GCA).

Differences between seasonal incidence were assessed by the chi² test and by the single cosinor analysis. The parameters calculated with the cosinor procedure were the MESOR (the rhythm adjusted mean over the time period analysed), amplitude (half the distance between the absolute maximum and minimum of the fitted curve), and acrophase (peak time of rhythmic change). Significance was defined as p<0.05.

In 71 patients symptoms started in winter, 49 in spring, 33 in summer, and 48 in autumn. The chi² test showed that the frequency of onset of PMR was significantly (p<0.001) increased in winter for all the patients and also for subsets by sex (men, p<0.01; women, p<0.04) and age (age <75, p<0.001; age >75, p<0.01) and sex (p = 0.03) (table 1). No rhythm was detected in patients with PMR/GCA.

This study shows a significant winter periodicity in the onset of PMR. These results are in agreement with many previous reports1–3 but contrast with others4–6 that failed to demonstrate seasonality. Differences in the composition of the group (such as high proportion of patients with PMR/GCA), size of the group, geographical location (northern versus southern Europe), and statistical procedure may explain these discrepancies. Unlike this study, previous reports checked the statistical significance of the time effect on the onset of symptoms only by the chi² test. That test, however, only indicates whether the counts are different in a different season of the year without necessarily implying the presence of a circannual cycle, and it gives no information as to its timing. On the contrary, the cosinor method provides a better chronobiological analysis and yields rhythmic characteristics such as the MESOR, amplitude, and acrophase, each with its variance estimate.

Two potentially synergistic mechanisms may have a role in the seasonality of PMR. Firstly, the infectious-like onset of PMR suggests a precipitating environmental factor as one of the causes, and a close temporal relationship between epidemics of Mycoplasma pneumoniae, Chlamydia pneumoniae, and parvovirus B19 and peaks of cases of PMR/GCA has been reported.1,2 However, reports of material with an infectious origin in temporal arteries have not been corroborated,3,9 and Peris found no relationship between the onset of PMR and parvovirus B19 infection.4 Secondly, some authors have reported seasonal variation of the immune system and inflammatory responsiveness.6 These seasonal changes, when associated with several unknown infectious agents, may
FDG-PET/CT scan of inflammatory spondylodiscitis lesions in ankylosing spondylitis, and short term evolution during anti-tumour necrosis factor treatment

D Wendling, O Blagosklonov, G Streit, G Lehuédé, E Toussirot, J-C Cardot


Table 1 Characteristics of the patients

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Patient No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>47</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
</tr>
<tr>
<td>AS duration (years)</td>
<td>16</td>
</tr>
<tr>
<td>HLA- B27</td>
<td>+</td>
</tr>
<tr>
<td>Localisation</td>
<td>L3-4</td>
</tr>
<tr>
<td>Biopsy</td>
<td>ND</td>
</tr>
<tr>
<td>Anti-TNF treatment</td>
<td>Infliximab</td>
</tr>
</tbody>
</table>

Positron emission tomography/computed tomography (PET/CT scan) represents a new molecular imaging modality using physiological tracers to assess a lesion’s metabolic state. [18F]Fluorodeoxyglucose (FDG) PET appears to be very good for the evaluation of cancer lesions and potentially useful in inflammatory rheumatic disorders, but there is scant information in ankylosing spondylitis (AS).

We evaluated an FDG-PET/CT scan (4 MBq/kg FDG injection, whole body acquisition using a Siemens Biograph Duo device, volumic fixation values are expressed as standardised uptake values (SUVs), in patients with AS (revised New York criteria) with magnetic resonance imaging (MRI) documented lumbar aseptic spondylodiscitis (disco-vertebral biopsy in two patients) requiring anti-tumour necrosis factor (TNF) treatment. A second PET evaluation
was performed at the time of the anti-TNF response assessment, between 6 and 8 weeks of treatment, in parallel with a second MRI examination, and clinical evaluation.

Short time (6–8 weeks) clinical outcome (tables 1 and 2) showed a good response in patient 2 (50% improvement in all measures), no response in patient 3 (fig 1), and incomplete response in patient 1 (20% improvement in C reactive protein (CRP), pain, metrology).

MRI evolution, without quantification, showed reduction of T2 weighted hypersignal and reduction of gadolinium enhancement for patients 1 and 2, and absence of modification for patient 3 (without clinical improvement).

FDG-PET/CT imaging showed a reduction of FDG uptake on the spondylodiscitis in all three patients. This reduction was significant in patient 1 (incomplete clinical response), borderline in patient 2 with good clinical response, and not significant in patient 3 (no clinical response). In patient 2, global FDG uptake heterogeneity in the lumbar spine made measurement difficult (very different measurement volumes between the two evaluations).

Aseptic spondylodiscitis is a classic feature in AS. An FDG-PET/CT scan may be used to explore several inflammatory disorders: vasculitis, rheumatoid arthritis, peripheral arthritis or psoriatic arthritis, with a good correlation between disease activity and mean SUV.

In our three cases, FDG uptake was evident at the site of discitis, with mean SUVs ranging from 1.8 to 2.6 and reduction after anti-TNF treatment. This reduced uptake may be due to an impairment of local inflammation, or to a cellular effect of the anti-TNF agent on bone marrow. We did not observe a correlation between reduction in FDG uptake and clinical and MRI evolution in these three cases. Nevertheless, the small number of patients does not allow a firm conclusion to be reached. The localisation of uptake, in the disc or the vertebral plate, should be taken into account and may interfere with the target volume and evaluation of the region of interest, especially when uptake is moderate and diffuse, as in our second case. This may be a limitation of this imaging technique in AS when the various pathophysiological

### Table 2: Evaluation of several variables before, during, and after treatment

<table>
<thead>
<tr>
<th>Variables</th>
<th>Time of valuation (week)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>ESR (mm/1st h)</td>
<td>79</td>
</tr>
<tr>
<td>CRP (mg/l)</td>
<td>33</td>
</tr>
<tr>
<td>BASDAI (0–10)</td>
<td>6.8</td>
</tr>
<tr>
<td>BASFI (0–10)</td>
<td>9.1</td>
</tr>
<tr>
<td>BAS-G (0–10)</td>
<td>9.6</td>
</tr>
<tr>
<td>Pain (0–10)</td>
<td>9.3</td>
</tr>
<tr>
<td>FFD (cm)</td>
<td>62</td>
</tr>
<tr>
<td>Schober (cm)</td>
<td>1</td>
</tr>
<tr>
<td>CE (cm)</td>
<td>2.5</td>
</tr>
<tr>
<td>OWd (cm)</td>
<td>6</td>
</tr>
<tr>
<td>SUV max</td>
<td>4.08</td>
</tr>
<tr>
<td>SUV min</td>
<td>2.05</td>
</tr>
<tr>
<td>SUV mean</td>
<td>2.61</td>
</tr>
<tr>
<td>SD</td>
<td>0.41</td>
</tr>
<tr>
<td>Volume (cm³)</td>
<td>10.81</td>
</tr>
</tbody>
</table>

ESR, erythrocyte sedimentation rate; CRP, C reactive protein; BASDAI, Bath Ankylosing Spondylitis Disease Activity Index; BASFI, Bath Ankylosing Spondylitis Functional Index; BAS-G, Bath Ankylosing Spondylitis Global; FFD, finger to floor distance; CE, chest expansion; OWd, occiput to wall distance; SUV, standardised uptake value.
mechanisms leading to aseptic discitis in AS are taken into account.1 In infectious spondylodiscitis, this technique proved its usefulness in topographic and differential diagnosis.2,3 Schmitz et al reported 12 cases of biopsy proven infectious spondylitis, with an initial mean (SD) SUV of 7.5 (3.8), and significant reduction after an 8 week treatment (mean SUV 1.75).4

This preliminary study underlines the potential interests and limitations of an FDG-PET/CT scan in AS.

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Accepted 1 May 2005

References

Healing of psoriatic skin lesions, and improvement of psoriatic arthritis resistant to immunosuppressive drugs, after infliximab treatment

S N Nikas, P V Voulgari, I P Takalou, P Katsimbri, A A Drosos

During recent years, much has been learnt about the immunopathology of psoriasis and psoriatic arthritis (PsA). There has been increasing evidence that proinflammatory cytokines, in particular tumour necrosis factor α (TNFα), may play a central part in potentiating the inflammatory process. Both CD4+ and CD8+ T cells are found in psoriatic lesions.1 Thus most of the treatments for psoriasis and PsA are immunosuppressive.2 However, there are several patients refractory to treatment in whom blockade of TNFα by anti-TNFα inhibitors may be useful.3

Five patients (three male, two female; mean (SD) age 41.0 (3.3) years) with longstanding disease (7.9 (3.7) years) refractory to immunosuppressive drugs and corticosteroids were studied. Although some clinical improvement was seen in their musculoskeletal complaints, psoriasis was poorly controlled, requiring frequent inpatient admissions to hospital.

Patients were treated with intravenous infliximab (5 mg/ kg, infusion time >2 hours), in a loading dose of 0, 2, 6, and 8 weeks thereafter for a period of 12 months. Patients were fully informed about the treatment and signed an informed consent. The area of skin affected was evaluated by the Psoriasis Area and Severity Index (PASI) score,4 while joint involvement was assessed by the Psoriatic Arthritis Responder Criteria (PsARC).5 The laboratory evaluation included C reactive protein (CRP; mg/l) and erythrocyte sedimentation rate (ESR; mm/1st h). All patients continued to receive the same doses of methotrexate (MTX) and ciclosporin A (CSA) during the study period, while the dose of steroids was tapered according to the patient’s response.

Of the five patients, three patients had sacroiliitis (two unilateral and one bilateral, stage III) and asymmetric oligoarthritis; one patient had polyarticular symmetric joint disease; and the other had polyarticular asymmetric joint disease. All patients had extensive plaque psoriasis with erythroderma, in two cases affecting 65–90% of the body surface area. The clinical response was rapid; after the third infliximab infusion about 90% of the skin lesions improved in all patients, and after the sixth infusion all patients had complete clinical remission and the skin was clear and healed (fig 1). A significant reduction of the PASI score and improvement of PsARC were noted, which were maintained throughout the study. This clinical improvement was associated with the reduction in the acute phase reactants (table 1). The drug was well tolerated, all patients completed the study and only a few patients had mild adverse events. After the third infusion two patients developed a sore throat, while another developed a urinary tract infection after the sixth infusion. In addition, one patient developed a mild allergic reaction after the third infusion. All patients completed the study and the adverse events resolved without sequelae.

Our observation confirms the results reported by others,6,7 who demonstrated a significant improvement in treating patients with PsA with infliximab. Their studies investigated primarily the articular component of the disease and to a lesser extent the cutaneous manifestations. As far as we
know, our study is the first that shows complete healing of the cutaneous lesions in patients with widespread recalcitrant psoriasis. A significant improvement in the articular component was also noted. Another point to take into consideration is that in our study we used infliximab in combination with MTX, CSA, and steroids. The above combination was demonstrated to be efficacious and safe in treating patients with rheumatoid arthritis and may avoid the formation of human antichimeric antibodies responsible for infliximab inefficacy and adverse drug reactions. Finally, the absence of serious adverse events might also be attributed to the small number of patients investigated in this study.

The findings of the present open label study provide evidence that multiple infusions of infliximab are effective and safe in clearing recalcitrant widespread psoriasis. Further larger studies are required to confirm our results.

**Table 1 Clinical and laboratory changes during infliximab treatment**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Week 0</th>
<th>Week 6</th>
<th>Week 24</th>
<th>Week 52</th>
<th>p Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tender joints score</td>
<td>6.4 (4.0)</td>
<td>1.6 (1.5)</td>
<td>1.8 (1.8)</td>
<td>1.4 (1.8)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Swollen joints score</td>
<td>2.6 (1.6)</td>
<td>0.2 (0.4)</td>
<td>0.2 (0.4)</td>
<td>0.2 (0.4)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Patient self assessment</td>
<td>6.9 (2.2)</td>
<td>2.5 (2.6)</td>
<td>2.4 (1.1)</td>
<td>2.1 (1.1)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Physician self assessment</td>
<td>6.7 (2.3)</td>
<td>2.4 (1.4)</td>
<td>2.4 (1.2)</td>
<td>2.5 (1.4)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>PASI score</td>
<td>51.2 (14.0)</td>
<td>10.0 (1.7)</td>
<td>0.8 (0.5)</td>
<td>0.8 (0.5)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>CRP (mg/l)</td>
<td>18.4 (16.7)</td>
<td>2.6 (5.8)</td>
<td>3.0 (3.3)</td>
<td>1.6 (2.2)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>ESR (mm/1st h)</td>
<td>42.4 (18.0)</td>
<td>16.2 (12.5)</td>
<td>14.2 (8.8)</td>
<td>12.8 (7.7)</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Results are shown as mean (SD).

*Wilcoxon test for pairs, comparison between week 0 and week 52.

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Accepted 11 April 2005

**REFERENCES**

Tumour necrosis factor α (TNFα) is known to affect gonadal cell viability and function by several pathways: inhibiting germ cell apoptosis;1 promoting Sertoli cell androgen receptor expression and activity;2 and inhibiting Leydig testicular cell steroidogenesis at the transcriptional level.3 Recently, infliximab (that is, chimeric monoclonal anti-TNFα antibody) has been shown to block the survival promoting effect of TNFα on seminiferous epithelium in vitro.4 These data prompted us to search for any alteration in gonadal function or spermatogenesis, or both, in patients undergoing anti-TNFα treatment.

At present, we have investigated three male patients (median age 40 years, range 35–51), all with ankylosing spondylitis (median disease duration 14 years, range 12–22), according to modified New York criteria,5 and treated with infliximab only (5 mg/kg/6 weeks, after the induction period).6 Effectively and safety of infliximab monotherapy for plaque type psoriasis: a randomized trial.7

Further studies are needed to confirm or refute the effect of TNFα on spermatogenesis. It would be useful to know of such an effect when planning anti-TNFα treatment in male patients.

**REFERENCES**


