the treatment of rheumatoid arthritis [4, 5]. There is preliminary evidence to support its use in several other inflammatory diseases [6–8] but there are no published reports of anti-TNFα treatment for dermatomyositis although cases have been presented in abstract form [9]. In this patient, treatment with infliximab has been temporally associated with a general deterioration in her clinical condition characterized by sepsis and subsequently development of non-Hodgkin’s lymphoma.

The management of refractory dermatomyositis is difficult and a high index of suspicion for malignancy must be maintained. Epidemiological evidence shows an association between dermatomyositis and malignancy, including non-Hodgkin’s lymphoma [10]. Immunosuppressive therapy is also known to increase the risk of developing malignancy [11]. There have been concerns regarding the potential development of malignancy following TNFα blockade. However, given the time-course in this patient, non-Hodgkin’s lymphoma seems more likely to be a consequence of dermatomyositis or immunosuppression but may have been unmasked by infliximab. This raises issues concerning giving infliximab to patients who have a syndrome with a recognized paraneoplastic association.

Treatment with infliximab did not produce an improvement in this patient’s skin disease. There is evidence that intravenous immunoglobulin may be useful in the treatment of refractory dermatomyositis, although cases have been presented in abstract form [9]. In this patient, treatment with infliximab has been temporally associated with a general deterioration in her clinical condition characterized by sepsis and subsequently development of non-Hodgkin’s lymphoma.

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Treatment with infliximab did not produce an improvement in this patient’s skin disease. There is evidence that intravenous immunoglobulin may be useful in the treatment of refractory dermatomyositis [2] which this case supports. Infliximab was used prior to intravenous immunoglobulin in this case because of recent safety concerns regarding the potential for transmission of Creutzfeldt–Jakob disease and subsequent reduction in the availability of immunoglobulins.

We suggest that whilst evidence exists supporting anti-TNFα therapy in certain rheumatic diseases, caution should be exercised when considering infliximab for the treatment of dermatomyositis. Further evaluation of its use in dermatomyositis is required.

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pathogenetic mechanisms in PsA and we aimed to ascertain the prevalence of positive EmA in a group of patients with PsA.

Ethical approval was obtained from the Central Oxford Research Ethics Committee. We invited 149 patients with PsA from the rheumatology clinics in Oxford to attend a special interest clinic for PsA. Patients were considered to have PsA if they had a seronegative inflammatory arthritis and psoriasis. Patients were excluded if their rheumatoid factor titre was >1:160 or if they had reactive arthritis with a clear infective trigger.

EmA were detected by direct immunofluorescence, as described in detail elsewhere [2]. Serum IgA was also determined to identify cases of IgA deficiency.

A total of 107 patients were finally recruited to the PsA special interest clinic between December 1998 and September 2000; eight did not respond to the letter, 17 did not attend their appointment, 11 declined, and six had other reasons for not taking part. Of the 107 participants, four attended prior to EmA being tested in our study, two were excluded as their diagnosis was not PsA (rheumatoid and reactive arthritis, respectively), one had never had psoriasis and was therefore excluded, one did not consent to venepuncture, and three blood samples did not arrive at the laboratory. Therefore 96 samples [51 males and 45 females aged between 19 and 71 yr (mean age 45.9 yr)] were collected for EmA analysis.

Endomysial antibody assays have a reported specificity of 94–100% and a sensitivity of 89–100% [5]; however, sensitivity was shown to be only 78% in a recent report [6]. EmA testing is currently the screening method of choice for gluten sensitivity, but this is being superseded by tissue transglutaminase ELISA (enzyme-linked immunosorbent assay), which in preliminary studies has superior sensitivity (98%) and specificity (98%) [7]. In our study all 96 patients were negative for EmA. The population prevalence of gluten sensitivity in the United Kingdom is estimated to be 0.5% [8], therefore our study shows that it is unlikely that PsA is strongly related to gluten sensitivity. Larger studies would be needed to identify the true prevalence of gluten sensitivity in PsA.

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Treatment of SAPHO with pamidronate

Sir, SAPHO is a syndrome of synovitis, acne, pustulosis, hyperostosis and osteitis [1, 2]. We report the resolution of symptoms following intravenous pamidronate in a SAPHO patient with pain which was refractory to conventional treatment.

A 42-yr-old male presented with severe anterior chest pain over the sternum. The pain occurred spontaneously but was exacerbated by movement and the application of pressure. On examination he was tender over the sternum and the sternoclavicular joints. There was pustulosis of the palms and soles, in keeping with psoriasis. The remainder of the physical examination was unremarkable.

Investigations showed that the erythrocyte sedimentation rate (ESR) was elevated at 50 mm/h but C-reactive protein was normal at <5 mg/ml. The bone profile, including alkaline phosphatase, was normal. Chest radiography showed prominent calcification of the chondral cartilages with osseous fusion of the first rib costal cartilages and hypertrophic new bone anteriorly. Isotope bone scan (Fig. 1A) showed intensely increased activity in the manubrium sterni, particularly on the right side and in the first segment of the body of the sternum. Radiographs of the sacroiliac joints were normal.

The clinical features and investigations resulted in a diagnosis of SAPHO. Treatment with non-steroidal anti-inflammatory drugs and analgesics failed to control his symptoms. Salazopyrin (salphasalazine) and methotrexate were ineffective, as were oral and intramuscular corticosteroid. The painful area was diffuse and considered unsuitable for local injection. For 5 yr, during these treatments, the patient continued to have severe pain and difficulty with his work as an air-traffic controller.

A trial of intravenous pamidronate was commenced (60 mg given at intervals of 3 months). The urinary hydroxyproline:creatinine ratio was measured prior to each infusion as an assessment of osteoclast function and bone turnover. The ratio was 21.8 (normally <20)