Letters to the Editor

R. Caporali, E. Bonacci, O. Epis, P. Morbini, C. Montecucco

Department of Rheumatology, University of Pavia, IRCCS San Matteo Foundation, Pavia Italy and Department of Pathology, University of Pavia, IRCCS San Matteo Foundation, Pavia Italy

Accepted 26 April 2007

Correspondence to: Roberto Caporali, MD, Department of Rheumatology, University of Pavia, IRCCS San Matteo Foundation, Piazzale Golgi 2, 27100 Pavia, Italy

E-mail: caporali@smatteo.pv.it


Rheumatology 2007;46:1625–1626
doi:10.1093/rheumatology/kem152
Advance Access publication 7 August 2007

Comment on: parotid gland biopsy compared with labial biopsy in the diagnosis of patients with primary Sjögren's Syndrome: reply

Sir,

We would like to thank Dr. Morbini and co-workers for their valuable remarks on our study comparing parotid gland with labial biopsy in Sjögren’s syndrome (SS) [1]. Morbini and co-workers addressed an important topic regarding the validity of salivary gland biopsies in the diagnosis of SS. In their well performed study regarding multilevel examination of labial gland biopsy specimens in the diagnosis of SS, they showed that the
diagnostic specificity of labial biopsies can be increased by almost 10% when using a cumulative focus score [2]. Multilevel evaluation of a labial gland biopsy may indeed improve the reliability of histological grading in SS, which particularly might be of additional value in potential SS cases with a focus score at the cut-off level. Although the amount of tissue available in a parotid biopsy is usually not a problem for SS diagnostics, as it occasionally may be in labial biopsies from patients with advanced SS, it might be very interesting to evaluate whether multilevel evaluation will also increase the specificity and/or sensitivity of parotid gland biopsies.

The second point that Morbini and co-workers mentioned in their letter is the low incidence of subjective morbidity after a labial biopsy in their cohort of patients. They recorded adverse events with the aid of a questionnaire [2]. This subjective assessment might underestimate the amount of local hypoesthesia after labial biopsy. That was the reason we performed a thorough neurological examination (two-point discrimination test) in order to evaluate the objective morbidity of a labial or parotid biopsy in addition to a subjective evaluation using a questionnaire [1]. In agreement with the study of Morbini and co-workers [2] the evaluation of the adverse effects was done by independent clinicians. Combining a subjective assessment with an objective assessment is essential as it is not unusual that patients do not complain about local paraesthesia, even when objective assessment indicates some degree of disturbed sensibility. Although this discrepancy between objective and subjective results might not be clinically relevant, such information might be crucial for comparative studies. Moreover, we agree that in skilled hands both a labial and a parotid biopsy will result in minimal adverse effects, but we rather often encounter in our daily practice patients with a permanent disturbed sensibility of the lower lip due to a diagnostic labial biopsy taken by less skilled clinicians.

At the end of their letter Morbini and co-workers mentioned that there is a need for large comparative studies in order to find out the best diagnostic tools for histopathological evaluation of SS. Morbini and co-workers have a preference for labial biopsies above parotid biopsies because of the specific surgical experience needed for parotid gland biopsies, while labial salivary gland biopsies may be performed directly by clinicians such as rheumatologists. Although taking a parotid gland biopsy as used by Pippe et al. [1] is a rather simple out-patient technique for e.g. an oral and maxillofacial surgeon, it is indeed not a procedure that is easy to perform in, for example a department of Rheumatology. However, there are some inherent advantages of a parotid biopsy over a labial biopsy in SS patients that are not mentioned by Morbini and co-workers. A parotid biopsy might be preferred for therapy evaluation as repeated biopsies can be taken from the same parotid gland (in combination with saliva samples from the same gland). As such a parotid gland can be used more easily to monitor disease progression and/or disease activity than a labial salivary gland. A second advantage of a parotid gland biopsy over a labial gland biopsy is the potential of parotid biopsies to early diagnose MALT and non-Hodgkin lymphomas, often already at a stage without clinical manifestation (e.g. no swelling of the parotid gland). Although the clinical significance of early detection of lymphoma located in parotid gland tissue is not yet defined, it is in potency an important advantage of parotid biopsies over labial biopsies as these lymphomas are rarely observed in labial salivary glands.

The authors have declared no conflicts of interest.

J. PIPPE, F. K. L. SPIKERVET, J. E. VAN DER WAL, C. G. M. KALLENGEN, A. VISSINK

Accepted 4 May 2007

Correspondence to: J. Pippe. E-mail: j.pippe@kchir.umcg.nl


Rheumatology 2007;46:1626
doi:10.1093/rheumatology/kem194
Advance Access publication 5 August 2007

Anti-TNF alpha therapy, lipid profile and carotid intimal thickness

SIR, Del Porto et al. [1] report significant reduction in carotid intimal thickness (cIMT) in patients with rheumatoid arthritis (RA) suitable for anti-TNF therapy and who experienced a clinical response to the drug, compared with similar suitable patients who chose to remain on methotrexate and prednisolone. This further underlines the relationship between inflammation and atherosclerosis in general, and systemic inflammation in RA and atherosclerosis in particular.

Several possible mechanisms for this observed effect are discussed, including anti-TNF-mediated down-regulation of T lymphocytes, and effects on lipoprotein metabolism, nitrous oxide production and the coagulation cascade. The effect of alteration of the lipid profile is not directly discussed, and although the lipid profile of the two groups before treatment is tabulated, no results are given for lipids after therapy. Anti-TNF therapy has been shown to favourably alter lipid profiles over time [2], and lipid-lowering drugs, including statins, have been demonstrated to have anti-inflammatory effects [3]. There is currently debate over whether lowering lipids per se might have a positive anti-inflammatory effect, aside from other anti-inflammatory mechanisms of statins; under these circumstances, it would be interesting to see data on the lipid profile of these groups after therapy, and if there was any relationship between the final lipid levels and cIMT changes.

DJA received honoraria from MSF, Sanofi-Aventis and Roche.

D. J. ARMSTRONG

Department of Rheumatology, University Hospital of North Durham, UK
Accepted 25 June 2007

Correspondence to: Dr D. J. Armstrong, MD, MRCP, FRCP, Consultant Rheumatologist, Department of Rheumatology, University Hospital of North Durham, North Road, Durham, DH1 5TW, UK. E-mail: oswald17727@hotmail.com


Rheumatology 2007;46:1626–1627
doi:10.1093/rheumatology/kem195
Advance Access publication 1 September 2007

Effects of tumour necrosis factor alpha blockade on lipid profile in active rheumatoid arthritis

SIR, We would like to thank Dr Armstrong for his helpful comment regarding lipid profile behaviour during anti-tumour