A 14-year-old Asian female presented with fever, cough, weight loss and left-sided supraclavicular lymphadenopathy. Infection was excluded and the autoimmune profile was non-diagnostic [ANA 1:1280 (Hep2)]. Lymph node biopsy was typical of KFD. Shortly after the biopsy she developed a widespread inflammatory polyarthritis, malar rash and headaches. Simultaneously, immunological features of SLE were detectable with positive anti-dsDNA antibodies and hypocomplementaemia and she was commenced on appropriate therapy. Her progress has been complicated by episodes of arthritis, pancytopenia secondary to active SLE, fevers and migraines requiring pulses of i.v. methylprednisolone. She developed diffuse proliferative glomerulonephritis [World Health Organisation (WHO) Class IV], which following intolerable side-effects with mycophenolate and later cyclophosphamide, was successfully treated with B-cell depletion therapy.

Since 1991, 32 reports of KFD associated with SLE have been published [5, 6]. On review, many describe the association of KFD diagnosed concomitantly with or following the diagnosis of SLE [4, 7], which in all probability represent lupus lymphadenitis. We expand the literature with the report of four cases in which KFD predated a clinical and immunological diagnosis of SLE by between 3 and 14 months. Unfortunately, however, there are currently no predictive markers to identify as to which of the patients with KFD will develop SLE [6–8].

Clinically, KFD is typically characterized by lymphadenopathy (predominantly cervical), acute fevers and other systemic features. Extra-nodal involvement is less common, although reported [9]. ANA is usually negative and whilst the natural history can occasionally be unpredictable in relation to severity and complications, most cases are self-limiting, improving within 6 months [5, 10]. The clinical and immunological features required for diagnosis of SLE are well documented and specific. Lupus lymphadenitis has been reported in between 12% and 59% of patients with SLE, but in contrast to KFD, is rarely the presenting feature [10]. Careful examination of lymph node histopathology in correlation with clinical features is the most reliable way to differentiate the two entities. KFD is typified by cortical and paracortical necrotizing nodules, apoptotic debris, proliferation of histiocytes and immunoblasts, abundant CD8+ T cells, and an absence/paucity of neutrophils [2, 6]. In contrast, lupus lymphadenitis is diagnosed in patients who meet the validated revised ACR criteria for SLE together with typical biopsy findings of necrotic and thrombosed blood vessels, presence of a necrotizing neutrophilic infiltrate and the pathognomonic feature, haematoxylin bodies [2].

Whilst it is important that the characteristic self-limiting form of necrotizing lymphadenitis and systemic illness of KFD be recognized, the possibility of other diseases including SLE should always be considered. Importantly, however, as in our four patients, SLE is known to develop in a small number following a previous diagnosis of KFD. The present lack of predictive markers for which patients with KFD will progress to SLE, means that all patients diagnosed with KFD should receive periodical clinical and serological follow-up for several years to detect possible evolution of SLE.

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**Elevation of alkaline phosphate in a pregnant patient with antiphospholipid syndrome: HELLP syndrome or not?**

Sir, Pregnant patients with APS may develop HELLP syndrome (haemolysis; elevated liver enzymes; low platelet count) that can manifest first by elevation of ALP level. However, other causes of ALP elevation must be discussed and include elevation of ALP of placental origin. We report for the first time an APS pregnant patient presenting with ALP increased over 15-fold of placental origin.

A 40-year-old patient with an APS was followed for her fifth pregnancy. Past obstetrical history included a normal pregnancy followed by two foetal deaths at 18 weeks of gestation (WG) and a spontaneous abortion at 8 WG. Repeated searches for aCL antibodies were positive. ANA were negative. Her clinical history was otherwise unremarkable. A diagnosis of primary obstetrical APS was made according to the usual criteria [1].

She was treated with aspirin and low molecular weight heparin (enoxaparin 0.4 ml twice a day). At 19 WG, serum ALP level was 200 U/l (normal values: 40–120). She had neither hypertension nor oedema. Results of other liver function tests, blood cell counts and urine tests were normal. Liver ultrasonographic examination was normal. During follow-up, as the patient remained symptom free, ALP increased and reached 1722 U/l at 36 WG without other biochemical abnormality. Obstetrical ultrasonographic examination and Doppler blood flow remained normal.
At that time, given the absence of any clinical or biochemical abnormalities suggestive of HELLP syndrome, an isolated placental ALP elevation was suspected. Serum ALP electrophoresis showed normal ALP level of liver (57 U/l) and bone (146 U/l) origin, whereas placental isozyme 1 ALP was 1054 U/l and placental isozyme 2 ALP was 465 U/l.

She delivered a healthy newborn of 2560 g at 37 WG. The placenta was normal and weighed 435 g. Serum ALP level was 216 U/l at 4 weeks post-partum and normal at 5 weeks post-partum (Fig. 1).

ALP is an enzyme produced by liver, bones, kidneys, small intestine and placenta. In a pregnant patient, elevation of ALP may be related to HELLP syndrome, intrahepatic cholestasis, malignancy or liver or bone diseases. However, a placental origin of ALP must also be discussed.

ALP is physiologically produced by placenta at the brush border membranes of the syncytiotrophoblast [2]. It appears in maternal serum between the 15th and the 26th WG [3] and increases during the third trimester [4]. Usually, ALP production or diffusion in maternal serum is not major and total serum ALP level remains normal. Some cases of unusual elevation of placental ALP have been described [2, 5–7]. The mechanism of serum placental ALP increase is not well understood. A genetic abnormality has been suspected in one case [6] and a link with a risk of pre-term delivery has been discussed [7].

Our case is the first described in a patient with APS and we did not observe any other cases among more than 200 pregnant patients with APS followed in our centre. In this setting, ALP electrophoresis can be useful to distinguish placental from hepatic or bone isozymes.

**Rheumatology key message**

- Placental alkaline phosphatase elevation can be independent of APS during pregnancy.

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Anakinra treatment for systemic onset juvenile idiopathic arthritis (SOJIA)

Sir, Systemic onset juvenile idiopathic arthritis (SOJIA) accounts for ~10–20% of all patients with JIA, but it accounts for increased morbidity and mortality compared with other forms of JIA [1]. A significant number of patients have ongoing disease activity despite aggressive treatment. A follow-up study found that the probability of disease remission 10 yrs after onset was only 37% [2]. Despite a variety of treatments some children with SOJIA have a refractory course with significant morbidity. Pasqual et al. [3] have published data indicating that IL-1 is a major mediator of the inflammatory cascade that underlies SOJIA, and that this cytokine represents a target for therapy in this disease. Anakinra is a recombinant form of human IL-1 receptor antagonist that inhibits activity of IL-1. Recently, case reports using anakinra have suggested efficacy in refractory SOJIA [4, 5]. We report our experience with anakinra in three centres in the UK.

Data were collected from three tertiary paediatric rheumatology centers in the UK on all their patients with SOJIA who had received anakinra. Seven patients were identified. ILAR classification was used to establish SOJIA diagnosis in all centers [6]. Data were retrospectively collected by case notes review of the seven patients using data collection sheets. Age at diagnosis, age at starting anakinra and all previously failed medications were recorded. Core set, clinical and laboratory findings were recorded prior to starting anakinra and at 1, 3, 6 and 12 months after starting anakinra. Serious infections, adverse events and injection site reactions were also recorded.

The median age at diagnosis of SOJIA was 5.3 yrs (range 2.1–14 yrs). The median age at starting anakinra was 8.5 yrs (range 5.2–15 yrs). The median follow-up time from starting anakinra was 1 yr (range 0.75–2.3 yrs). Previous failed treatments included methotrexate (n = 6), cyclosporin (n = 4), immunoglobulin (n = 5), etanercept (n = 2) and infliximab (n = 2). Four patients had active