The most striking clinical relevance of MRI in early RA is its potential for a poor outcome and such a patient should be managed aggressively.

Disclosure statement: The author has declared no conflicts of interest.

F. M. McQueen1

1Department of Molecular Medicine and Pathology, University of Auckland, Auckland, New Zealand

Accepted 26 November 2008

Correspondence to: F. M. McQueen, Department of Molecular Medicine and Pathology, Faculty of Medicine and Health Sciences, University of Auckland, Private Bag 92019, Auckland, New Zealand. E-mail: f.mcqueen@auckland.ac.nz

Rheumatology 2009;48:451–452
doi:10.1093/rheumatology/ken451
Advance Access publication 16 January 2009

Comment on: Prevalence, serological features, response to treatment and outcome of critical peripheral ischaemia in a cohort of lupus patients

Sir, Jeffery et al.1 have presented the data of seven patients with SLE drawn from a cohort of 487 patients followed over 28 yrs

© The Author 2009. Published by Oxford University Press on behalf of the British Society for Rheumatology. All rights reserved. For Permissions, please email: journals.permissions@oxfordjournals.org
who had critical peripheral ischaemia. Interestingly, two of these patients had conditions (meningococcal sepsis and disseminated intravascular coagulation) which themselves can lead to digital ischaemia even without lupus as a comorbid condition. We present the data of 20 patients with gangrene of at least a finger or toe from a cohort of 344 patients of SLE seen over the last 10 yrs. This cohort consists predominantly of a female South Indian population attending a tertiary referral centre. We excluded the data of patients with reversible ischaemic changes.

The mean age of our cohort is 29.2 ± 10.7 yrs and mean duration of follow-up 38.56 ± 42.84 months. Of the 20 patients with gangrene of one or more digits, in 10 patients peripheral ischaemia was the presenting symptom leading to the diagnosis of SLE. The median duration of SLE in the other 10 patients was 31.5 months (range 7–78 months). The mean age of patients with gangrene was 37.3 ± 14.6 yrs. The observations on the clinical features of lupus in these 20 patients were as follows. Eight patients had malar rash, none had a discoid rash, four had photosensitivity, 17 patients had arthritis, four patients had lupus nephritis and six patients had haematological involvement. Only one patient reported RP. Antibodies to dsDNA were significantly elevated in 18 of the 19 patients in whom the data were available. Complement levels were reduced in 7 of 14 patients in whom they were measured. The aCLs (IgG and IgM) were assayed using Bio-Rad kits (Bio-Rad Laboratories, Hercules, CA, USA). Cut-off for negative value was considered as 23 GPL for IgG aCL and 11 MPL for IgM aCL. Three patients were positive for IgG aCL and three for IgM aCL, both being positive in one patient. Activated partial thromboplastin time was elevated in only two patients. Four patients were lost to follow-up after the initial admission. In the remaining 16 patients, the median follow-up after gangrene was 16 months with a range of 1–80 months. Four patients had recurrence of an ischaemic event, two in the same site and two in other sites, i.e. pulmonary thrombus and stroke.

According to our unit policy the initial therapy of digital ischaemia in SLE involves high dose steroids, intravenous (i.v.) heparin and oral anti-platelet drugs followed by oral anti-coagulation and monthly pulses of i.v. cyclophosphamide for 6 months. The active ischaemia responded to therapy in all patients. Intravenous prostaglandin (alprostadil) was used only for persistent pain or progressive gangrene. It was needed in two patients. As the authors point out, the prevalence of aPLs was higher in our studies than in theirs and probably explained why they have managed to treat their patients relatively successfully using quite intense immunosuppression (monthly pulses of intravenous cyclophosphamide for 6 months) in contrast to our preference for intensive prostaglandin therapy. They suggested that immunosuppressive intravenous prostaglandins may not be necessary, as initial management of gangrene in lupus patients.

The vasculitis in lupus is related to up-regulation of adhesion molecules on the endothelial cells probably as a result of interaction with circulating auto-antibodies and immune complexes [2]. The digital gangrene in our cohort is probably due to active vasculitis. This is probably the reason why methylprednisolone pulses, which have an early membrane stabilizing effect and later act on many mediators of inflammation [3], are successful in the therapy of digital gangrene of lupus. Prostaglandins dilate blood vessels and have an anti-platelet effect and so may also be effective in digital ischaemia consistent with the policy of some units to use it as part of the initial therapeutic package.

To conclude, prevalence of digital gangrene in this Indian cohort is higher. The age of the patients with gangrene is higher than the mean age of the rest of the cohort. In 50% of the patients with digital ischaemia it occurred early in the course of lupus. The aCLs are negative in majority of our patients, in contrast to the suggestion of over-representation of aCLs in the index study. Almost all patients have active SLE with elevated dsDNA and low complements. The digital gangrene in our cohort is probably due to active vasculitis rather than a non-inflammatory vasculopathy. We believe that intravenous prostaglandin can be offered as therapy to patients who do not respond to initial therapy.

Disclosure statement: The authors have declared no conflicts of interest.

L. RAJASEKHAR1, N. V. JAYACHANDRAN1, V. N. N. PRABU1, G. NARSIMULU1

1Department of Rheumatology, Nizam’s Institute of Medical Sciences, Panajagutta, Hyderabad, Andhra Pradesh, India

Accepted 13 November 2008

Correspondence to: L. Rajasekhar, Department of Rheumatology, Nizam’s Institute of Medical Sciences, Panajagutta, Hyderabad-500082, India. E-mail: lizarajasekhar@yahoo.com


Rheumatology 2009;48:452–453
doi:10.1093/rheumatology/ken474
Advance Access publication 27 January 2009

Comment on: Prevalence, serological features, response to treatment and outcome of critical peripheral ischaemia in a cohort of lupus patients: reply

Sir, We read with great interest the description of digital gangrene in lupus patients in an Indian population described by Rajasekhar et al. [1] in response to our recent publication in Rheumatology [2]. As the authors point out, the prevalence of aPLs was higher in our studies than in theirs and probably explained why they have managed to treat their patients relatively successfully using quite intense immunosuppression (monthly pulses of intravenous cyclophosphamide for 6 months) in contrast to our preference for intensive prostaglandin therapy. They suggested that immunosuppressive intravenous prostaglandins may not be necessary, as initial management of gangrene in lupus and if there are good grounds for believing that vasculitis alone in the absence of any accompanying thrombosis is thought to be the culprit, dispensing with prostaglandins may be an option. However, in reality, pre-gangrenous and, indeed, gangrenous lesions, due to digital ischaemia may develop with remarkable rapidity and certainly whilst waiting for results of blood tests, including aPLs, to come back from the laboratory, we would strongly advocate the use of intense intravenous vasodilatation if there is any doubt as to the underlying cause.

Disclosure statement: The authors have declared no conflicts of interest.

C. NARSHI1, R. JEFFERY1, D. A.ISENBERG1

1Centre for Rheumatology, Division of Medicine, University College London, London, UK

Accepted 21 November 2008

Correspondence to: D. A. Isenberg, Centre for Rheumatology, UCL Division of Medicine, Room 331, 3rd Floor, Windeyer Building, 46 Cleveland Street, London W1T 4JF, UK. E-mail: joan.perry@ucl.ac.uk