Letters to the Editor

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Refractory anti-synthetase syndrome treated with rituximab

Sir, We read with interest the article by Sem et al. [1] concerning rituximab treatment of the anti-synthetase syndrome (ASS) in the August issue of Rheumatology. Similar to them, we also noted a paucity of published literature on the effects of rituximab in ASS, and therefore wish to report our experience with a similar case.

Our patient was a 30-year-old plumber who was diagnosed with ASS in the year 2000 on the basis of proximal muscle weakness (hip flexion Grade 3/5 bilaterally), elevated creatinine kinase (CK) levels of >8000 U/l, characteristic histological findings on muscle biopsy and positive anti-Jo-1 antibodies. His CT chest showed evidence of interstitial lung disease.

He had a dramatic initial clinical response to steroids and his CK levels fell to 1400 U/l, but over the following year he was unable to decrease his steroids <20 mg without a return of his symptoms and a rise in his CK levels. Over the following 2–3 years AZA, MTX, mycophenolate mofetil, cyclosporin and intravenous immunoglobulins were all tried sequentially with varying apparent, but short-lived, benefits. He remained on steroids during this time.

In June 2005, he commenced anti-TNF therapy. Unfortunately he had an anaphylactic reaction to infliximab, derived no benefit from entanercept and had only short-lived benefit from adalimumab. There were no significant effects on his CK levels with anti-TNF therapy.

In 2007, he was treated with rituximab 500 mg weekly for 6 weeks. He had a good symptomatic improvement, his CK levels fell dramatically from 5600 U/l to 1800 U/l (Fig. 1) and for the first time since his diagnosis he was able to return to work. The benefit was sustained for 6 months when his CK levels rose again to 2800 U/l and an MRI of his thighs showed ongoing myositis. Further treatment with rituximab 500 mg weekly for 4 weeks was successful both in terms of his physical function and laboratory parameters (CK reduced to 750 U/l). He remains well and is now totally off steroids with a normal CK (<200 U/l). We agree that this case report does not allow us to draw firm conclusions on the use of rituximab in ASS; however, our patient’s disease seemed to be refractory to all other forms of immunosuppression including anti-TNF treatment. To date there are only a few published case series with very small numbers on the use of rituximab in different forms of PM [2–5]. Therefore, we agree with the authors that since CD20 depletion therapy may be a new and valuable approach in these patients larger controlled studies are needed to look at individual issues and effects.

Rheumatology key message

Rituximab may be a new and valuable treatment approach in patients with ASS.

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References


Fig. 1 A fall in CK levels during rituximab treatment.