antibodies [3]. In addition, ethnicity might provide another explanation. In China and Japan, only 24% and 15%, respectively, of infants with NLE present with heart injuries [4, 5]. The incidence differs from that in Caucasians, which is >50% [6]. The baby and the mother are still under close follow-up for the potential risk of developing autoimmune diseases in the future [7, 8].

**Rheumatology key message**

- In this baby with neonatal lupus erythematosus, a malar rash on the face disappeared spontaneously.

### Acknowledgements

We thank Nkungu Daniel for his help with language polishing.

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

### References


### Letters to the Editor

**SIR, We read with interest the article by Glaspole et al. [1] in which the authors report a case of certolizumab-induced interstitial lung disease (ILD) in a patient with RA. We would like to highlight that there are indeed a number of existing documented cases of certolizumab-induced pulmonary toxicity in the literature [2–4]. Pearce et al. [2] describe an initial case in 2011 whereby a patient developed certolizumab-induced ILD following eight doses of certolizumab in combination with MTX. High-resolution CT (HRCT) showed ground glass attenuation following certolizumab. This particular patient suffered an impaired outcome despite i.v. methylprednisolone, requiring long-term home oxygen.

The second case, highlighted by our own centre, details a 67-year-old ex-smoking male [3]. This gentleman had a previous episode of MTX-induced pneumonitis. Following cessation of MTX, chest X-ray changes and impaired transfer factor resolved. His baseline chest X-ray prior to certolizumab was normal. Deterioration in his chest X-ray findings prompted a HRCT, again showing evidence of severe interstitial fibrosis with honeycombing and ground glass shadowing. Unfortunately, despite aggressive treatment, his condition deteriorated and death ensued.

A further case is described by Lager et al. [4]. They describe a 72-year-old woman who developed severe acute pneumonitis following treatment with certolizumab. Again, HRCT findings indicated interstitial changes with ground glass attenuation and an impaired outcome was also noted, with the patient requiring home oxygen therapy.

We also noted that Glaspole et al. [1] highlighted a quicker onset of action of symptoms than previously documented in the case series by Perez-Alvarez et al. [5]. It is unclear from the description the time lag between onset of symptoms and duration of certolizumab treatment. Indeed, in the previous cases highlighted [2–4], onset occurred at 16, 15 and 8 weeks, respectively.

We agree there is likely a class effect with regard to the risk of pneumonitis with anti-TNF use, with similar findings having been described previously with other anti-TNF agents [5]. These cases serve to highlight the vigilance needed in those patients with RA presenting with new or deteriorating respiratory symptoms and on concurrent anti-TNF therapy.

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

Eimear M. Savage1,2, Auleen M. Millar1,2 and Allister J. Taggart1

1. Department of Rheumatology, Musgrave Park Hospital, Belfast and 2. Department of Rheumatology, Antrim Area Hospital, Antrim, UK.
Letters to the Editor

Accepted 5 February 2014
Correspondence to: Eimear M. Savage, Department of Rheumatology, Musgrave Park Hospital, Stockman’s Lane, Belfast BT9 7JB, UK. E-mail: savageeimear@gmail.com

References


Rheumatology 2014;53:1155
doi:10.1093/rheumatology/keu144
Advance Access publication 27 March 2014

Comment on: A case of certolizumab-induced interstitial lung disease in a patient with rheumatoid arthritis: reply

Sir, We thank Savage et al. [1] for highlighting the presence of other case reports of certolizumab-associated interstitial lung disease (ILD) [2-4]. Two of the cases were published in 2012 and therefore were earlier than our own, rendering our assertion, made in good faith at the time of writing, that our case was the first to be published incorrect. Nevertheless, together with our case, they corroborate the impression that certolizumab carries a similar risk to other TNF-α inhibitors with respect to the development of ILD. Our own case developed breathlessness ~14 weeks after beginning certolizumab therapy. In conjunction with the time to symptom onset observed in the other cases of between 8 and 16 weeks, this supports the impression that certolizumab is associated with a relatively more rapid onset of symptoms than other TNF-α inhibitors, given the majority of cases in the series by Perez-Alvarez et al. [5] appeared after at least 6 months of therapy.

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

Ian Glaspole1,2, Ryan Hoy1,3 and Peter Ryan2
1Department of Allergy, Immunology and Respiratory Medicine, Alfred Hospital, Melbourne and 2Department of Medicine and 3Department of Epidemiology and Preventive Medicine, Monash University, Alfred Hospital, Melbourne, VIC, Australia.
Accepted 6 February 2014
Correspondence to: Ian Glaspole, Department of Allergy, Immunology and Respiratory Medicine, Alfred Hospital, Commercial Road, Melbourne, VIC 3004, Australia. E-mail: i.glaspole@alfred.org.au

References