Accelerated nodulosis immediately after initiating weekly low dose methotrexate for rheumatoid arthritis

Sir,

There have been many reports of the occurrence of subcutaneous nodules in rheumatoid arthritis (RA) patients after methotrexate (MTX) therapy 

(A-N) has been named accelerated nodulosis (AN). AN has also been observed in psoriasis (7), during azathioprine therapy (8), with vascu-

This review describes a patient with RA who developed AN immediately after the initiation of weekly low-dose MTX therapy.

A 41-year-old man presented to our hospital in November 1996 with polyarthritis of 5 years duration. The patient showed arthritis of the wrists and the small joints of the hands, elbows, knees, and ankles. No subcutaneous nodules were detected and he had no other extraarticular manifestations. His Ritchie index was 5 and his functional class was II.

Blood tests showed the following: ESR (Wintrobe method) 20 mm/hr, CRP 0.36 mg/L, RF 105 IU/ml, and the absence of antinuclear antibodies. Joint radiographs showed erosive changes on the meta-

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Our knowledge is limited to reports in the literature of AN developing after such a small dose, and in such an unusual location. Furthermore, the nodules were generally smaller in size (< 0.5 cm in diameter).

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We conclude that AN may occur in RA despite a very small cumulative dose of MTX. However, we do not know whether the successful re-challenge was serendipitous or due to the addition of hydroxychloroquine.

Accelerated nodules differ from spontaneously occurring subcutaneous nodules in many ways (7). First, they develop and grow rapidly. Secondly, they occur preferentially in the fingers whereas subcutaneous nodules are generally located either on the Achilles tendon or on the extensor surface of the forearm distal to the olecranon. Finally, they are generally smaller in size (< 0.5 cm in diameter).

AN usually disappear within several weeks or months after MTX is stopped, but their development is not necessarily a contraindication for the continuation of MTX therapy, since they may regress even with MTX (7, 9, 10) or by adding hydroxychloroquine (4).

In our patient the nodules occurred immediately after the initiation of weekly low-dose MTX therapy (cumulative dose 15 mg). To our knowledge there are no reports in the literature of AN developing after such a small dose, and in such an unusual location. Furthermore, the nodules were relatively large (> 1 cm in size). The patient denied any previous eruption of subcutaneous nodules.

We conclude that AN may occur in RA despite a very small cumulative dose of MTX. However, we do not know whether the successful re-challenge was serendipitous or due to the addition of hydroxychloroquine.

References

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