Letters to the Editor

Erosive psoriatic polyarthritis: A report of 2 asymptomatic cases

Sirs,

Psoriatic arthritis (PsA) is characterized by a frequent asymmetrical involvement of the joints, the common localization in the spine and by the tendency to evolving in ankylosis. Painless spondylitis (1, 2), sacroiliitis (3) ed enthesitis (4) have been described in the literature. We report 2 cases of longstanding asymptomatic erosive peripheral PsA, one of which was discovered accidentally because of its association with another painful rheumatic disorder.

Patient 1. In March 1994 a 74-year-old male patient suffering from RS3PE syndrome for one month came under our observation. This disease was localized in the hands and feet and was diagnosed according to the clinical picture and laboratory findings reported by McCarty (5). Ecography revealed soft tissue swelling without tenosynovitis. The patient also complained of guttate psoriasis for 60 years, but he never previously suffered from arthralgias, arthritis, dactylitis or entesitis. Roentgenograms of the hands unexpectedly disclosed a typical picture of PsA characterized by marginal erosions asymmetrically localized in some PIP joints and in several DIP joints. Periostitis was also irregularly distributed. Osteopenia was absent. Feet, spine and sacroiliac joints were undamaged. Neurologic examination and upper limb electromyography were normal; in particular, signs of sensory neuropathy were absent.

A short course of corticosteroid therapy (Deflazacort 12 mg/daily for 2 weeks and 6 mg/daily for a further 2 weeks) induced a complete and persisting remission of the RS3PE symptoms. At the moment there were no clinical signs attributable to PsA. No treatment was instituted. To date the joints, finger functioning, and the ESR and C-reactive protein values remain normal; the radiographic picture is unchanged.

Patient 2. A 69-year-old white woman presented in September 1998 with a 2-month history of mild polyarthralgias and swelling of the right ankle and wrists. Moreover, physical examination revealed asymmetrical shortening and/or ankylosis of several toes. A mild use-related bilateral metatarsalgia was present on walking. Roentgenograms of the feet disclosed a typical picture of longstanding psoriatic arthritis mutilans: erosions, acroosteolysis asymmetrically involving the phalangeal and metacarpal bones, and "telescoping digits". Two PIP and 3 MCP joints were fused. A less severe asymmetrical erosive arthritis was also identified in the hands and wrists. The spine and sacroiliac joints were spared. Some lesions of guttate psoriasis were present on the legs. Neurologic investigation did not show any alteration. The patient had never suffered from arthritis, dactylitis or entesitis and recalled only sporadic episodes of arthralgias sometimes in the spine, sometimes in an upper or lower limb. These data were confirmed by the family doctor. Our extensive examinations showed only a mildly increased ESR (30 mm/1st hour) and C-reactive protein (0.9 mg/dl; normal values < 0.5 mg/dl). We decided to administer sulfasalazine 2 g/daily, which resulted in a complete remission of the arthritis and normalization of the indicators of inflammation in 2 months. Metatarsalgia on walking (due to PsA-induced modifications of the feet) persists. Until recently (sulfasalazine is now administered at the dose of 1.5 g/daily), the remission has been stable and the radiographic findings are unchanged.

Our observations show that in PsA asymptomatic involvement is possible not only in the spine (1, 2), sacroiliac joints (3) and enthesis (4), but also in the peripheral joints. This silent arthritis can occur in a mild and self-limiting form (Patient 1) or with a destructive course (Patient 2). Asymptomatic psoriatic polyarthritis is probably rare but it is very difficult to determine its actual prevalence due to the absence (Patient 1) or late appearance (Patient 2) of the clinical manifestations (pain and articular swelling) that usually lead the patient to consulting a physician. In particular, the diagnosis was accidental in the first case and extremely late in the second case. Both of our patients have guttate psoriasis of the skin (the nails are undamaged); the possible significance of this association should be confirmed.

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Expression of Fas antigen (CD95) on peripheral blood lymphocytes in Behçet's disease

Sirs,

Behçet's disease (BD) is a chronic, inflammatory disorder affecting various organ systems (1). The etiology and pathogenesis of BD are unknown, but there is considerable data indicating that immunological abnormalities are important (2,3). Numerous kinds of infectious microorganisms have been postulated as causative agents of BD in genetically susceptible individuals (4, 5). The complex interaction of genetic and enviromental factors seems to be responsible for immunological dysregulation, and an inflammation triggered by immunological mechanisms causes the disorder. Apoptosis is important in the regulation and functioning of the immune system and plays significant roles in the control of the immune response (6). The Fas Ag (CD95) is a 45 kDa cell-surface protein belonging to the tumour necrosis factor (TNF) family. Interaction of Fas Ag (CD95) with its specific ligand triggers the apoptotic death of T and B lymphocytes (7). Therefore, in order to analyze the possible role of apoptosis in BD, we studied the expression of Fas antigen on peripheral blood lymphyocytes from BD patients.

Our study group consisted of 62 patients (34 patients with active BD and 28 patients with inactive BD) and 29 age and sex-matched healthy adults as controls. The diagnosis of BD was estabilished using the criteria of the International Study Group for BD (8). Disease activity was based on clinical findings at the time of venipuncture. Patients lacking any clinical signs were categorized as having inactive disease. Patients with major oral aphthae and genital ulcerations, arthritis, ocular manifestations, neurologic manifestations and/or large vessel involvement constituted the group with active disease. At the time of the study, 46 patients were taking only colchicine and the remaining 18 were taking no drugs.

Whole blood samples were directly stained with two or three-color monoclonal antibodies (Becton Dickinson, San Jose, CA) and analyzed by a FACSort flow cytometer (Becton Dickinson). Blood samples were collected in EDTA tubes and used within 2 hrs of storage at room temperature. In order to