ment (8).
In conclusion, this is the first case reporting the successful treatment of GBS following gold therapy with high dose IVIG.

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Cutaneous vasculitis associated with mixed cryoglobulinemia in adult Still's disease

Sirs,
Adult Still's disease (ASD) is a systemic inflammatory disorder of unknown origin, characterized by high spiking fever, arthralgias or arthritis, sore throat, and an evanescent rash often occurring during the fever spikes (1-3). We describe a 47-year-old man fulfilling the diagnostic criteria of ASD (1, 3, 4) who is unique in having developed mixed cryoglobulinemia, leukocytoclastic cutaneous vasculitis and mild mesangial glomerulonephritis during the phase of active disease.
Our patient had a 10-day history of high fever (> 39.5ºC), diffuse arthalgias and myalgias, and an evanescent salmon pink rash prior to admission, as well as a one month history of sore throat, low-grade fever, mild abdominal pain and weight loss of 5 kg. Remarkably, at the age of 6 and 8 years he had two episodes of high fever and arthralgias which fully resolved after a 3-month treatment with high doses of aspirin. On admission he also had hepatosplenomegaly, anemia, leukocytosis, strikingly elevated C-reactive protein and ferritin levels, mild liver dysfunction and normal renal function. Serum immunoglobulins IgG and IgA were elevated, IgM was normal, while complement levels were at the lower limit of normal. Rheumatoid factor, antinuclear antibodies, antineutrophil cytoplasmic antibodies and an extensive work-up for infection were all negative. Of note, cryoglobulins were detectable as polyclonal IgG, IgA, and IgM.
On the second day of hospitalization a mild migratory, itchy, maculopapular rash appeared on the head, upper trunk, back, buttocks and groins. The rash evolved into purpuric plaques after two days and disappeared soon after. On the fifth day several annular purpuric plaques on the ankles and dorsal area of the feet and a symmetric confluent purpuric plaque on the shins were observed (Fig. 1). Skin biopsy findings were compatible with leukocytoclastic vasculitis. In the following days his general condition deteriorated to the point that he was unable to walk, cutaneous lesions became fixed, and renal dysfunction demonstrated by the presence of granular casts, mild pyuria and hematuria and elevated serum urea, was observed. Renal biopsy revealed rare vessel hyaline deposits, mesangial alterations and mild hypercellularity with C_3 and IgM deposits on immunofluorescence. Bone marrow and liver biopsy findings were unremarkable. At the 10th day methylprednisolone (72 mg/day) and methotrexate (17.5 mg/week) were started (5); during the following days a dramatic clinical response, including remission of skin vasculitis, was observed. By the seventh week he had resumed all of his daily activities, treatment was discontinued at the 14th month and he did extremely well during the following 6 months. Laboratory examinations, including repeated determination of cryoglobulins, were unremarkable.

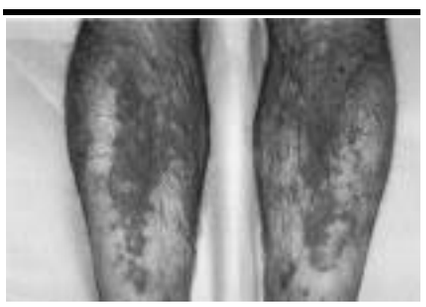

Fig. 1. Demarcated annular purpuric plaques with a palpable border and clearing in the center, without necrosis or ulceration; smaller 3-5 mm purpuric papules surround the plaques.

Clearly, our patient fulfilled the diagnostic criteria of ASD (1, 3, 4), which was confirmed during the 20-month follow-up. Because of his childhood episodes of fever and arthralgias the diagnosis of Still's disease of childhood onset is tempting; however, since he denied any similar episodes for the next 40 years, he was classified as having an adult-onset disease (1, 6, 7). We systematically excluded viral infections, sepsis, tuberculosis, sarcoidosis, malignancies, systemic connective tissue diseases (1, 2), and Schnitzel's syndrome (8), not only because ASD is a relatively rare disease, but also because of the atypical coexistence of both skin and renal involvement. Cutaneous vasculitis and glomerulonephritis in the course of ASD have been described only once and twice in the past, respectively (9, 10). To the best of our knowledge no previous cases of ASD associated with mixed cryoglobulinemia have been reported. Perhaps clinicians are overlooking a possibly not uncommon aspect of this disease, since during the course of a severe, acute inflammatory response such as ASD transient cryoglobulin formation is not unexpected. This case suggests that ASD should be included in the list of systemic conditions that may be complicated with mixed cryoglobulinemia.

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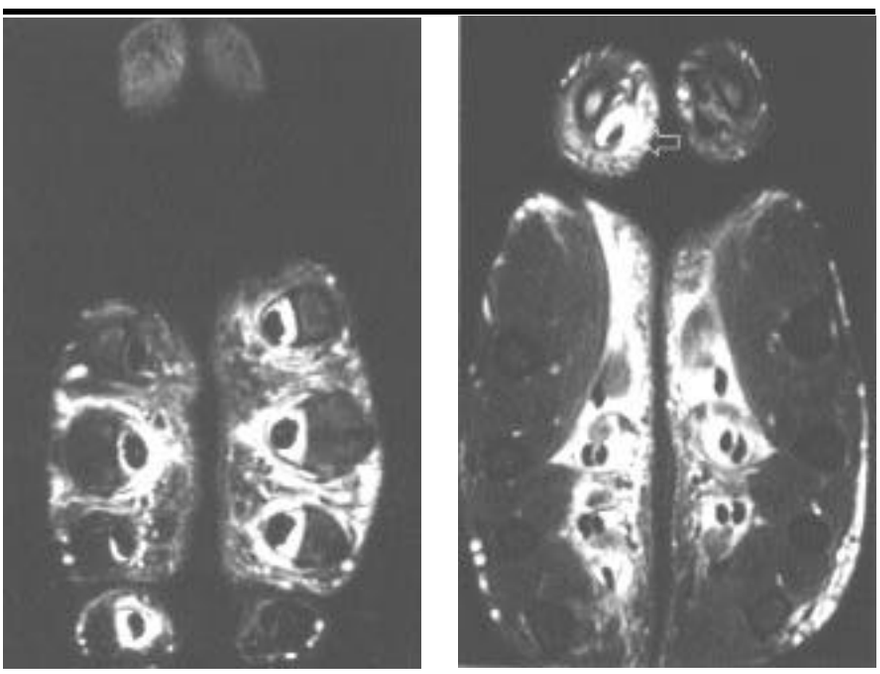
Dactylitis involving most of the fingers

Sirs,

Dactylitis or "sausage-like" digit is a clinical hallmark of spondyloathritis (SpA) (1-3). Although more frequent in psoriatic arthritis (PsA) (1, 4), dactylitis has been observed in all forms of SpA including the undifferentiated forms (1-3). Recent studies using ultrasound and magnetic resonance imaging (MRI) have established that dactylitis is due to flexor tenosynovitis and arthritis of the interphalangeal and metacarpophalangeal (or metatarsophalangeal) joints is not a *condition sine qua non* for the "sausage-shaped" feature (5-7). Dactylitis is usually asymmetric and involves few fingers and/or toes.

We have recently come across a 37-year-old man suffering from PsA and showing dactylitis of most of his fingers. His family history was negative for SpA and psoriasis. His medical history revealed that he had been suffering from psoriasis for 18 years. Four months before the consultation he developed "sausage-like" swelling of most fingers together with Achilles enthesitis. Physical examination disclosed dactylitis of the second, third and fourth fingers of the right hand and of the first, third, fourth and fifth left fingers. There was also a soft tissue swelling along his left Achilles tendon and at his calcaneal insertion. The only aspect of the laboratory evaluation worthy of note was a C-reactive protein level of 20.6 mg/liter (normal < 5). HLA typing showed A2, A30, B38, and B51. Magnetic resonance imaging revealed fluid in the synovial sheaths of all the dactylitic fingers (Fig. 1). Ultrasonography showed a moderate diffuse thickening of the left Achilles tendon together with an enlarged bursa. The patient was given methotrexate at a dose of 10 mg/day and diclofenac at a dose of 100 mg/day with good results.

The present report emphasizes that dactylitis may simultaneously involve most of the fingers.



(a) **(b)**

Fig. 1. (a) T2-weighted image at the level of the proximal interphalangeal joints showing fluid in the synovial sheaths of the 3rd, 4th and 5th left fingers and in the 2nd, 3rd and 4th right fingers. (**b**) T2-weighted image at the level of the metacarpophalangeal joints showing also the involvement of the 1st left finger (arrow).

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