mic microcytic anemia (Hb 10.2 gr/dl, MCV 81 fl, MCH 24 pg), and positive antinuclear antibodies (1:5120 anticentromere). Calcium, phosphate and parathormone serum levels were normal, as well as renal function and calciuria; creatine phosphokinase and aldolase were normal.

Chest X-ray was normal, a transthoracic echocardiogram revealed increased right ventricular systolic pressure (50 mmHg). Renal ultrasonography showed small hyper-echogenic spots (probably calcifications) on both renal pelvis. Esophagogram with barium revealed dilatation of thoracic esophagus.

Shoulders, hands and pelvis X-ray showed widespread calcifications in the superficial and deep tissues (Fig. 1 a-d). The patient was dismissed on therapy consisting of cyclic intravenous infusions of iloprost and oral omeprazole, acetylsalicylic acid 100 mg/day, methylprednisolone 4 mg/day, ACE-inhibitor and bosentan, which resulted in an improvement of dyspnea and dysphagia but no changes in her widespread calcifications.

This is an unusual case of lSSc with widespread periarticular and soft tissue calcifications. Indeed, in lSSc calcifications are usually small, subcutaneous and may become superficial, ulcerate the skin and lead to secondary infections (6). Subcutaneous calcification deposits at sites of trauma such as the forearms, elbows or fingers, occur in all subsets of scleroderma but are more prominent in lSSc and in patients with anticentromere antibodies (6). Calcinosis mimicking a tumoral process (7) and calcinosis universalis have been previously described in patients with lSSc (4, 5) and no medical therapy can modify the progression of calcinosis. Low-dose warfarin, reported to be efficacious in calcinosis universalis by Berger *et al*. (8), but not by Lassoued *et al*. (9), did not obtain any result in our patient.

Broad calcium deposition may also be observed in myositis ossificans progresiva which is inherited in an autosomal dominant pattern, and is first noted during childhood. Myositis ossificans can be localized or widespread but is associated with congenital defects including microdactyly of the large toe and thumb, exocitosis, absence of the two upper incisors, hypogenitalism, absence of the ear lobules and deafness (10).

Finally the differential diagnosis with calcinosis cutis universalis must be kept in mind when the deposition of calcium crystals is extensive but localized to the cutis (11).

The patient described here did not present clinical aspects of dermatomyositis, psoriasis, polymyositis or myositis ossificans and her renal function was normal. We consider her widespread periarticular and deep tissue calcifications to be a form of calcinosis universalis occurring as a complication of lSSc.

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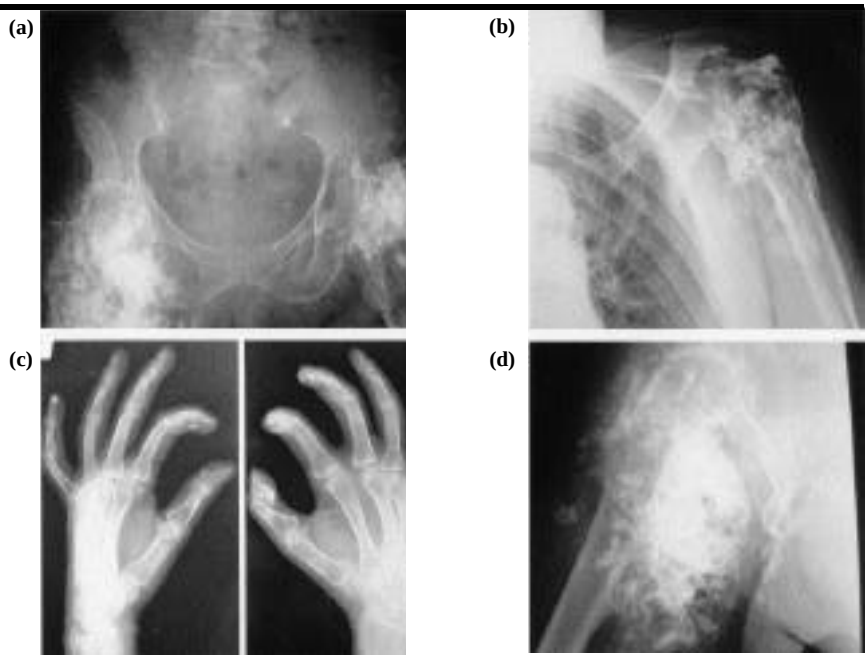

Fig. 1. X-ray images of ectopic calcifications at different levels: pelvis (**a**); left shoulder (**b**); hands (**c**); and right hip and thigh (**d**).

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"Long-term results of multiple synovectomy for patients with refractory RA" by H. Nakamura *et al.*: Erratum corrige

Sirs,

We would like to publish the notification of an error in our paper "Long-term results of multiple synovectomy for patients with refractory rheumatoid arthritis. Effects on disease activity and radiological progression" by H. Nakamura *et al*. (*Clin Exp Rheumatol* 2004; 22: 151-7). It has been brought to the authors' attention that two earlier articles should have been cited in the paper, regarding the development of multiple synovectomy.

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