Failure of unicompartmental knee replacement in a patient with psoriatic arthropathy

Sirs,

Unicompartmental knee arthroplasty is a well-documented alternative for osteoarthritis in the treatment of locally restricted osteoarthritides in young patients (1, 2). In the case of inflammatory arthritides, the situation is disappointingly different (3). Here we would like to report a case that emphasizes the importance of proper evaluation of the patient's joint symptoms when a unicompartmental arthroplasty is considered in a psoriasis patient.

A 55-year-old male building contractor had had psoriasis for 20 years but he had never experienced any joint symptoms that would have been considered psoriatic arthritis. He had successfully undergone demiprosthetoplasty 3 years previously in his left knee with osteoarthritides being the indication. However, during a period of a few months when the patient had worked on all fours, the knee had developed worsening pain and swelling that ultimately led to the rupture of a Baker's cyst. A month later the pain still continued and he sought medical advice. Knee aspiration disclosed cloudy synovial fluid, which was considered purulent. As CRP was high (Fig. 1) and the patient had fever, infection of the knee prosthesis was suspected and intravenous antibiotics were commenced. Because septic fever continued, demiprosthes was removed and the joint was debridged a week later. None of the bacterial cultures taken were positive.

After the operation, CRP and ESR remained still relatively high and the knee remained symptomatic despite the extended use of intravenous antibiotics (Fig. 1). Therefore the patient was referred to a rheumatologist, who detected synovitis in the wrists, elbows and the contralateral knee. Psoriatic arthritis was diagnosed and antibiotics were changed to antirheumatics (prednisolone 15 mg o.d., sulphasalazopyridine 1 gm b.i.d.), which led to remission of the joint symptoms. After 3 months of treatment the patient received a total knee implant to his left knee. The Knee Society Knee Scores (4) after 68 days of active treatment. A count of swollen joints is also shown.

Fig. 1. The effect of various antibiotics and antimicrobial drugs on C-reactive protein level (CRP) during the first 68 days of active treatment. A count of swollen joints is also shown.

Dear Sirs,

Cyclosporine in addition to infliximab and methotrexate in refractory rheumatoid arthritis

In this letter we report the results of a trial aimed at evaluating whether the addition of cyclosporine A (CsA), an agent often used in the combination therapies for rheumatoid arthritis (RA) (1), is a feasible option in cases of RA refractory to the association infliximab and methotrexate (MTX). The primary objective of this study was to evaluate the safety of combined infliximab, CsA and MTX therapy in adult RA patients, but the efficacy of the treatment was also assessed. This pilot, 6-month open-label study was carried out in four Italian Rheumatology centres after the approval of the local Ethics Committees. The inclusion criteria were: a diagnosis of RA (ACR criteria) (2), an age of 18-75 years, no contraindications to the use of CsA, patient's willingness to participate to the study (written informed consent), and an (original) Disease Activity Score (DAS) ≥ 3.0 despite combined therapy with infliximab (3-5 mg/kg every 6-8 weeks) and MTX (10-15 mg/week) for at least 6 months. The infliximab and MTX doses and times of administration were left unchanged; the initial CsA dose was 3.0 mg/kg/day in 2 oral administrations. Safety and tolerability were evaluated by carefully questioning and examining the patients for adverse events, and by performing all stan-
Erratum corrige

The paper "The fibrinolytic system components are increased in systemic sclerosis and modulated by Alprostadil (alpha1 inhibitors)" by F. Bindielli, F. Bartoli, E. Perfetto, A. Del Rosso, A. Moggi-Pignone, S. Guiducci, M. Cinelli, C. Fatini, S. Generini, A. Gabrielli, R. Giacomelli, S. Maddali Bongi, R. Abbate, M. Del Rosso, M. Matucci Cerinic, published in Clin Exp Rheumatol 2005; 23(5): 671-677 was funded by grant number 04/2001 of Scleroderma foundation and by the Italian MIUR.