The natural text of the provided document page is not clearly visible due to the image quality. However, it appears to be discussing analyses of ADAMTS13 activity and its inhibitor in patients with thrombotic thrombocytopenic purpura secondary to connective tissue diseases. The text mentions various medical conditions and therapies, including plasma exchange (PE), methylprednisolone (mPSL), and vincristine (VCR). It also references conditions such as Sjögren's syndrome (SjS), microscopic polyangiitis (MPA), and lupus nephritis. The text includes tables and figures that detail patient information, treatments, and outcomes. The context suggests a focus on clinical trials or observational studies in the field of immunology and hematology. The text is complex and technical, typical of medical research documentation.
Fever with rash following zolendronic acid administration

Dear Sirs,

The amino-biphosphonate zolendronic acid is primarily used for the treatment of bone metastases and/or humoral hypercalcemia of malignancy, as well as in the management of Paget’s disease (1). Allergic reactions with skin involvement (mainly pruritus, and hives), fever, and transient hematologic changes (mainly leukocytosis with relevant lymphocytopenia) have been described within 3 days after biphosphonate infusion (2). We describe a patient presenting with protracted fever and a rash 10 days after zolendronic acid administration.

A 64-year-old woman was admitted due to fever and a skin rash. She suffered from neglected rheumatoid arthritis and received methotrexate, prednisone, folic acid, oral calcium and vitamin-D supplements. A dual energy x-ray absorptiometry showed a t-score of −3.5. Ten days prior to admission, and while afibrate, she was given zolendronic acid for osteoporosis according to a clinical protocol. Six hours later, the patient experienced fever (39°C) with chills. The fever persisted, and 10 days later she developed a pruritic maculopapular rash in the lower extremities.

The patient was a housekeeper, non-smoker, did not drink alcohol, and recalled no allergic reactions. On admission, her temperature was 38.5°C. Physical examination revealed a confluent maculopapular rash in the medial aspects of both thighs (Fig. 1), and joint deformities of wrists, hands, ankles and knees. Blood serology, blood and urine cultures and appropriate imaging techniques failed to disclose any infectious causes. Major laboratory findings were: increased C-reactive protein levels (CRP, 61mg/L) and erythrocyte sedimentation rate (48mm/h), while the white blood cell and eosinophil count were normal. The patient was treated with intravenous prednisone 25mg/day and oral lornadidine 10mg/day. Two days later the rash subsided and the patient was afibrate.

A review of the available literature regarding serious skin reactions associated with biphosphonate administration discloses discontinuation of biphosphonate treatment due to fever and a cutaneous rash (3), generalized maculopapular rash with lesions in the buccal and genital mucosa and keratitis (4), superficial gyrate erythema as a cutaneous reaction to alendronate for osteoporosis (5), and hives, fever, and transient hematologic changes (mainly leukocytosis with relevant lymphocytopenia) have been described within 3 days after biphosphonate infusion (2). We describe a patient presenting with protracted fever and a rash 10 days after zolendronic acid administration. A 64-year-old woman was admitted due to fever and a skin rash. She suffered from neglected rheumatoid arthritis and received methotrexate, prednisone, folic acid, oral calcium and vitamin-D supplements. A dual energy x-ray absorptiometry showed a t-score of −3.5. Ten days prior to admission, and while afibrate, she was given zolendronic acid for osteoporosis according to a clinical protocol. Six hours later, the patient experienced fever (39°C) with chills. The fever persisted, and 10 days later she developed a pruritic maculopapular rash in the lower extremities.

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References