

complete PSS by positive lower lip biopsy that had MSG focus score >1, using the American-European criteria 2002⁵). 110/160 patients (68.75%) were mainly due to xerogenic medications. Severe obstructive sleep apnea syndrome (OSAS) was diagnosed in 6/160 patients (3.75%) (according to the American Academy of Sleep Medicine, Chicago Criteria 1999) by polysomnographic analysis. Thirty-eight (23.75%) patients were sero-positive for thyroperoxidase antibody (TPO-Ab) and/or thyroglobulin antibody (Tg-Ab) (of these patients 33/160 (20.6%) were diagnosed as having AIHT), 15 (10.2%) had a positive antinuclear antibody (ANA) assay (titer count >1:160), and 5 (3.5%) had a positive parietal cell antibody (titer count >1:160). All were sero-negative for anti-Ro/SS-A and anti-La/SS-B. In previous studies mucosal sicca symptoms were described as one of the common clinical manifestations of CFS^{6,7} as seen in our serie. Nishikai et al. and Sirois et al. had found sicca symptoms in 73% and 52% of their series respectively.^{6,7} As possible causes in our study, we determined that the prevalence of sicca symptoms (especially xerostomia) induced by psychotropic medications with anticholinergic side effects (amitriptyline, clonazepam, etc.) was high as described in several studies. Drugs with anticholinergic actions decrease salivary gland secretion by neurochemical blockade. It is usually dose related and reversible when medication is discontinued.⁷ We also found a group of CFS patients with sicca symptoms that may be attributed to AIHT and OSAS. This suggests that these two disorders share common pathophysiological features with CFS. Interestingly, in patients with OSAS, CFS symptoms were improved by using continuous nasal positive airway pressure (CPAP). Any potential relationship between CFS and PSS is complicated by the lack of a sensitive test or agreement regarding the diagnostic criteria for PSS. Nishikai et al. examined a group of 75 seronegative patients diagnosed with CFS and found that 22 (29%) met the European criteria 1993 for PSS.⁶ Sirois et al. also examined 25 patients diagnosed with CFS and found that 32% met diagnostic criteria for PSS according to the European criteria 1993.⁷ These results were not similar to ours in the study we present (11 patients if we included patients with incomplete PSS) as we described previously (Table 1). In searching of causes of this poor association, several considerations have to be taken into account in our study. 1st, in our study we used the 2002 criteria that require mandatory: (1) a positive salivary gland biopsy (only done in 5 patients), or (2) the presence of antibodies to SSA/Ro and/or to SS-B/La (negative in all patients). The serological item was also met in the 1993 criteria (used by Nishikai et al. and Sirois et al.,^{6,7}) but only if a test for rheumatoid factor or ANA was positive. This condition has probably increased the prevalence of PSS in their studies. 2nd, symptoms or signs of PSS do not always begin at the same time and that patients with incomplete SS may be will met the diagnostic criteria 2002 at some point in the future. In summary, in our study about 70% of CFS patients with sicca syndrome

Table 1

Causes of sicca symptoms in chronic fatigue syndrome' patients.

| Causes of sicca symptoms in chronic fatigue syndrome' patients | N°. patients (%): 160 (80.4) |
|--|---------------------------------|
| Xerogenic medications | 110 (68.75) |
| Autoimmune hypothyroidism | 33 (20.6) |
| Primary Sjögren syndrome (incomplete/complete) | 11 (6.8) (9/2 patients) |
| Obstructive sleep apnea syndrome | 6 (3.75) |

are related to be drug-induced. Therefore, xerogenic medications, as possible cause, must be excluded. However, we recommend that patients who have been diagnosed with CFS and manifest mucosal sicca symptoms should be also screened for SS, AIHT and/or OSAS; and should be regarded as a comorbidity of CFS, not a diagnostic exclusion criterion.

Conflict of interest

The authors declare no conflict of interest.

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Pigmented villonodular synovitis diagnostic delay due to coexistence with ankylosing spondylitis



Retraso en el diagnóstico de sinovitis villonodular pigmentada por coexistencia con espondilitis anquilosante

Dear Editor,

A 57-year-old man with longstanding ankylosing spondylitis (AS) was treated successfully with etanercept since January 2006,

except for persistent left elbow swelling. Three local corticosteroid injections and radiosynovectomy with 3 mCi 186-Rhenium proved to be useless. Elbow involvement is sporadically seen in AS,¹ and the persistence despite the intra-articular treatment made us consider the possibility of a coexistent arthropathy, such as an opportunistic infections (mycobacteria, fungi), synovial sarcoma, joint metastasis or lipoma arborescens. A first magnetic resonance imaging (MRI) was ordered, showing an unspecific synovial hypertrophy. Joint aspiration revealed an inflammatory non-hemorrhagic fluid with repeatedly negative cultures, and an open biopsy resulted in non-specific synovitis, ruling out infections and malignancies.

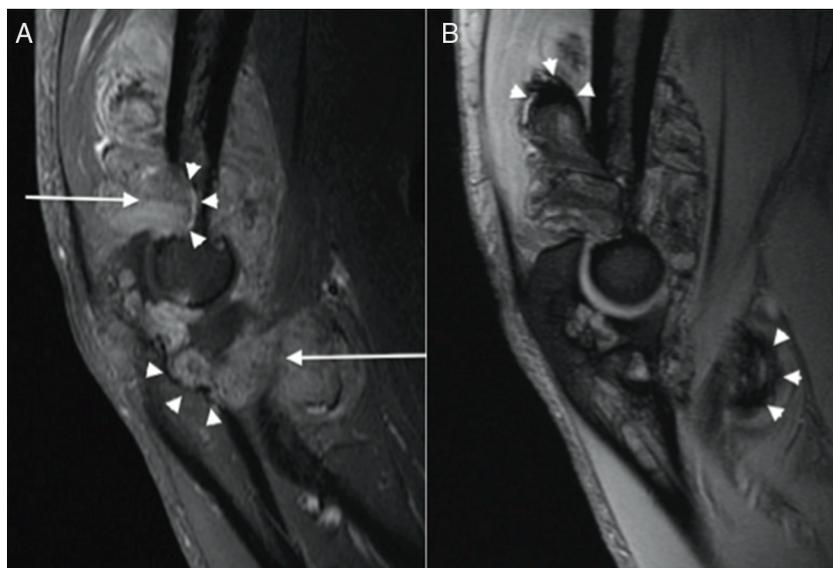


Fig. 1. (A) Sagittal T1 Fat-saturated image of the left elbow after intravenous gadolinium administration, showing an enhancing soft-tissue mass (arrows) associated to bone erosions (arrowheads). (B) Sagittal T2* weighted image, showing areas of marked low signal intensity (arrowheads) suggestive of hemosiderin deposits.

In June 2010, an X-ray highlighted the development of bone erosions. A new MRI (Fig. 1) demonstrated at this time an enhancing soft-tissue mass with magnetic susceptibility effect of hemosiderin on T2*-weighted imaging, associated with subchondral bone cysts and extrinsic erosions. Surgical synovectomy was requested, and histopathologic examination noted villonodular hyperplasia and multiple multinucleated macrophages laden with hemosiderin, characteristic features of pigmented villonodular synovitis (PVNS).

PVNS is a rare neoplastic-like pathological entity of unknown etiology affecting the synovium of the joint, tendon or bursa.² It is usually a monoarticular process carrying with pain, swelling – often mild and intermittent – and progressive decreased range of motion. It affects in decreasing order of frequency the knee, hip, ankle, and shoulder, while elbows are rarely involved.³ MRI findings are highly suggestive of the diagnosis, as the characteristic low signal intensity on T2*-weighted sequences relates to the hemosiderin-laden macrophagic infiltrate seen on histological specimens,⁴ which is an important aid to the clinician to make differential diagnosis with other entities showing identical clinical picture, such as synovial or fibrous tumors, amyloid deposits and proliferative processes. Nonetheless, similar MRI features could be found in other hemorrhagic and chronic hyperplastic synovial disorders (as in rheumatoid arthritis, arthropathy secondary to hemorrhagic diathesis, chronic articular traumatism, haemangioma, synovial sarcoma), making the histological confirmation unavoidable.⁵

In our case, the coexistence with a known cause of inflammatory arthritis, as well as the negative results of the previous techniques, delayed the final diagnosis. Although it has been published improvement of PVNS with TNF α blockade,⁶ our patient did not experience any benefit during etanercept treatment prescribed for his ankylosing spondylitis.

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