SRC is a potentially mortal complication with a prevalence of 3.3% in our hospital, more frequently at the start of the diffuse forms, and is able to present on diagnosis, as occurred in 3 patients of our series where the SRC was diagnosed from SS.

Risk factors predicting SRC have been described as: anemia, recent cardiac involvement, anti-RNA polimerase III antibodies and the use of corticoids (>15–20 mg/day).[1,2,5] In the majority of our patients no possible trigger was identified. One of our patients had been in treatment with corticoids at doses above 7.5 mg/day.

There are no data to show that pre-existing factors such as high blood pressure, proteinuria, raised creatinine levels, anti Scl-70, anticentromere antibody, or previous histological renal changes are associated with a higher frequency in the development of the SRC.[2]

Morbimortality by SRC is high and difficult to manage. It is a medical emergency, initially focused on BP control. ACEi are the drugs of choice, even in patients with renal failure. There is controversy regarding its prophylactic use as previous treatment with ACEi prior to the diagnosis of SRC may obscure its presentation.[7]

Dual therapy: ACEi and the endothelin inhibitor (bosentan) have been used in a series of 6 patients, with a follow-up of 5 months with improvement of glomerular filtration, with no changes in mortality and without studies to endorse its safety.[7] Sixty per cent of patients will require renal replacement therapy.[2,6]

When there are signs of accelerated blood pressure with oliguric renal failure sometimes accompanied by thrombotic microangiopathy of unexplained causes and cardiological involvement (pericarditis, cardiac blockage) we must direct out investigations to the diagnosis of an SS, usually diffuse, since SRC is a treatable complication if there is early identification.

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Rheumatoid arthritis patient preferences for the treatment administration route☆

Preferencias en la vía de administración del tratamiento de pacientes con artritis reumatoide

Dear Editor,

Treatment for rheumatoid arthritis (RA) has advanced greatly over the last 20 years with the incorporation of biologic therapies to the therapeutic arsenal the rheumatologist has at his or her disposal. Initial biologic intravenous (IV) treatments led to a large number of subcutaneous (SC) drugs, and in recent years new non biologic oral drugs have come onto the market. Up until now the patient had little say regarding the ideal administration route, but this has recently changed.[1–3] Patient opinion is increasingly more important in choosing the mechanism of action of a biologic, and also its form of administration.[4]

In order to determine the current opinion of a sample of patients with rheumatoid arthritis (RA) attended in our centre all patients with RA who used the rheumatology service were successfully selected for 2 weeks. Each patient was asked 3 questions by the nursing staff (day hospital and biologic therapy unit) or by their regular rheumatologist (outpatient consultations). The administration route of the current treatment of each patient was also recorded, forming patient groups with oral administration (only oral treatment), subcutaneous administration (subcutaneous treatment with or without oral treatment) and intravenous treatment (with or without oral treatment). The first question was: what is the ideal administration route for you in a RA treatment? The second was: Why did you choose this administration route? And the last was: did you at any time talk about the administration route with the rheumatologist in charge of your treatment? Response options patients could give for the first questions were 3, oral, subcutaneous or intravenous administration route and for the third question were 2, yes or no. The second question allowed for more of an open response which was summarised in the options contained in Table 1. Those patients who had responded to the questions in the day hospital or the functional unit of biologics were excluded when they were attended by outpatient departments.

Overall patient responses are contained in Table 1. The patients with oral treatment received methotrexate (7 patients) leflunomide (4 patients) and azathioprine (one patient); the patients with subcutaneous treatment received etanercept (6 patients), adalimumab (4 patients), golimumab (4 patients), certolizumab (2 patients), abatacept (one patient), tocilizumab (3 patients) and methotrexate (4 patients); and the patients with intravenous treatment received infliximab (23 patients), tocilizumab (18 patients), rituximab (11 patients) and abatacept (5 patients). Those patients with oral treatments were content with the oral administration route (10/12), whilst the majority of patients in SC treatment would have preferred an oral drug (16/24 patients) due to its convenience (69%). With regard to the patients treated with intravenous therapies, surprisingly, the majority (44/57) preferred the IV route, in contrast to that expressed in several published studies.[2] The good

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Table 1
Responses to the questions asked to patients with rheumatoid arthritis.

Current treatment actual Number 93	Preference of administration route Number (%)	Reason for preference Number (%)	Talked to rheumatologist Number (%)
Oral → 12	Oral → 33 (35,5)	Convenience → 32 (34,4)	Yes → 37 (41,9)
Subcutaneous → 24	Subcutaneous → 14 (15)	Efficacy → 20 (21,5)	No → 57 (58,1)
Intravenous → 57	Intravenous → 46 (49,5)	Phobia of needle → 5 (5,4)	
		Safety → 15 (16,1)	

relationship with the nurse and the broad experience of some of the patients with the day hospital could be factors implicated in these results. Even so, almost a quarter of the patients preferred an oral or SC treatment.

In a similar study, presented at an international congress, which included 41 patients with RA, over half of them (53%) indicated that oral administration was ideal and 34% SC administration.[5] There is a great difference with our sample since only 25% of patients had biologic treatments (IV or SC). However, the majority of patients included in this study and of our patients with SC tended to choose the oral route as the ideal one for its convenience.

Almost half of our patients responded that they preferred the intravenous route, but the majority were patients who were currently receiving IV treatment (only 2 patients who were not currently receiving IV treatment preferred this administration route). The most commonly given reasons for this were the efficacy (18/44) and safety (15/44) of the IV treatment.

Communication between physician and patient is key when choosing the appropriate treatment and it is notable that over half of our patients said they had not previously spoken about this aspect of their treatment with the rheumatologist in charge of their treatment. Although this result may only apply to our centre, it highlights the importance of involving patients in all aspects of their treatment.

The patient's opinion when choosing administration route is important. Although the intravenous route is initially rejected by the majority of patients, once established many of them agree to maintaining intravenous treatment due to the higher perceived sensation of efficacy and safety. The subcutaneous route, however, although greatly increased in recent years is not the preferred route by many patients, who would mostly choose oral treatments.

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Leukocytoclastic vasculitis manifested as a Koebner phenomenon☆

Vasculitis leucocitoclástica manifestada como fenómeno de Koebner

Dear Editor,

Koebner's isomorphic phenomenon consists of the reproduction of lesions typical of a dermatosis in areas that have suffered prior trauma, identical both clinically and histopathologically to the pre-existing dermatosis.[1,2] Its pathogenesis remains little known, and is probably multifactorial, although it has been suggested that capillary changes take place in the dermis that precede all the morphological changes.[3] Although it is well known in conditions such as psoriasis or vitiligo, Koebner's phenomenon has been described in many other dermatoses.[1] Because there are so few cases published in the literature, vasculitis is included in the group of diseases that manifest this phenomenon less frequently.[1,4] We present a case of idiopathic leukocytoclastic vasculitis with a striking Koebner's phenomenon in areas of scratching.

A 53-year-old woman, with no history of interest, consulted with a 3-day history of pruriginous erythematous-purpuric lesions on both lower limbs. The lesions were palpable, and did not disappear on diascopy. On both anterior pre-tibial surfaces they grouped and converged presenting a clear linear distribution, which was more intense on the right side (Fig. 1A and B). Although the patient admitted scratching due to her pruritis, there were no signs of abrasion. When her clinical history was taken she denied any intake of mushrooms or drugs. And she reported no gastrointestinal, respiratory tract, joint pain or other symptoms in previous days. A differential diagnosis was suggested between vasculitis or purpuric gloves and socks manifested as Koebner's phenomenon, and flagellate dermatitis. Peripheral blood, urine sediment analysis and chest x-ray showed no alterations, and autoimmune studies (ANA, ANCA, C3, C4 and CH50), and serologies (HBV, HCV and HIV) were negative. Skin biopsy reported leukocytoclastic vasculitis, and direct immunofluorescence study was negative.

Small-vessel leukocytoclastic vasculitis of the skin is mediated by a type III hypersensitivity reaction, and is due to the development of circulating immune complexes and their deposit in vessels

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