Do rheumatologists think about sex?

¿Pienzan los reumatólogos en el sexo?

Dear Editor:

We read in interest Espinoza and García-Valladares’s article entitled ‘Of Bugs and joints’. We agree that the epidemiology of reactive arthritis (ReA) is difficult to determine, especially in the absence of any internationally validated diagnostic criteria or guidelines. Whilst the clinical features of a ReA secondary to a sexually transmitted infection (STI) are indistinguishable from those caused by an enteric organism, the management could potentially be different. As was discussed, there is evidence that chlamydia induced ReA may benefit from a prolonged course of combination antibiotics.

We wondered how good clinicians were at identifying the responsible organism? Is sexually acquired ReA (SARA), an under-recognised diagnosis, perhaps due to a reluctance from the rheumatologist to discuss and investigate such matters?

We conducted an audit to establish whether patients with suspected ReA were screened for STIs. The first clinic letter of all new referrals <30 years of age to both the general rheumatology and the early arthritis clinics in the preceding 6 months was reviewed. Out of 244 referrals, 42 patients were considered to potentially have ReA and of these only 24% (10/42) were screened for an STI (all negative).

It is not reassuring that no STIs were detected because over three quarters of patients were not tested. STIs are common in the young sexually active population, with chlamydia affecting 5–10% of those under 24 years, and in females especially it can be completely asymptomatic. If a patient denies any ‘promiscuous activities’ or appears to be in a stable relationship should they still be screened?

Cutaneous lupus erythematosus induced by the treatment with tumor necrosis factor antagonists

Lupus eritematoso cutáneo inducido por la terapia biológica con antagonistas del factor de necrosis tumoral

Dear Editor,

We have carefully read the excellent review by Hernandez et al., with regard to skin lesions that occur during treatment with antagonist of tumor necrosis factor (anti-TNF), and we would like to make some additional comments with respect to cutaneous lupus erythematosus (LE) induced by such drugs.

As the authors report, the development of autoantibodies is a frequent event in patients receiving anti-TNF drugs, with an estimated prevalence of ANA positivity ranging from 25% to 80% and anti-DNA ranging from 5% to 15%. However, as they state, the appearance of LE is quite rare. Postmarketing studies estimate the incidence of induced LE at 0.19%–0.22% for infliximab, 0.18% for etanercept and 0.10% for adalimumab. The slightly higher frequency of LE induced with infliximab as they state, the appearance of LE is quite rare. Postmarketing studies estimate the incidence of induced LE at 0.19%–0.22% for infliximab, 0.18% for etanercept and 0.10% for adalimumab. The slightly higher frequency of LE induced with infliximab as they state, the appearance of LE is quite rare. Postmarketing studies estimate the incidence of induced LE at 0.19%–0.22% for infliximab, 0.18% for etanercept and 0.10% for adalimumab.

There may be some overlap of RA and LE before treatment. LE cases induced by anti-TNF drugs comply with 4 or more ACR classification criteria in 40%, 3 criteria in 21%, and 2 or less in 39%. Up to 67% of cases have cutaneous manifestations, corresponding generally to maculopapular, pruritic erythematous rash affecting photosensitive areas, as mentioned by the authors, however, the spectrum is much broader. Both LE-specific lesions (cutaneous acute, subacute and discoid), and other nonspecific findings including urticarial lesions, scarring, alopecia and purpura may occur. Within difficult to classify cutaneous LE lesions, there has also been published cases of LE tumidus and lupus pernio (LP) induced by anti-TNF. LE tumidus is characterized by the appearance of papules on exposed areas, erythematous plaques or nodules without other associated epidermal changes; one of the cases found in the literature occurred with infliximab and adalimumab in another, both in RA patients. Our group conducted a review of 5 cases of LP associated with anti-TNF, a rare form of cutaneous LE characterized by papules or plaques with erythematous violaceous acral distribution that simulate ischemic injury. Four of these cases occurred in patients with RA and one in ankylosing spondylitis.
In summary, although induced LE is a rare adverse event seen during anti-TNF treatment, it is important to have in mind because of its varied clinical expression, especially on the skin, and to identify those cases that actually are due to this entity, given the trend that may lead to overdiagnosis.

References


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