The purpose of this study was to determine the prevalence of CFS in a consecutive series of 199 patients with chronic fatigue syndrome. The prevalence of CFS is estimated to be between 0.5 and 2.5%, predominantly in women (4:1). Patients with PSS, also known as primary Sjögren’s syndrome (PSS), may also complain of sicca symptoms in up to 30–87%, and are more likely to have thyroid disorder and sleep disruption.2,3 That may suggest an underlying role of the immune system in these patients. Primary Sjögren’s syndrome (PSS) is a systemic autoimmune disease, that presents chronic exocrine glands hypofunction leading to xerostomia and/or xerophthalmia, and extraglandular involvement, of which autoimmune hypothyroidism (AIHT) is the most common autoimmune disease developed4. Patients with PSS, also experience symptoms like musculoskeletal and neurocognitive symptoms more than 50%, and the two disorders share some similar immunologic defects.5 The purpose of this study was to determine the causality of sicca symptoms in 199 consecutive patients diagnosed as having CFS, and the possible association with PSS, although few studies that have examined this association (between 2010 and 2012 in our chronic fatigue unit of Joan XXIII University Hospital) were performed after the patient visit, so many of the patients excluded were those who refused to participate, claiming physical difficulty to go and get tested, which may have been a selection bias, having lost the sickest patients.

In conclusion, based on our results we do not consider routine ABI testing justified in asymptomatic patients with RA from a cardiovascular point of view.

**References**


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**Etiology of sicca syndrome in a consecutive series of 199 patients with chronic fatigue syndrome**

**Etiología del síndrome seco en una serie consecutiva de 199 pacientes con síndrome de fatiga crónica**

**Dear Sir,**

Chronic fatigue syndrome (CFS) is a heterogeneous and multisystemic disorder of unknown pathogenesis and etiology. It is characterized by prolonged generalized and abnormal fatigue post-exercise (98%), recurrent headache (90%) and problems of concentration and memory (85%) that have lasted for at least 6 months. It is accompanied by such other symptoms as tender lymph nodes (80%), musculoskeletal pain (75%) and psychiatric problems (65%).1,2 The prevalence of CFS is estimated to be between 0.5 and 2.5%, predominantly in women (4:1).2,3 Many patients with CFS also complain of sicca symptoms in up to 30–87%, and are more likely to have thyroid disorder and sleep disruption.2,3 That may suggest an underlying role of the immune system in these patients. Primary Sjögren’s syndrome (PSS) is a systemic autoimmune disease, that presents chronic exocrine glands hypofunction leading to xerostomia and/or xerophthalmia, and extraglandular involvement, of which autoimmune hypothyroidism (AIHT) is the most common autoimmune disease developed4. Patients with PSS, also experience CFS-like musculoskeletal and neurocognitive symptoms more than 50%, and the two disorders share some similar immunologic defects.5 The purpose of this study was to determine the causality of sicca symptoms in 199 consecutive patients diagnosed as having CFS, and the possible association with PSS, although few studies that have examined this association (between 2010 and 2012 in our chronic fatigue unit of Joan XXIII University Hospital) according to the Fukuda’s criteria of 1994. One hundred sixty-seven patients (84%) were women. The age of onset of symptoms was 41 ± 10 years. Mucosal sicca symptoms were complained by 160 patients (80.4%): 11/160 (6.8%) patients were diagnosed with PSS (9 patients were incomplete PSS and 2 patients were...
We also found a group of CFS patients (R. Qanneta). Sirois et al. Anna Pàmies b As in searching of causes of this poor These results were not similar to ours in the study we kanita229@hotmail.com (AS) was treated successfully with etanercept since January 2006, por coexistencia con espondilitis anquilosante Retraso en el diagnóstico de sinovitis villonodular pigmentada as seen in our serie. Nishikai et al. and Sirois et al. had found sicca symptoms in 73% and 52% of their series respectively. 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. 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. 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. 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.), 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 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. References 1. Carruthers BM, Van de Sande MI, De Meirleir KL, Klimas NG, Broderick G, Mitchell T, et al. Myalgic encephalomyelitis: International Consensus Criteria. J Intern Med. 2011;270:327–38. 2. Ruiz E, Alegre J, Garcia Quintana AM, Aliste L, Blazquez A, Fernandez de Sevilla T. Chronic fatigue syndrome: study of a consecutive series of 824 cases assessed in two specialized units. Rev Clin Esp. 2011;211:385–90. 3. Steinberg P, Pheley A, Peterson PK. Influence of immediate hypersensitivity skin reactions on delayed reactions in patients with chronic fatigue syndrome. J Allergy Clin Immunol. 1996;98:1126–8. 4. Barendregt PJ, Visser MRM, Smets EMA, Tulen JHM, Van den Meiracker AH, Boomsma F, et al. Fatigue in primary Sjögren's syndrome. Ann Rheum Dis. 1998;57:291–5. 5. Vitali C, Bombardieri S, Jonsson R, Moutsopoulos HM, Alexander EL, Carsons SE, et al. Classification criteria for Sjögren's syndrome: a revised version of the European criteria proposed by the European-American Consensus Group. Ann Rheum Dis. 2002;61:554–8. 6. Nishikai M, Akiya K, Tojo T, Onoda N, Tani M, Shimizu K. Seronegative Sjögren's syndrome manifested as a subset of chronic fatigue syndrome. Br J Rheumatol. 1996;35:471–4. 7. Sirois DA, Natelson B. Clinicopathological findings consistent with primary Sjögren's syndrome in a subset of patients diagnosed with chronic fatigue syndrome: preliminary observations. J Rheumatol. 2001;28:126–31. Rami Qanneta a, b Ramon Fontova b Anna Pàmies b a Chronic Fatigue Unit, Department of Rheumatology, Hospital Universitari Joan XXIII, Tarragona, Spain b Department of Rheumatology, Hospital Universitari Joan XXIII, Tarragona, Spain Corresponding author. E-mail address: rami_kanita229@hotmail.com (R. Qanneta). 

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, 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 metas-tasis or lipoma arborescents. 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.