

algunos puntos controversiales<sup>12</sup> y estas se han tomado como base para un estudio multicéntrico y multinacional, que se está realizando con el objeto de proponer criterios clínicos para la clasificación de gota que puedan utilizarse en los diferentes estudios y por médicos de primer contacto<sup>13</sup>. Seguramente, la mejor detección de esta enfermedad será determinante en los reportes de la frecuencia de la misma.

## Bibliografía

- Hall AP, Barry PE, Dawber TR, McNamara PM. Epidemiology of gout and hyperuricemia: A long-term population study. *Am J Med.* 1967;42:27–37.
- O'Sullivan JB. Gout in a New England town: a prevalence study in Sudbury, Massachusetts. *Ann Rheum Dis.* 1972;31:166–9.
- Lawrence RC, Felson DT, Helmick CG, Arnold LM, Choi H, Deyo RA, et al., National Arthritis Data Workgroup. Estimates of the prevalence of arthritis and other rheumatic conditions in the United States. Part II. *Arthritis Rheum.* 2008;58:26–35.
- Peláez-Ballestas I, Sanin LH, Moreno-Montoya J, Álvarez-Nemegyei J, Burgos-Vargas R, Garza-Elizondo M, et al., Grupo de Estudio Epidemiológico de Enfermedades Músculo Articulares (GEEMA). Epidemiology of the rheumatic diseases in Mexico. A study of 5 regions based on the COPCORD methodology. *J Rheumatol Suppl.* 2011;86:3–8. Erratum in: *J Rheumatol Suppl.* 2011;38:585.
- Arromdee E, Michet CJ, Crowson CS, O'Fallon WM, Gabriel SE. Epidemiology of gout: Is the incidence rising? *J Rheumatol.* 2002;29:2403–6.
- Rothenbacher D, Choi HK, García LA. Contemporary epidemiology of gout in the UK general population. *Arthritis Res Ther.* 2011;13:R39.
- Wallace SL, Robinson H, Masi AT, Decker JL, McCarty DJ, Yu TF. Preliminary criteria for the classification of the acute arthritis of primary gout. *Arthritis Rheum.* 1977;20:895–900.
- Malik A, Schumacher HR, Dinnella JE, Clayburne GM. Clinical diagnostic criteria for gout. *J Clin Rheumatol.* 2009;15:22–4.
- Janssens HJ, Janssen M, van de Lisdonk EH, Fransen J, van Riel PL, van Weel C. The limited validity of the criteria of the American College of Rheumatology for classifying gout patients in primary care. *Ann Rheum Dis.* 2010;69:1255–6.
- Janssens HJ, Janssen M, van de Lisdonk EH, Fransen J, van Riel PL, van Weel C. A diagnostic rule for acute gouty arthritis in primary care without joint fluid analysis. *Arch Intern Med.* 2010;170:1120–6.
- Vázquez-Mellado J, Hernández-Cuevas CB, Álvarez-Hernández E, Ventura-Ríos L, Peláez-Ballestas I, Casasola-Vargas J, et al. The diagnostic value of the proposal for clinical gout diagnosis (CGD). *Clin Rheumatol.* 2012;31:429–34.
- Pascual E, Andrés M, Vela P. Criteria for gout diagnosis? *J Rheumatol.* 2013;40:356–8.
- Prowse RL, Dalbeth N, Kavanaugh A, Adebajo AO, Gaffo AL, Terkeltaub R, et al. A Delphi exercise to identify characteristic features of gout –Opinions from patients and physicians, the first stage in developing new classification criteria. *J Rheumatol.* 2013;40:498–505.

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<http://dx.doi.org/10.1016/j.reuma.2013.06.003>

## Eosinophilic pneumonia in a patient with anticentromere antibody



### Neumonía eosinofílica en pacientes con anticuerpos anticentroméricos

We read with interest the article by Jaimes-Hernández et al. (*Reumatol Clin* 2012 May–June issue) on eosinophilic pneumonia in patients with autoimmune phenomenon or immunoallergic disease.<sup>1</sup> We would like to share our experience with a patient whose condition was similar to that reported by Jaimes-Hernández et al.<sup>1</sup>

A 75-year-old woman was admitted to our hospital because of one-week history of left chest pain. She was never smoker. She had a seven-year history of atrial fibrillation and, thereafter, was prescribed warfarin. On admission, she had no rales in both lungs, and the musculoskeletal examination was also unremarkable. She had no Raynaud's phenomenon, scleroderma, and dysphagia. The chest X-ray and computed tomography revealed bilateral nonsegmental peripheral infiltrates mainly in the left lung. Laboratory data on admission were as follows: white blood cell 4900/ $\mu$ L (eosinophils: 245/ $\mu$ L), C-reactive protein 3.77 mg/dL, anti-nuclear antibody 1:640, anticentromere antibody 1:640, rheumatoid factor 4 U/mL. RP3-ANCA, MPO-ANCA, anti-ribonucleoprotein antibody, and anti-topoisomerase I antibody were negative. All tests for acid-fast bacilli including culture, and serologic and microscopic testing for fungi was negative. A bronchoalveolar lavage obtained from left upper lobe showed total cell count  $8.4 \times 10^5$ /mL with 16.7% eosinophilia. Transbronchial biopsy was not performed because the patient had warfarin for atrial fibrillation. The patient was diagnosed as having eosinophilic pneumonia and was started on 30 mg prednisolone per day. After two weeks of treatment pulmonary infiltrates had normalized. She was successfully weaned off the prednisolone over a period of two months and followed up without recurrence of eosinophilic pneumonia.

Although very rare, there have been some reports with regard to marked eosinophilic pulmonary infiltration in patients, who had

high titers of antiautoimmune antibodies.<sup>2,3</sup> Both of them were diagnosed as having Churg-Strauss syndrome.<sup>2,3</sup> Our patient had no sign and symptoms of Churg-Strauss syndrome nor any autoimmune diseases.

Our patient had a high titer of anticentromere antibody in her serum without any symptoms of CREST syndrome. There might be a possibility that eosinophilic pneumonia developed incidentally in a patient with high titer of anticentromere antibody in serum. However, the case reported by Jaimes-Hernández et al.<sup>1</sup> and ourselves suggested that a certain type of eosinophilic pneumonia might have some relationship with autoimmune phenomenon.

## Bibliografía

- Jaimes-Hernández J, Mendoza-Fuentes A, Meléndez-Mercado CI, Aranda-Pereira P. Chronic eosinophilic pneumonia: autoimmune phenomenon or immunoallergic disease? Case report and literature review. *Reumatol Clin.* 2012;8:145–8.
- Masuzaki H, Iwanishi M, Umemiya M, Misaki K, Sumitomo S, Fujimura N, et al. A rare case of allergic granulomatous angitis (Churg Strauss syndrome) with positive anti-glomerular basement membrane (GBM) antibody in serum. *Nihon Kyobu Shikkan Gakkai Zasshi.* 1991;29:1644–50.
- Nakagawa A, Yamaguchi T, Amano H, Takao T. A case of Churg-Strauss syndrome in which MPO-ANCA (antibodies to myeloperoxidase) appeared to reflect the disease activity. *Nihon Kyobu Shikkan Gakkai Zasshi.* 1995;33:543–7.

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<http://dx.doi.org/10.1016/j.reuma.2013.05.009>