

Dr. Nagashima and Dr. Minota reply

To the Editor:

We thank Dr. Cavagna and colleagues for their comments on our report¹. In their case series, 2 out of 12 patients with anti-Jo-1 antibodies had both anticyclic citrullinated peptide antibody (anti-CCP) and marginal erosions on the hands and feet revealed by radiographs. As they stated, there is increasing evidence that anti-CCP-positive patients with connective tissue diseases have a risk of developing erosive arthritis. At least we can say that antisynthetase antibodies have no role in causing erosion in antisynthetase syndrome (ASS).

Although all the patients with arthritis in their series (11 of 12) fulfilled the American College of Rheumatology (ACR) criteria for rheumatoid arthritis (RA), only 2 patients had marginal erosions. That is, even among patients with ASS who fulfill the ACR criteria for RA, erosions are uncommon. The association of polymyositis (PM) or dermatomyositis (DM) with RA has long been known, with 3% to 20% of PM/DM patients being reported to have coexisting RA². However, as with the patients described by Cavagna, *et al*, occurrence of true erosive RA may be less common than expected. On the other hand, both of our 2 patients had recalcitrant seropositive nodular and erosive RA. Further, our Patient 2 subsequently developed foot drop, suggesting peripheral neuropathy. The clinical course of our Patient 2 since the publication of our report¹ is described here.

She was admitted again with fever and sudden severe pain in her right foot. Right foot drop and paresthesia of the adjacent area were noted on the next day. Laboratory findings were as follows: white blood cell count 17,100/ μ l with 93% neutrophils; C-reactive protein 11.4 mg/dl (normal < 0.06); antinuclear antibody titer 1:80; rheumatoid factor (RF) 1:5120; anti-CCP 928 U/ml (normal < 4.5); and complement C3 and C4, 84 mg/dl (normal 86–160) and 9 mg/dl (normal 18–25), respectively. Antineutrophil cytoplasmic antibodies for myeloperoxidase and proteinase-3 were negative. Although no evidence of vasculitis was found in the biopsy specimen

of the right sural nerve, she was clinically diagnosed as having rheumatoid vasculitis. She was treated with methylprednisolone pulse therapy (1 g/day for 3 days), followed by prednisolone at 45 mg/day (1 mg/kg). Amyloid deposits were observed in the biopsy specimen obtained from the duodenal mucosa. Although DM occasionally accompanies cutaneous vasculitis, our patient had no cutaneous ulcers and no typical DM rash. Based on the severity of joint destruction, the high serum titer of RF, the rheumatoid nodules, and low serum complement level, she was diagnosed as having “rheumatoid” vasculitis. To our knowledge, such an association is also quite rare.

Patients with ASS who have anti-CCP positivity tend to develop erosions, although the severity varies from case to case. However, whether ASS patients with typical subluxing arthropathy (floppy thumbs, no erosions, and not fitting the ACR criteria for RA) have anti-CCP or not still remains to be determined.

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