Methotrexate and Chronic Uveitis Associated with Juvenile Idiopathic Arthritis

To the Editor:

We read with interest the article by Dr. Foeldvari and colleagues1 about the efficacy of methotrexate (MTX) in the management of chronic uveitis in patients with juvenile idiopathic arthritis. It is to our understanding that ophthalmic data were derived from a review of the patients’ charts. The authors have solicited a thorough pool of information, but 2 areas of important information seem to be overlooked.

First, the standard treatment for chronic bilateral anterior uveitis usually comprises topical corticosteroids and mydriatics, followed by immunosuppressive agents in severe cases, and surgical intervention in the event of ophthalmic complications2. It is important to note that even with the commencement of systemic immunosuppressive agents, concomitant topical corticosteroids are usually retained, with frequency of topical application adjusted with observation of anterior chamber inflammation2. In the study in question, information on topical corticosteroid regimens during concurrent MTX therapy was largely lacking. The authors reported a good treatment response with MTX and attributed treatment remission solely to MTX, while disregarding the antiinflammatory therapeutic benefit of concomitant topical corticosteroid. This will undoubtedly incur significant bias and confounding influence.

Second, MTX is an immunosuppressive agent not without adverse reactions3. For instance, it was found that as many as 20% of the pediatric patients taking regular MTX developed distressing side effects like nausea3. Hence, inquiries into the potential untoward side effects and the associated precautionary measures for early detection of drug toxicity are almost mandatory in patients taking regular methotrexate3. These important pieces of information were, however, not clearly stated in the article.

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REFERENCES

Dr. Foeldvari and Ms Wierk reply

To the Editor:

We read with interest the comments from Dr. Chan and Dr. Liu. In response to their questions: all patients in our cohort were treated before the start of MTX with topical steroids, and some received topical steroids when MTX was initiated and if a flare occurred during the MTX treatment. The current treatment concept, as suggested1, is that higher doses of topical steroid treatment over 3 months should be avoided because of the known long-term side effects, such as cataracts and increased intraocular pressure. Need for surgery of the eye should be reduced with the immunosuppressive treatment, because surgery, while it temporarily corrects the damage of inflammation, does not control the inflammation. MTX treatment prevents the threat of inflammation in the eyes. Some patients even need the addition of a tumor necrosis factor-α inhibitor, as did some patients in our study. We defined remission as being achieved if we managed to reduce the topical steroid treatment to less than one drop per day.

Regarding the concerns about MTX as an immunosuppressive agent, we can say that the long-term side effects of MTX in the treatment of JIA or JIA-associated uveitis are insignificant, and current studies suggest a decrease in the frequency of laboratory monitoring2. Chan and Liu are correct that nausea is a common side effect of MTX treatment, but in many patients, as in our study population, the switch to parenteral MTX application resolved this problem. In some patients the gastrointestinal side effects were the reason patients were switched from MTX to leflunomide, as mentioned in our report.

All patients received regular monitoring of laboratory values, according to the German treatment guidelines for MTX in the treatment of JIA1. They did not experience any serious laboratory side effects. We should point out that all patients received folic acid supplement 2.5 mg every 3 days.

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REFERENCES

Problems with Definitions of Disease Patterns in Psoriatic Arthritis

To the Editor:

The editorial by Taylor, et al1 was most interesting but deserves to be completed. Although the title refers to problems with the definition of axial and
peripheral disease patterns in psoriatic arthritis (PsA), only the axial patterns were really detailed. We think that the definitions of both axial and peripheral disease remain problematic. In addition, there is still confusion when distinguishing between true axial PsA and psoriasis with coincidental ankylosing spondylitis and between true peripheral PsA and psoriasis with coincidental rheumatoid arthritis (RA).

We do not believe the Moll and Wright criteria\(^2\) (an inflammatory arthritis associated with psoriasis in the absence of rheumatoid factor, RF) are sufficient because it is well known that patients with RA may be seronegative for RF at disease onset and as the disease progresses. For this reason we proposed that much of what is seen as very early inflammatory arthritis associated with psoriasis in the absence of rheumatoid arthritis and another cause of monoarthritis including RA. It may now be time to revisit ESSG criteria because their concept of SpA is too broad\(^3\). Only the axial patterns of PsA, enterocolopathies, reactive arthritides, and of course, ankylosing spondylitis should be classified as SpA based on objective data for axial disease. Finally we must be cautious about consensus exercises among experts in PsA as well as in early arthritis, as we have previously shown\(^5\).

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REFERENCES
Table 1. Clinical characteristics of patients with systemic juvenile idiopathic arthritis/adult onset Still’s disease and nasal septal perforation.

<table>
<thead>
<tr>
<th></th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
</tr>
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<tbody>
<tr>
<td>Sex</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Age at onset, yrs</td>
<td>4.5</td>
<td>14.5</td>
<td>16.5</td>
</tr>
<tr>
<td>Disease duration at nasal septal perforation</td>
<td>6.5 yrs</td>
<td>9 mo</td>
<td>10 mo</td>
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<tr>
<td>Disease course</td>
<td>Persistent</td>
<td>Persistent</td>
<td>Persistent</td>
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<tr>
<td>Systemic features</td>
<td>Fever, rash, hepatitisplenomegaly, lymphadenopathy</td>
<td>Fever, rash, hepatitisplenomegaly</td>
<td>Fever, rash, hepatitisplenomegaly</td>
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<tr>
<td>Arthritis</td>
<td>Poliarthritis</td>
<td>Polyarthritis</td>
<td>Polyarthritis</td>
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<tr>
<td>Complications</td>
<td>2 episodes of MAS</td>
<td>Poliarthritis</td>
<td>None</td>
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<tr>
<td>Nasal symptoms</td>
<td>Obstruction, pain</td>
<td>Myocarditis, myositis, Whistling</td>
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<td>CT findings from sinuses</td>
<td>Minimal mucosal thickening</td>
<td>ND</td>
<td>ND</td>
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<td>Chest CT/radiograph</td>
<td>Normal</td>
<td>Serositis only</td>
<td>Normal</td>
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<td>Autoantibodies</td>
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<td>ANA neg, RF neg, ANCA neg.</td>
<td>ANA neg, RF neg</td>
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<td>Pathology</td>
<td>Skin biopsy: small vessel neutrophilic vasculitis</td>
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<td>Medications (*current)</td>
<td>NSAID, corticosteroids*, MTX, IVIG, cyclosporine A, infliximab, etanercept, anakinra, tacrolimus*</td>
<td>Indomethacin*, corticosteroids*, IVIG</td>
<td>Indomethacin*, corticosteroids*, MTX*</td>
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