INSTRUCTIONS FOR LETTERS TO THE EDITOR

Editorial comment in the form of a Letter to the Editor is invited. The length of a letter should not exceed 800 words, with a maximum of 10 references and no more than 2 figures or tables; and no subdivision for an abstract, methods, or results. Letters should have no more than 4 authors. Financial associations or other possible conflicts of interest should be disclosed.

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Methotrexate and Chronic Uveitis Associated with Juvenile Idiopathic Arthritis

To the Editor:

We read with interest the article by Dr. Foeldvari and colleagues[1] 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 complications[2]. 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 inflammation[2]. 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 reactions[3]. For instance, it was found that as many as 20% of the pediatric patients taking regular MTX developed distressing side effects like nausea[3]. 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 methotrexate[3]. These important pieces of information were, however, not clearly stated in the article.

ALICE Y.K. CHAN, MRCP, FHKAM(Rheumatology), Social Hygiene Service, Department of Health, Hong Kong; DAVID T.L. LIU, MRCS, Department of Ophthalmology and Visual Sciences, Prince of Wales Hospital, Shatin, Hong Kong, People's Republic of China. Address reprint requests to Dr. Liu. E-mail: david_tlliu@yahoo.com

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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 suggested[1], is that higher doses of topical steroid treatment over 3 months should be avoided because of the known longterm 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 longterm 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 monitoring[2]. 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 JIA[3]. 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.

IVAN FOELDVARI, MD; ANGELA WIERK, Study Nurse, Pediatric Rheumatologic Clinic, Allgemeinen Krankenhaus Eilbek, Friedrichsberger Strasse 60, D-22081 Hamburg, Germany.

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Problems with Definitions of Disease Patterns in Psoriatic Arthritis

To the Editor:

The editorial by Taylor, *et al*[1] was most interesting but deserves to be completed. Although the title refers to problems with the definition of axial and

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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 remains unclassifiable and possibly undifferentiated[3]. This is not only true for the symmetric pattern of peripheral disease but also for asymmetrical oligoarthritis. In the literature, classification of patterns of PsA is complicated by the difficulty of assessing sacroiliitis on plain radiography[4]. Assessment is now easier owing to performance characteristics of tomographic densitometry in cases of dubious radiographic sacroiliitis as well as magnetic resonance imaging (MRI) in cases of normal sacroiliac joints on plain radiography. Indeed it is well known that radiographic sacroiliitis can develop over time.

We agree with the authors that the European Spondylarthropathy Study Group (ESSG) criteria for spondyloarthropathy[5] (SpA) show poor sensitivity and specificity when applied to a case series of patients with PsA and RA[6]. For example, a patient with knee monoarthritis and psoriasis meets SpA criteria despite a possible coincidence between psoriasis and another cause of monoarthritis including RA. It may now be time to revisit ESSG criteria because their concept of SpA is too broad[7]. 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[8].

PAUL LE GOFF, MD, 62 Bis rue Yves Collet, 29200 Brest, France.

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Dr. Helliwell, *et al* reply

To the Editor:

We thank Dr. Le Goff for his interest in our editorial[1] and welcome his comments. The purpose of our editorial was to highlight current difficulties with subgroup definition for cases already diagnosed as psoriatic arthritis (PsA). Dr. Le Goff's comments are primarily concerned with classification into PsA and non-PsA, particularly in early disease. We agree that most classification criteria only apply to established disease. This is also true for the newly developed classification criteria for PsA. Data from the aforementioned CASPAR study[2] do not support the suggestion that cases of seronegative rheumatoid arthritis are misclassified as PsA. This suggests that although the Moll and Wright criteria are used by most investigators, other, unstated, clinical criteria (such as dactylitis and enthesitis) are employed. Early disease remains problematic and may well be undifferentiated initially, so that criteria specific for PsA (or any other inflammatory arthritis) may be impossible to develop without sophisticated imaging (such as magnetic resonance imaging). We also agree that "evidence" is generally preferable to "eminence", but sometimes consensus opinion can offer a useful starting point.

PHILIP HELLIWELL, MD, PHD, Academic Unit of Musculoskeletal Medicine, University of Leeds, 36 Clarendon Road, Leeds, UK; WILL TAYLOR, MD, Rehabilitation Teaching and Research Unit, Department of Medicine, Wellington School of Medicine and Health Sciences, University of Otago, Wellington, New Zealand; HANS ZMIERCZAK, MD, Department of Rheumatology, Ghent University Hospital, Ghent, Belgium.

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Correction

Avčin T, Silverman ED, Forte V, Schneider R. Nasal septal perforation: a novel clinical manifestation of systemic juvenile idiopathic arthritis/adult onset Still's disease. Table 1 was omitted and should appear as shown on the following page. We regret the error.

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

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

ND: not done, MAS: macrophage activation syndrome, ANA: antinuclear antibodies. RF: rheumatoid factor, ANCA: antineutrophil cytoplasmic antibodies, NSAID: nonsteroidal antiinflammatory drugs, MTX: methotrexate, IVIG: intravenous immunoglobulin, CT: computer tomography.

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