Editorial

Weathering a Macrophage Storm

In rheumatology circles, macrophage activation syndrome (MAS) describes a potentially life-threatening complication of systemic inflammatory disorders, frequently making matters worse for those with systemic juvenile idiopathic arthritis (sJIA) and its adult counterpart, adult-onset Still disease (AOSD). A dysfunctional immune response results in continuous activation and expansion of T lymphocytes and macrophages, leading to an overproduction of proinflammatory cytokines (a cytokine storm) and resulting in multiorgan dysfunction. Like the related disorder, secondary hemophagocytic lymphohistiocytosis (HLH), MAS features include high, unremitting fever, hyperferritinemia, hepatosplenomegaly, lymphadenopathy, pancytopenia, and hypofibrinogenemia. Other laboratory abnormalities include elevated liver enzymes, D-dimers, lactate dehydrogenase, and triglycerides (TGC). Soluble interleukin 2 receptor α (sCD25) may be elevated, but testing is often not available at an on-site laboratory and therefore is not routinely done at the time of diagnosis1,2,3,4. Histopathology often reveals characteristic increased hemophagocytic activity in the bone marrow (and other tissues), with positive CD163 (histiocyte) staining, although this feature is often not present in initial stages and is neither highly sensitive nor specific for MAS5,6.

Most commonly studied as a complication of sJIA, the reported prevalence of MAS is estimated to be about 10%; however, reports suggest subclinical MAS may be present in 30%–40% of patients with sJIA7,8. There are several diagnostic challenges in the early recognition of MAS, particularly in distinguishing it from a flare of sJIA or AOSD. Moreover, there is no single pathognomonic feature of MAS, and many clinical features and laboratory abnormalities overlap with those of systemic inflammatory disorders, making it difficult to distinguish the underlying disease from the life-threatening comorbidity1,2,3,4. Further, until very recently, there were no universal validated criteria to aid in diagnosis. However, patient data–based classification criteria for MAS in patients with sJIA were recently reported1,9. The criteria were developed in an iterative process over several years and relied on real patient data and controls (> 1100 subjects from 33 countries). The final criteria were chosen by MAS experts selecting from nearly 1000 computer-generated combinations of clinical and laboratory findings. The final MAS criteria for children with sJIA proved to be both sensitive (0.73) and specific (0.99). The diagnosis of MAS can be made in a febrile patient with sJIA or suspected sJIA who has a serum ferritin level > 684 ng/ml plus any 2 of the following: platelet count ≤ 181 × 10^9/l, aspartate aminotransferase > 48 units/l, TGC > 156 mg/dl, or fibrinogen ≤ 360 mg/dl (Table 1)1,9. These relatively few total criteria are routinely readily available and timely.

The clinical overlap of MAS and secondary HLH has led some practitioners to use the longer-standing HLH-2004 diagnostic guidelines, which require 5 of the following 8 criteria to be met for diagnosis: fever, splenomegaly, cytopenias (affecting ≥ 2 of 3: hemoglobin < 90 g/l, platelets < 100 × 10^9/l, neutrophils < 1.0 × 10^9/l), hypertriglyceridemia (≥ 265 mg/dl) and/or hypofibrinogenemia (≤ 1.5 g/l), hemophagocytosis in bone marrow or spleen or lymph nodes, low or absent natural killer cell activity, ferritin ≥ 500 µg/l, and sCD25 ≥ 2400 units/ml10,11. Using this strict set of criteria may delay diagnosis in patients with a less severe initial presentation, putting them at risk for rapid clinical decline and potential death from delayed treatment. To improve upon this, Fardet, et al developed a modified scoring system (HScore)12, based on the HLH-2004 criteria, to estimate a patient’s risk of having secondary HLH; however, this has not been validated in patients with an underlying rheumatic systemic inflammatory condition such as sJIA or AOSD. In fact, a majority of patients included in this study had HLH secondary to an underlying malignancy or infection12. Nevertheless, the HScore is being explored in other clinical settings of children and adults with secondary HLH13,14.

In this issue of The Journal, Ahn, et al15 present an
ticoid dosage and more frequent use of cyclosporine, the hospitalization15. Clinical manifestations were similar patients with MAS, 61.1% had MAS at the time of with AOSD met criteria for sJIA associated MAS. Of the 36 MAS criteria. They found that 56.2% of hospitalized patients and those without MAS based on the 2016 pediatric sJIA MAS/secondary HLH and compared it to those with MAS who developed MAS after admission. Ahn, compared the HScore to estimate a patient’s risk of having the categories: those with MAS prior to admission, and those with MAS prior to admission, similar to what others have seen in associated MAS. These criteria may thus aid in a prompt diagnosis and subsequent aggressive and targeted treatment of MAS to better improve longterm morbidity and mortality in those with AOSD. The 2016 MAS criteria are based largely on laboratory values, with fever being the only clinical manifestation1. Some of these laboratory abnormalities can be seen in other systemic inflammatory conditions, such as systemic lupus erythematosus (SLE) and Kawasaki disease, making it difficult to generalize the criteria to include all rheumatologic conditions. It is therefore important to have additional validation studies to determine the clinical relevance of these criteria with respect to other specific inflammatory conditions.

Validated MAS criteria for rheumatic conditions will allow for more controlled treatment studies. To date, there is no standardized treatment protocol, and management remains largely anecdotal. Traditionally, high-dose corticosteroids have been the mainstay of treatment. Addition of cyclosporine has also been used and may be beneficial in patients refractory to steroids1,2,3,4. Etoposide has been included as standard treatment per HLH-1994 and HLH-2004 protocols; however, there are significant risks associated with cytotoxic chemotherapy, and it may not be the best choice for MAS patients with underlying rheumatologic disorders10,11. By comparison, several recent case series have suggested targeted interleukin 1 inhibition with anakinra may be a safe and effective first-line therapy for controlling MAS17,18,19. To better study safety and efficacy of treatments, it is crucial to validate classification criteria for various inflammatory disorders to be used in clinical trials.

With a mortality rate of 8% among patients with sJIA, and likely a notably higher one for those with AOSD, it is important for practitioners to recognize MAS early and to treat it aggressively in hopes of improving patient survival20. While this current AOSD study has several limitations, including a small patient sample, restriction to hospitalized patients, and lack of treatment outcomes, it serves as an initial study to explore the clinical relevance of the 2016 sJIA MAS
criteria in patients with AOSD, a related systemic inflammatory condition. With additional studies, it may be possible to apply modified MAS criteria for sJIA patients to those with pediatric and adult SLE, Kawasaki disease, spondyloarthritis, etc., with the potential for earlier recognition and treatment, in hopes of reducing overall mortality for patients with rheumatic disorders.

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REFERENCES


