
Authors’ reply

We appreciate the opportunity to respond to comments generated by our leader entitled “Prophylactic use of antibiotics and immunisations in patients with systemic lupus erythematosus”. Hepburn and Davies address several important issues about the prophylactic use of antibiotics in treating patients with systemic lupus erythematosus (SLE) who also have hypocomplementaemia or functional asplenia, or both. They suggest that the increased incidence of infections with encapsulated organisms in patients with SLE is related to defective clearance secondary to functional asplenia, immunosuppressive treatment, and defective opsonisation. All these potential explanations seem plausible, but it is important to note that not all patients with SLE and neisserial infections are receiving immunosuppressive agents at the time of their infection.

As emphasised in our article, we agree that it is important to recognise cohorts of patients who are at risk of developing certain infections. However, in the case of neisserial infections, the evidence to support prophylactic antibiotics for patients with SLE and hypocomplementaemia is not clear. In a small case series of patients with SLE and neisserial infections, Mitchell and colleagues suggested the following possible risk factors: female sex, young age, renal disease, and persistent hypocomplementaemia. Although it is clear that in children with haemoglobinopathies and splenic dysfunction who receive oral penicillin prophylaxis, pneumococcal bacteremia is reduced dramatically, little information supports the use of this strategy in asplenic adults.

In summary, optimal strategies to decrease the incidence of infections should remain a priority for all doctors caring for patients with SLE. However, in those who are asplenic, we reiterate the importance of vaccinations against pneumococcus and Haemophilus influenzae type B. Currently, no data support the role of prophylactic penicillin or other antibiotics in patients with SLE who are asplenic or have persistent hypocomplementaemia, but this should be further investigated with more definitive studies. For now, the best approach for doctors caring for patients with SLE is to immunise them with appropriate vaccinations, consider antibiotic prophylaxis in certain situations, and maintain a high degree of awareness for the diagnosis of bacteria and other pathogens, especially those that are prevalent in the community in which you care for the patients.

W R Gilliland, G C Tsokos
USUHS/VIRAIR, 503 Robert Grant Road, Bldg 503, Rm 1A32, Silver Spring, MD 20910–7500, USA

Correspondence to: Dr G C Tsokos; gtokos@usuhs.mil

References

Was it a case of Takayasu arteritis?

Recently, the case of a 9 year old boy presenting with cardiac failure was presented in the Annals of the Rheumatic Diseases. It was reported as a case of Takayasu’s arteritis in a child with a CD4+ lymphopenia and dysgammaglobulinaemia. I have a number of problems with this case:

- As presented in table 1 in the letter, this 9 year old child has a normal CD4 cell count with a low total lymphocyte count. Is the table wrong or did this child actually have a normal CD4 lymphocyte count?
- The dysgammaglobulinaemia actually consisted of a modest rise in the IgG level, with a normal IgA, and a borderline low IgM level of rather questionable relevance in such a sick young child.
- The evidence for Takayasu’s arteritis is rather circumstantial, based entirely on magnetic resonance imaging with some suggestive clinical findings in a very sick child presenting with cardiac failure. Surely in such a case, especially when the end result was death soon after initiating immunosuppressive treatment, attempts should have been made to secure a pathological diagnosis, either before or after the final outcome. No mention of this was made in the report.
- I remain unconvinced that this was a case of Takayasu’s arteritis and there is no evidence presented to suggest that this child did have a CD4+ lymphopenia.

M D Smith
Flinders University of South Australia

Correspondence to: Dr M D Smith, Rheumatology Research Unit, Repatriation General Hospital, Daw Road, Daw Park, South Australia 5041, Australia; Malcolm.smith@rgh.sa.gov.au

Reference

Author’s reply

We thank Dr Smith for his comments and would like to reply to the points he made.

Firstly, we agree that the absolute CD4 number was not correct in the table. It was incorrectly converted in the editorial process from the value/mm$^3$ and should have been 0.29×10$^9$/l rather than 2×10$^9$/l. We regret that this point was overlooked on the proofs.

Secondly, a polyclonal hypergammaglobulinaemia is present in one third of cases with Takayasu arteritis. The serum immunoglobulin levels of our patient are consistent with Takayasu arteritis. Dr Smith mentioned a modest rise in the IgG level, with a normal IgA level, but our patient had high levels of both IgG and IgA.

Finally, the classification criteria for Takayasu arteritis according to the American College of Rheumatology (ACR) are: (a) age at disease onset in years <40; (b) claudication of the arms and legs; (c) decreased brachial artery pulse; (d) blood pressure difference > 10 mm Hg, (e) bruit over subclavian arteries or aorta; (f) arteriogram abnormality. Our patients had all six of these criteria. In addition to the ACR criteria, our patient had one obligatory, one major, and five minor criteria for the clinical diagnosis of Takayasu’s disease according to Ishikawa’s criteria.

These criteria comprise one obligatory criterion, two major criteria, and nine minor criteria. In addition to the obligatory criterion, one major and two or more minor criteria suggest a high probability of the presence of Takayasu’s disease.

These data prove that there is no reason to doubt the diagnosis of this case as Takayasu arteritis. Additionally, the patient had a low CD4 count associated with hypergammaglobulinaemia.

S S Kilic
Department of Paediatrics, Immunology Division, Uludag University Medical Faculty, Göökde Bursa 16059, Turkey

Correspondence to: Dr S S Kilic; sebemkilic@uludag.edu.tr

Reference

www.annrheumdis.com