Rheumatology

18. Self Reported Prevalence of Rheumatological Disease is Higher as Compared to Cardiovascular Diseases and Diabetes Combined

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Aim: To determine the self reported prevalence of rheumatological diseases as compared to other diseases like cardiovascular diseases and diabetes in general population.

Methods: An epidemiological survey was carried out by door-to-door visit using a structured phase 1 questionnaire of Community Oriented Programme for Control of Rheumatic Disease (COPCORD) in six villages in rural area and an urban colony in city of Lucknow. 891 villagers (≥ 15 yrs) and 1591 urban dwellers (irrespective of age) were surveyed. The Questionnaire derived self-reported information of various diseases like Rheumatological, Cardiovascular (Ischemic and Rheumatic Heart Disease, Hypertension), Diabetes, Tuberculosis, Diarrhoea, Dysnea, Cough, ENT and Eye problems.

Observation: The following percentages of various diseases - Rheumatological diseases - 30.8% and 8.3%, Cardiovascular diseases - 9.9% and 0.1%, Diabetes - 4.3% and 0.1%, Tuberculosis 1.1% and 0.5%, Diarrhea 2.4% and 0.5%, Dyspnea 6.1% and 3.3%, cough 2.0% and 8.0%, ENT 3.9% and 2.7%, eye problems 13.3% and 7.7% in urban and rural area respectively.

Conclusion: We conclude that prevalence of rheumatological diseases is strikingly higher than cardiovascular diseases and diabetes combined, and this merits further attention.

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20. A Clinical Study of Systemic Lupus Erythematous with Special Reference to Haematological Manifestations

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Objective: 1. Clinical profile of SLE patients and clinical manifestations of haematological involvement. 2. Spectrum of haematological involvement in SLE.

Methodology: This study was conducted in the Department of Medicine and allied specialties of Gauhati Medical College and Hospital from August 2002 to October 2003. Forty patients of SLE, diagnosed by the American College of Rheumatology (ACR) criterion, were selected for the study. All the patients were subjected to a detailed clinical examination and relevant investigations.

Results: There was a marked female predominance in our study (F:M : 19:1). The disease was found to be more common in the younger age groups, maximum incidence between 21-30 years. Most of the patients in the present study presented with constitutional symptoms (97.5%), mucocutaneous involvement (87.5%) and musculoskeletal features (65%). Renal involvement was found in 52.5% of patients. Haematological manifestations was found in 100% of patients, most commonly in the form of anaemia of chronic disease in 75%. Hemolytic anaemia was found in 15%, iron deficiency anaemia in 25% and equal incidence of hypopcellular marrow and erythroid hyperplasia in 37.5%. Megakaryocytosis was found in 62.5% of patients, all with thrombocytopenia. Splenomegaly, lymphadenopathy and circulating anticoagulants were found in 35%, 10% and 5% of patients respectively in the present study.

Conclusion: This study, which is the first of its kind from this part of the country. The results of this study have shown that haematological involvement is frequent and is varied. Various haemostatic abnormalities from hypercoagulable states like antiphospholipid syndrome on one end to bleeding syndromes due to antibodies to clotting factors and platelets are also seen. The results of this study demonstrate good concordance in respect of most of the observations of earlier investigators. Though, revealing at the same time much higher incidence of haematologic manifestations.

*24. Mixed Connective Tissue Disease: Not a Rare Entity in India

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Introduction: Mixed connective tissue disease (MCTD) is a distinct entity associated with a specific antibody to an extractable nuclear antigen (ENA). It has been considered to be a rare entity and there is a paucity of literature from India. The studies on MCTD have been predominantly case record reviews and not fact finding prospective studies with active investigation. Hence the representation in these studies could be inadequate. This study prospectively analyzes the prevalence and clinical profile of MCTD in our population. This is the first study of its kind that studied the antibody profile to ten ENAs.

Material and Methods: Out of 2250 patients attending the rheumatology clinic of a tertiary care setting in Southern India during the period January 2002 to June 2004, thirteen consecutive patients with a diagnosis of MCTD (Kasukawa et al criteria) were included in the study. An extensive clinical examination, laboratory investigations, pulmonary function tests (PFT) with DLCO, 2-D echocardiography and ophthalmology consultation was obtained in all patients. A CT scan of the chest was done in all patients with respiratory complaints or an abnormal PFT. Antinuclear antibody (ANA) testing was done by indirect immunofluorescence (IF) on Hep-2010 and primate liver cell lines using commercially procured composite slides (Euroimmun). A trained observer read IF patterns. Antibodies to ENA were tested by the immunoblot technique using a commercially procured kit containing ten antigens (Euroimmun, Euroline : ANA profile 1). Rheumatoid factor (RF) was tested by latex agglutination.

Results: MCTD constitutes 0.58% of all rheumatic diseases in our centre. The median age of onset of symptoms was 36 years (IQR 22-39). The M:F ratio was 1:12. The most common manifestation was polyarthritis (10/13) followed by puffy fingers, Raynaud’s phenomenon and sclerodactyly (9/13). Inflammatory myositis was seen in 6 patients, dysphagia in four, ILD, PAH and secondary Sjogren’s syndrome in 3 patients each. All patients
were positive for antibodies to U1RNP and 3 were positive for anti-Ro.

Conclusion: The present study saw a higher than expected prevalence of MCTD in our population. The clinico-immunological profile of MCTD in our population is highlighted.

25. Treatment of Stage I and Stage II Sarcoidosis with Hydroxychloroquine One Year Experience

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Sarcoidosis is a systemic granulomatous disorder of uncertain etiology affecting young adults. Pulmonary involvement with bilateral hilar and mediastinal adenopathy is the commonest clinical presentation. Clinical and radiological features compatible with sarcoidosis along with histological evidence of non-necrotizing granulomas in the involved tissue establish the diagnosis. Other characteristics of this disorder are cutaneous anergy (as evidenced by a negative mantoux test), a heightened Th1 type of response and hypergammaglobulinemia to a varity of antigens.

Corticosteroids have been the mainstay of treatment in this condition, with good results. However, occurrence of severe adverse effects like diabetes mellitus, hypertension, dyslipidemias, cataracts and osteoporosis in such patients treated with corticosteroids, prompted us to try Hydroxychloroquine (HCQ) in symptomatic Stage I and Stage II sarcoidosis. Over a 1 year period from July 2003 to June 2004 thirty three patients with clinical and histological picture compatible with stage I and II sarcoidosis were treated with HCQ 600 mg, 400 mg and 200 mg daily, for two months each respectively. These patients were followed up with clinical (including fundus examination for ocular toxicity of HCQ), radiological evaluation including high resolution and contrast-enhanced computed tomography (CECT and HRCT) and Lung function tests with diffusion lung capacity for carbon monoxide (DLCO) at 3, 6, 9 and 12 months. 5 patients were lost to follow up.

There was marked symptomatic improvement with resolution of fever and constitutional symptoms in all but three patients. Chest x-ray (CXR) and CT showed partial or complete resolution of hilar and mediastinal adenopathy in 25. Lung function tests in 18 patients revealed improvement in forced vital capacity (FVC) and forced expiratory volume in one second (FEV1). Percentage predicted FEV1 at 3,6 and 9 months increased from 75 ± 13, 81.5 ± 16.8, 84 ± 15 and 84.1 ± 11 respectively. FVC (% predicted) at the same time increased from 78.7 ± 14 to 81.21 ± 15, 80 ± 17 and 81.3 ± 11.1. FEV1/FVC changed from baseline (% predicted) 98 ± 10 to 101% ± 9, 100 ± 16 and 100 ± 05. DLCO could be done in 15 patients only and remained unchanged at (predicted) 50,51 and 57,52 at 0.3,6 and 9 months. Lung functions remained unchanged after 9 months. Three patients worsened, with increased dyspnea, cough and increased hilar adenopathy and pulmonary infiltrates, while on treatment with HCQ. HCQ was discontinued and these patients and were successfully treated with corticosteroids (2 patients)/methotrexate (1 patient).

Most patients tolerated the drug well without serious side effects.

Conclusion: HCQ is a promising new agent in treatment of early stages of sarcoidosis. It has a unique mechanism of action and is free of any serious adverse effects. Larger randomized control trials are needed before prescription of HCQ becomes established in sarcoidosis.

136. Clinico-Immunological Profile of Antiphospholipid Syndrome (APS)

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Background and Objectives: APS is an important acquired thrombophilic disorder with protein manifestations, which has been well established in different studies. Keeping this fact in mind, a prospective study was performed to analyze and evaluate various clinical and immunological profile of different subsets of APS.

Methodology: This observational study was conducted at Rheumatology Clinic and Medicine Department of NRSMC and H, Kolkata and BMC, Burdwan from Jan’01 to June’04. Cases satisfying American College of Rheumatology (ACR) criteria of APS were taken for analysis. Thorough history, meticulous clinical examination and different investigations like complete blood count, ESR, urine analysis, rheumatoid factor (RF), ANA, CRP, anticardiolipin antibody (aCL), VDRL, lupus anticoagulant (LA) and different coagulation tests like aPTT/dRVVT were performed in addition to imaging and doppler studies. Study of anti-b2-glycoprotein I antibodies were not done.

Results: The cohort consisted of forty patients of which 28 were females and 12 were males (F:M = 2.3:1). The age group ranged from 17-62 yrs (mean 38 yrs) and mean duration of illness was 2.6 yrs (range 2-47 months). Primary APS was recorded in 19, secondary APS in 22 cases, of which SLE was the commonest association. The clinical variables were: deep vein thrombosis (DVT) 35%, cerebral venous thrombosis 15%, foetal loss 17.5%, pre-eclampsia 10%, haemolytic anaemia 7.5%, thrombocytopenia 22.5%, stroke 12.5%, arterial thrombosis 5%, catastrophic APS 2.5%, cardiac valve dysfunction 22.5%, Budd-Chiari syndrome 2.5%, pulmonary embolism 2.5%, malignant hypertension with renal insufficiency 2.5%, digital gangrene 7.5% and livido reticularis 5%. The immunological variables were: LS 45%, aCL 22.5% (IgG aCL 90.3%), IgM aCL 29% and both in 19.3%, LA+aCL 22.5%, VDRL 7.5%, RF 5%, ANA 22.5% (all belonged to secondary APS), and raised CRP in 7.5% cases.

Majority of patients with DVT or foetal loss were aCL +ve than LA+ve. Arterial thrombosis was commoner in secondary APS in comparison to primary variety.

Conclusion: APS is being increasingly documented and it needs a high index of suspicion for diagnosis. It can be concluded that tests of APS should be done in various clinical presentations mentioned above, where usual laboratory tests fail to provide an aetiology.