the case of methotrexate, we already expect a result after 3 months.

The explanation for the systemic effect of articulossynovectomy via open or arthroscopic surgery can be the reduction of the total amount of inflammatory tissue by removing hypertrophic synovium from the body. In contrast, radiosynoviorthesis leads only to fibrosation of the synovial tissue, in the case of yttrium-90 in a medium range of 3.6 mm. Deeper synovial layers are not reached by the nuclide [1–4].

While there was no difference concerning RF values between groups 1 and 2, the results of ESR and CRP seem to favour the arthroscopic approach. We would like to point out that disease activity in patients treated by open surgery was a little bit higher, shown by the quantity of synovial swelling and existence of the additional popliteal cyst, and draw the following conclusions from our study: (1) radiosynoviorthesis with yttrium-90, which we would like to recommend only in mild and moderate synovitis, because the medium range of yttrium is 3.6 mm, has no systemic effect on the underlying inflammatory disease; (2) articulossynovec-
tomy performed via the arthroscopic or open approach seems to reduce the total inflammatory activity, which can be seen by reduction of ESR, CRP and RF levels.

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Sulphasalazine in the Treatment of HIV-Related Spondyloarthropathy

Sir—Against a background of widespread use in rheumatoid arthritis, sulphasalazine has shown promising results in the treatment of spondyloarthropathy, particularly psoriatic arthritis [1]. There are also anecdotal reports of a beneficial effect in spondyloarthropathy associated with human immunodeficiency virus (HIV) infection [2, 3]. The following is an account of our experience with sulphasalazine in the treatment of 14 black Zambian patients with HIV-related spondyloarthropathy.

All patients fulfilled the European Spondyloarthropathy Study Group (ESSG) criteria [4]. Inclusion criteria were an inadequate response to maximum doses of indomethacin, the involvement of at least six joints and disease duration of 6 months or more. Sulphasalazine was introduced at a dose of 1 g daily and increased according to clinical response to a maximum of 3 g daily. Patients were assessed at monthly intervals and the disease activity assessed using a pain score (visual analogue scale, VAS), joint count, patient assessment (VAS) and physician assessment (five-point scale); full blood count, hepatic and renal function tests were performed every 4 weeks for 6 months. A duplicate anonymous test for HIV was carried out on all patients. The clinical stage of HIV infection was assigned according to the WHO classification [5]. The study was approved by the hospital ethical committee, and informed consent obtained from all patients. Of the 14 patients, two had entéric reactive arthritis, six complete Reiter’s syndrome and six an undifferentiated spondyloarthropathy. There were 10 male and four female patients aged 28–47 yr. The duration of disease was 6 and 8 months, respectively, in the two reactive arthritis cases. The mean duration of disease in the Reiter’s patients was 29 and 33 months in those with undifferentiated spondyloarthropathy. The mean duration of active disease was 8 months for the whole group. Thirteen patients completed 3 months and 11 completed 6 months of treatment. The majority of patients took 1.5 g of sulphasalazine daily. There were two non-responders. The remainder showed a varied

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TABLE I

<table>
<thead>
<tr>
<th>Pain score (mean ± s.e.)</th>
<th>Tender joints</th>
<th>Swollen joints</th>
<th>Patient assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(VAS)</td>
<td></td>
<td></td>
<td>(five-point scale)</td>
</tr>
<tr>
<td>0/12</td>
<td>6.1 ± 0.5</td>
<td>16.6 ± 2.0</td>
<td>6.4 ± 1.5</td>
</tr>
<tr>
<td>3/12</td>
<td>3.4 ± 0.6</td>
<td>5.4 ± 2.1</td>
<td>3.0 ± 2.0</td>
</tr>
<tr>
<td>6/12</td>
<td>2.5 ± 0.6</td>
<td>2.8 ± 1.9</td>
<td>0.4 ± 0.4</td>
</tr>
</tbody>
</table>

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response and in some it was excellent, as shown in Table I. There was no noticeable difference in the effect of treatment between each subgroup. Those who responded generally noticed improvement after 1 month, nearing maximum by 3 months. No case of hepatic, renal or haematological toxicity was observed. The mean haemoglobin rose from 9.5 ± 0.5 to 10.5 ± 0.69 g/dl; the platelet count fell from 401 ± 50 × 10^9/l to 286 ± 41 × 10^9/l; the mean ESR fell from 115 ± 11.7 mm/h (Westergren) to 97 ± 9.5 mm/h. HIV infection is associated with hyperglobulinaemia, which probably masked any change in ESR due to reduction of inflammation. One patient developed a skin rash, which disappeared with dosage reduction. Nine patients were in HIV clinical stage 0, two in stage 1 and three in stage 2. One patient withdrew because of dizziness after 1 month, one withdrew following no response and one died at 4 months with subacute bacterial endocarditis.

Our results confirm previous anecdotal accounts of the efficacy of sulphasalazine in HIV-related spondyloarthropathy [2, 3, 5]. We were impressed by the early response noted by others [2, 3]. Clearly, the time has now come to carry out a controlled clinical trial of this compound in view of these encouraging results.

We wish to thank Pharmacia Limited for supplying the sulphasalazine used in this study.

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**Rheumatic Disorders at a Zambian Teaching Hospital**

Sir—Rheumatoid arthritis (RA), gout and systemic lupus erythematosus (SLE) have all been described with increasing frequency in the populations of sub-Saharan Africa, while the spondyloarthropathies are considered rare [1]. There is, however, a growing suspicion of a link between the spondyloarthropathies and infection with the HIV virus in the African setting [2, 3]. We have characterized the clinical syndromes of 507 consecutive patients who attended an arthritis clinic between April 1994 and December 1995 at the University Teaching Hospital, Lusaka. Patients were referred from city health centres and GP clinics, the hospital filter clinic, casualty department, medical and surgical in-patient and out-patient services. Although established as a teaching hospital/tertiary referral centre, this is the only hospital facility for Lusaka’s population of 1.3 million, and through its casualty and filter clinic functions as a primary care utility.

A diagnosis of RA, SLE, gout, spondyloarthropathy and rheumatic fever was given to patients who fulfilled the appropriate diagnostic criteria, and ‘undiifferentiated arthritis’ to those who did not. A duplicate unlinked test for HIV was carried out on consenting adult patients. The study was approved by the hospital ethics committee. The diagnosis and HIV status of all patients are summarized in Table I. The spondyloarthropathy subgroups are reactive arthritis 119, undiifferentiated spondyloarthropathy 113, ankylosing spondylitis one and psoriatic arthritis 11.

This study has defined the relative frequency of rheumatic disorders in patients attending a referral hospital in Lusaka. Selection was not likely to have greatly affected the results of the study as most patients who attend the hospital’s out-patient clinic, filter clinic and the emergency department are self-referrals. The identification of patients with RA, gout and juvenile chronic arthritis reflects the growing awareness of these disorders in this region. However, the overwhelming prevalence of spondyloarthropathy is remarkable and the high prevalence of HIV infection in this group contrasts with a lower prevalence in patients with undiifferentiated arthritis and gout, and its absence in RA. The HIV seroprevalence among adults attending medical out-patient clinics is estimated at around 50% and for the inhabitants of urban Lusaka ~30% [4]. Our data therefore support an association between HIV infection and spondyloarthropathy in the African setting.

The appearance of what is in Caucasians an HLA-B27-linked disorder is remarkable, given the low frequency of this antigen in African populations of this region [5] and the relative rarity of