metalloproteinases (MMP-1) and their tissue inhibitors (TIMP-1).

It has been suggested that possible imbalance between these is responsible for rapid corneal keratolysis [5]. It has also been postulated that the process is a cell-mediated response to corneal epithelial damage, which would help explain why PUK can be a recurrent problem with the potential of being reactivated by corneal stimuli such as intra-ocular surgery [3, 5].

The incidence of PUK in patients with RA increases after cataract surgery [2, 3, 6]. In particular, there are suggested links with the presence of Sjögren's syndrome, previous PUK or scleritis or the presence of active rheumatoid vasculitis.

Bernauer et al. [7] reported on the surgical management of 29 patients with RA-complicated corneal perforations. The authors concluded that immunosuppression significantly improved the survival of penetrating grafts (42% graft survival after 1 yr vs 11% without immunosuppression; P = 0.02) and suggested delaying graft surgery if possible for 6 weeks to allow time for adequate preoperative immunosuppression.

Treatment for spontaneous PUK is with immunosuppressive therapy and local ocular treatment. Although treatment in the form of immunosuppression is generally accepted [1, 4, 8–10], there is little consensus on which immunosuppressive agents to use. The authors have had very good results with the use of intravenous cyclophosphamide in the treatment of spontaneous PUK, and it has been widely used in destructive ocular inflammatory conditions and systemic vasculitis.

Although immunosuppression may reduce mortality following the development of PUK, there is often significant residual ocular damage. It is apparent, therefore, that prophylactic immunosuppression in high-risk patients may not only reduce mortality but also prevent the ocular complications and therefore reduce visual morbidity.

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A case of Behçet’s disease with scleromalacia perforans

Sir, We report the case of a patient with Behçet’s disease (BD) who developed scleromalacia perforans (SP) of the right eye, and our therapeutic approach. As far as we know this is the first report of a BD patient with SP.

SIR, We report the case of a patient with Behçet’s disease (BD) who developed scleromalacia perforans (SP) of the right eye, and our therapeutic approach. As far as we know this is the first report of a BD patient with SP.
In May 2002, a 38-yr-old woman with BD was admitted to our department for the first time due to disease exacerbation. She had a history of recurrent oral aphthosis from the age of 18, arthralgia and episodes of arthritis in both wrists, knees and ankle joints from 1991, recurrent pustular lesions on her left leg from 1992 and episodes of unilateral or bilateral iridocyclitis from 1996. There was no history of chondritis. In 1997 a diagnosis of BD was made and treatment with oral methotrexate at a dose of 12.5 mg/week was introduced. There was improvement of articular symptoms and a decrease in ocular attacks, which were treated with topical steroids, but no remission of mucocutaneous manifestations. In 2000 episcleritis of the right eye, which progressed to SP, was diagnosed. From 2001 the recurrent pustular lesions tended to form bleeding erosions, which healed without leaving scars. Treatment with cyclosporin A 250 mg/day was added, but 6 months later the patient stopped taking it because of no improvement in SP and the pustular lesions.

On admission, the patient had arthritis in both wrist and knee joints, oral aphthosis and pustular lesions on her left leg. Ophthalmological examination showed SP (Fig. 1) and iridocyclitis of her right eye, with decreased visual acuity (6/10) but without retinal lesions. Radiographic studies of her chest, wrist, hip, knee and ankle joints were normal. There was normocytic, normochromic anaemia and increases in inflammatory markers (erythrocyte sedimentation rate 67 mm/1st h, C-reactive protein 14 mg/l). Urinary analysis, biochemical measurements and laboratory tests for hepatitis B and C and C3 and C4 were normal. Rheumatoid factor, lupus anticoagulant and antinuclear, antidiDNA, anti-Ro, anti-La, anti-Sm, anticardiolipin and antineutrophil cytoplasmic antibodies were negative. HLA typing showed A2, A24, B18, Bx and Cw7. Although there was no diarrhoea and no signs of suspected inflammatory bowel disease, endoscopic examination and biopsy of the colon were performed, with normal findings.

Treatment with prednisolone 75 mg/day with normal tapering and substitution of azathioprine 150 mg/day for methotrexate was initiated. With the exception of SP of the right eye, clinical amelioration was achieved. However, iridocyclitis of the right eye and pustular lesions relapsed on a prednisolone dose of 10 mg/day. Because the disease was refractory, it was decided to treat the patient with infliximab 5 mg/kg in weeks 0, 2 and 6, and thereafter every 8 weeks. Treatment with infliximab, azathioprine and prednisolone (5 mg/day) sustained the improvement in BD, except for the SP lesion. Due to a large scleral defect, surgical patching with donor bank sclera followed by corticosteroid immunosuppression was performed, and was successful. From June 2003 prednisolone was stopped and the remission of disease was sustained with infliximab infusions and azathioprine 150 mg/day.

The patient of this case, with a history of recurrent oral aphthosis, recurrent iridocyclitis, recurrent pustular lesions and episcleritis that progressed to SP, fulfilled the International Study Group criteria for BD [1]. BD is a chronic, multisystemic, occlusive vasculitis characterized mainly by mucocutaneous and ophthalmological lesions. The hallmark of ocular involvement is acute, recurrent, severe iridocyclitis. However, episcleritis, scleritis, retinal and choroidal vasculitis, optic neuritis, retina oedema and haemorrhages, and central retinal artery or vein occlusion can also occur [2]. Corticosteroids, immunosuppressive drugs, such as azathioprine, methotrexate, cyclosporin A, chlorambucil and cyclophosphamide, and interferon-α are used for the treatment of ocular manifestations. However, the control of ocular inflammation is not always successful [3]. Many case reports [4, 5] and cohort studies [6, 7] have shown that infliximab, a humanized mouse monoclonal antibody against TNF-α, is remarkably effective in BD with refractory mucocutaneous or ocular manifestations to immunosuppressive treatment.

SP, a relatively asymptomatic necrotizing scleritis without inflammation, usually occurs in rheumatoid arthritis. This complication has also been observed in vasculitides and relapsing polychondritis [8]. There is progressive thinning and atrophy of the episclera without evidence of active inflammation, and it is accompanied by the development of localized areas of scleral infarction. Systemic treatment with corticosteroids and immunosuppressive agents is required for cases with severe necrotizing scleritis [2]. Surgical treatment is indicated in instances of necrotizing scleritis that has advanced to the point of perforation of the globe. The physician must also control the underlying immunoregulatory dysfunction that has caused the destruction to protect the graft initially and the patient’s eye subsequently [9]. A recent report has demonstrated the efficacy of infliximab for scleritis when conventional immunosuppression has failed [10].

This report indicates two interesting points. First, SP should be added to uncommon but possible manifestations of BD. Secondly, TNF-α blockade seems to be an effective, new therapeutic approach for BD with refractory mucocutaneous and ocular manifestations.

Ethical committee approval and patient written consent were obtained for the initiation of infliximab infusions.
The authors have declared no conflict of interest.

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Infliximab-induced cerebral thrombophlebitis

SIR. A 31-yr-old HLA-B27-positive White male had been suffering from refractory ankylosing spondylitis (axial and peripheral involvement) for the preceding 6 yr. He was treated daily with prednisone (20 mg), omeprazole (20 mg) and an analgesic composed of paracetamol, caffeine and dextropropoxyphene. The first infusion of infliximab at a dose of 3 mg/kg was administered over 2.5 h.

Rapidly after the initiation of the infusion, the patient experienced dizziness with a mild bilateral frontal headache. Seventy-two hours later the headaches intensified, becoming disabling and requiring hospitalization. Neurological examination and lumbar puncture were normal. A cerebral MRI angiogram showed thrombosis of the left lateral sinus (Fig. 1). The aetiological investigations for this cerebral thrombophlebitis were negative.

Fig. 1. Cerebral MRI angiogram with thrombosis of the left lateral sinus.