view to reducing the size of the lesions. However, apart from a transient decrease in size of the swelling on oral steroids, there was no response to steroids or methotrexate. She also failed a trial of hydroxychloroquine and cyclosporin.

Childhood sarcoidosis is a rare disease with an estimated incidence of 0.22–0.27 per 100 000 in one study [1]. It is a chronic idiopathic disorder characterized by the accumulation of mononuclear phagocytes with formation of non-caseating granulomas. The clinical manifestations are protean in nature.

Cutaneous involvement is seen in a quarter of cases in adult patients. In children, skin involvement is seen in about 77% of young children and 24–40% of older children [2]. There are a few reports of isolated cutaneous sarcoidosis in children [3]. Our patient had isolated musculocutaneous involvement. Cutaneous sarcoidosis has been described to be responsive to steroids, methotrexate, hydroxychloroquine and other agents [4, 5].

In our patient the diagnostic possibilities included infectious and neoplastic causes. After excluding infection and malignancy, diagnosis of sarcoidosis was based on the raised ACE levels on several occasions and characteristic histopathological changes.

Our patient’s cutaneous manifestations were unresponsive to steroids, methotrexate and hydroxychloroquine. It is quite possible that other agents may work, but immunosuppressive therapy may not be warranted in asymptomatic disease. In this case, the patient opted for treatment because of the disfigurement. Our case highlights the rarer manifestations of cutaneous sarcoidosis and the possibility of a poor response to therapy.

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Suicides in persons suffering from rheumatoid arthritis

SIR, I read with interest the detailed report by Timonen et al [1] assessing suicides in patients with rheumatoid arthritis (RA). They studied suicides of RA patients using official death certificates based on forensic medico-legal investigation of Oulu, Finland and found 19 suicide victims to be RA patients. As a result, they concluded that the presence of depressive disorders and a history of at least one suicide attempt were risks for suicide completion. They also observed a unique phenomenon—half of suicidal patients with RA were women. This tendency is not in agreement with suicide cases in non-RA individuals: in general, men are at a higher risk than women. Of the 21 suicide victims, eight patients (female:male, 6:2) had been admitted to hospital owing to psychiatric problems prior to suicide completion. Because patients with systemic lupus erythematosus (SLE) have a relatively high risk for suicide [2–4] and because women are at a higher risk of developing SLE, some of the six RA patients who committed suicide might have had concurrent SLE. In addition, I would like the order of the onset time of the two diseases to be confirmed, i.e. did RA precede psychiatric disease or did psychiatric disease precede RA. When patients with psychiatric disease develop RA and subsequently attempt suicide, it is reasonable to assume that such suicides are related to psychiatric disease. Therefore, I would be very grateful if information on the presence of co-morbid rheumatic diseases and the onset time of both RA and psychiatric disease could be provided. They would be very helpful in understanding the mechanism that induces suicide in patients with rheumatic diseases such as RA and SLE.

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Reply

We thank Dr Matsukawa for the interest in our article. In response to the specific points addressed by Dr Matsukawa, we have now made some additional analyses. First, none of the suicide victims in our database had suffered from systemic lupus erythematosus (SLE). However, it has to be remembered that all somatic diagnoses of suicide victims were based on hospital admissions extracted from the National Finnish Hospital Discharge Register. Thus, there remains the possibility that our data included some cases of SLE treated as out-patients, which were missed. Second, Dr Matsukawa wanted to confirm the order of onset of the diseases, i.e. whether rheumatoid arthritis (RA) preceded psychiatric disease, or vice versa. We have now performed further analyses specifically with regard to this question. We used subjects with osteoarthritis (OA) as the control group. However, of all the psychiatric disorders, only the information on hospital-treated depression was used, because depression is known to be a major risk factor in suicidal behaviour. Figure 1 shows the Kaplan-Meier estimates for the temporal relationship between first admission due to RA/OA and subsequent first hospitalization due to depression. In all cases with both RA and depression (n=9), RA always preceded depression. Further, of all the cases with OA and depression, in 9 out of 12 cases depression followed OA. These analyses did not alter the major results of our paper, but actually provided us with important additional information in understanding the connection between RA and suicidal behaviour.

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Infliximab cost-effectiveness/safety?

SIR, There is no question that tumour necrosis factor inhibitors have made a major difference in our ability to control rheumatoid arthritis. Claims [1–4] related to cost-effectiveness of one such inhibitor, infliximab (Remicade), must be more closely examined.

It is ‘bothersome’ to find allegations that one can demonstrate lifetime cost-effectiveness based on limitation of use to only 1 or 2 yr of therapy [1–4] with a medication whose benefits disappear to baseline with its cessation [5, 6]. Kobelt et al.’s [1] recent article must be reconciled with their 2001 American College of Rheumatology meeting presentation [2]. They reported US$6600 extra cost offset the direct costs of methotrexate therapy by $1190, suggesting a cost per ‘quality of life’ gain of $29 900. This study was very difficult to assess, as multiple clinical trials were combined and their listed direct product cost was less than half that in clinical practice in both the UK and the USA. They reported a cost-effectiveness ratio of $38 200 per discounted quality-adjusted life year (QALY). However, this (similar to the present study) was predicated on the use of infliximab for no more than 2 yr! Their more recent study is similarly difficult to interpret, as it uses historical controls of individuals with early rheumatoid arthritis (different catchment group from infliximab group) from a disparate time period (5–15 yr prior). The assumption that treatment approaches were the same for the historical and infliximab groups makes the unwarranted assumption of absence of

![Fig. 1. Time (yr) between first admission due to rheumatoid arthritis or osteoarthritis and subsequent first hospitalization due to depression among 1585 suicide victims from the province of Oulu in northern Finland.](image-url)