Parotid gland biopsy compared with labial biopsy in the diagnosis of Sjögren's syndrome: reply

Sir, We thank Dr Friedman and Dr Miller for their remarks regarding the observed 6% of long-term loss of sensibility of the lip after taking a labial biopsy for diagnostic purposes in our study [1]. According to their letter, they did not observe any long-term sensory loss after taking a labial biopsy using the technique described in their article [2]. Their technique for taking a labial biopsy consisted of an office-based method of taking labial gland biopsies applying a very small incision that even did not need suturing in all cases. Although Friedman and Miller stated in their letter that they had not observed permanent sensory loss in their study sample (118 patients), they reported two cases of long-term numbness in their paper (2%) [2]. Moreover, their paper does not provide a description of how the sensory function was evaluated. Such information is essential as judgement by an independent researcher, being not the surgeon who took the biopsies, will provide an unbiased outcome in this respect. Therefore, we feel that our data are more reliable in this respect than figures provided after judgment by the physician who performed the biopsy. Furthermore, the sensory losses of 2 or 6% as reported in their and our paper, respectively, are both on the lower end of sensory loss after labial biopsies as reported in the literature [1]. Moreover, it is unrealistic that in larger labial biopsy series no cases of permanent numbness will occur. In their anatomical study Alsaad et al. [3] revealed that there is no safe anatomical space for minor surgical procedures in the lower lip to avoid cutaneous numbness. Finally, we do not understand what is meant by a diagnostic sensitivity of 100% as mentioned in their reply. Such a diagnostic sensitivity of labial biopsies, for example, Sjögren's syndrome is unrealistic and not supported by the data reported in their study. Friedman and Miller [2] reported in their study that the labial biopsies of 66% (and not 100%) of the patients referred for diagnostic evaluation of the clinical diagnosis of Sjögren's syndrome were positive. It is, however, hard to interpret their data as there is no mention in their paper which diagnostic criteria for Sjögren's syndrome they have used. It even might have been that they diagnosed Sjögren's syndrome only on the basis of the labial biopsy.

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Comment on ‘Drug-related pulmonary problems in patients with rheumatoid arthritis’

Sir, The editorial by Dr Saravanan and Dr Kelly about drug-associated lung disease in rheumatoid arthritis (RA) [1] is welcome and timely. However, we think that there are two important issues related to the passage: ‘...The reported incidence of “methotrexate pneumonitis” in RA varies widely, from 0.86% to 6.9%, the risk being maximal in the first year of treatment. Its overall frequency is 1 in every 100 patient-years [15].’

(1) The sources related to the frequencies for methotrexate pneumonitis should be provided and clarified. In Table 3 of reference 15 of the editorial [2] this frequency is given as 0.7% (16/2436). We, however, understand from the text and Table 7 that there were only 13 courses (13/2436 = 0.5%) of methotrexate that needed to be stopped due to pneumonitis. In any event either percentage is lower than the lowest frequency quoted in the editorial. This needs clarification. It should also be added that the editorial gives the adverse effect frequency as patient-years while the quoted Grove et al.’s study [2] gives the frequency as courses of methotrexate that needed to be stopped due to toxicity.

We also surely need to know more about the source especially for the alarming 6.7% frequency of pneumonitis with methotrexate, the anchor drug in RA treatment. We had previously reported our experience with methotrexate in a weekly academic rheumatology clinic over 13 years in 248 patients and among these, in only three patients the methotrexate had to be stopped due to toxicity.

(2) On the other hand the latter part of the passage provides a good example why the imprecise patient-years unit should be abandoned in giving incidences related to adverse effects. Like others in the past [4, 5], we also have recently stated [6] this practice had problems. Some drug reactions as a rule occur early in the treatment course and in only a few individuals, as, we understand, in the case of pneumonitis during methotrexate use under discussion. Apart from the relatively few patients with these early adverse effects, the remaining patients who are prescribed the drug will never get these reactions however long they use the drug. This unduly inflates the denominator of the related incidence ratio and thus will have the potential of under representing the problem related to this particular adverse effect.

The same is also true for late appearing adverse effects. If the effect is a late appearing event—like neoplasms after...