necrosis factor (TNF-α) treatment. Such a topic is of increasing interest in the literature, despite lack of long-term definitive supporting evidence [1–4]. Actually, in patients with rheumatoid arthritis (RA) under anti-TNF-α treatment, early and transient high-density lipoprotein (HDL) level increase [1, 2], but even late atherogenic index (total/HDL cholesterol) worsening has been reported [3].

In our study, significant reduction of common carotid artery intima-media thickness (cIMT) values has been observed in patients with active RA steadily responsive to anti-TNF-α agents [5]. Despite the fact that data regarding lipid profile have not been shown, total-, HDL-, low-density lipoprotein (LDL)- cholesterol and triglyceride levels were actually measured before, 3, 6 and 12 months after therapy. We did not observe any significant change of lipoprotein pattern both in patients treated with disease modifying anti-rheumatic drugs (DMARDs) plus TNF-α blockers (group A) and in those treated with only DMARDs (group B) at any time (Table 1). Moreover, no significant differences have been observed in the above-reported parameters between the two groups at any time (Table 1), nor any significant correlation between lipid profile and cIMT (Spearman’s correlation test). In agreement with the literature data [3], we suggest that lipid level modification should not be included among the main effects by which anti-TNF-α agents may influence atherosclerotic risk profile in active RA.

In our study, only five patients (three in Group A and two in Group B) were also treated with statins (simvastatin 20 mg/daily); all of them had started such therapy at least one year before the enrolment. Despite the fact that statin anti-inflammatory effects have been largely demonstrated in atherosclerosis (ATS) [6] and suggested also in RA patients treated with only DMARDs [7], we did not find any significant difference, at any time, in inflammatory marker levels or lipid plasma concentrations between statin-treated and not-treated patients. Our results suggest that in high-grade systemic inflammatory diseases, such as active RA responsive to anti-TNF-α agents, statin anti-inflammatory effect may hardly be considered playing a crucial role.

In conclusion, although the Armstrong’s remark appears very intriguing, plasma lipid profile do not seem to be significantly influenced by anti-TNF-α agents; the described statin anti-inflammatory effect also seems to be unapparent in this particular context, as overcome by the potent anti-inflammatory effect of TNF-α inhibitory treatment.

All the patients gave their written informed consent before being included in the study, which was performed according to the principles reported in the Declaration of Helsinki. This study has been ethically approved by the Faculty of Medicine Committee.

The authors have declared no conflicts of interest.
suggest another angle to the debate regarding the rheumatoid factor (RF).

Pike et al. [2] first suggested the name RF in 1949. In his original paper he states ‘the property of agglutinating sensitised sheep cells to a marked degree appears to be almost exclusively with the serum in rheumatoid arthritis. The phenomenon is due to a factor, which is present in the serum globulins and its effect is diminished on storage for a considerable period. Until this factor is more completely characterised, it may be conveniently termed the rheumatoid factor.’

We conducted a small study to assess the effect of the term RF on primary care physicians (PCPs), who are the main users of the test for RF, and on patients who had this test (the study was part of an MSc in Rheumatology and had ethical committee approval). We thought the results were interesting. It showed that 56.3% of PCP thought that patients assume that they have rheumatoid arthritis (RA), when informed that they had a positive RF. Also, 51.4% of PCPs thought that changing the term RF would cause less anxiety in patients and 72.4% thought that it would also make the explanation of the test results to patients easier.

The majority of patients (73.7%) who were told that had a positive RF assumed that they had RA. Despite explanation by their PCP, 63.6% stated that having a positive RF caused them anxiety and concern.

In the group of patients who were told that they did not have a positive RF, 15 out of 16 (93.8%) assumed that they did not have RA.

We concluded that the term RF appears to lead to over-reliance on its significance in making or excluding the diagnosis of RA. It seems to imply that its presence or absence confirms with the presence or absence of RA, at least in the mind of most patients even after explanation. It gives unjustified anxiety, fear or even reassurance.

Now the nature of this auto-antibody is fully characterized, perhaps it is time to update Pike’s convenient term to a more scientifically accurate and less anxiety-provoking term.

We suggest a competition for renaming the RF should be launched.

**Rheumatology key message**

- The term rheumatoid factor is non-scientific, misleading and confusing to patients and non-rheumatologists. It should be renamed.

The authors have declared no conflicts of interest.

R. SHABAN, R. HULL

Department of Rheumatology, Portsmouth Hospitals Trust, Southwick Road, Cosham, Portsmouth PO6 3LY, UK

Accepted 4 July 2007

Correspondence to: Ragai Shaban, Department of Rheumatology, Portsmouth Hospitals Trust, Southwick Road, Cosham, Portsmouth PO6 3LY, UK

E-mail: Ragai.Shaban@port’hosp.nhs.uk


Rheumatology 2007;46:1628–1629
doi:10.1093/rheumatology/kem208

Advance Access publication 1 September 2007

A case of Raynaud’s phenomenon in mixed connective tissue disease responding to Rituximab therapy—response

Sir, We wish to respond to the recent case report of a patient with mixed connective tissue disease whose Raynaud’s phenomenon responded to Rituximab therapy [1]. We would like to report a patient with undifferentiated, anti-nuclear antibody (ANA)-positive, connective tissue disease whose Raynaud’s phenomenon did not respond to Rituximab.

A 32-year-old woman presented in 2004 with severe triphasic Raynaud’s, livedo, joint arthralgia and a strongly positive ANA (nucleolar staining, 1:1600 titre). She had normal nail fold capillaries, no scierodactyly and cardio-respiratory examination and investigation were normal. She had a history of mild asthma since childhood. Nifedipine SR increasing to 30 mg t.d.s. was commenced, in combination sequentially with aspirin 75 mg o.d., ramipril 2.5–5 mg o.d., fluoxetine 40 mg o.d. and cessation of smoking (previously 5–10 cigarettes per day).

Over the following 12 months she developed multiple digital ulcers, on occasions infected and required multiple hospital admissions for i.v. antibiotics and iloprost (5 days, 12 h/day at 6 g/h maximum tolerated). Her Raynaud’s became increasingly severe, with symptoms even on holiday abroad, and she required regular opiate analgesia for digital pain (morphine sulphate slow release tablets 60 mg b.d.).

Due to ongoing severe Raynaud’s and persistence of high titre ANA, immunosuppression was considered. Unfortunately, 6 months’ treatment with azathioprine 200 mg daily and prednisolone 10 mg (with higher doses up to 60 mg o.d. at induction) failed to improve the clinical picture.

A year after initial presentation she developed increasing shortness of breath. High resolution computed tomography (HRCT) of the chest showed mosaic attenuation throughout, maximal in the bases and linear atelectasis in the right middle and lower lobes. Pulmonary function tests showed mild obstructive spirometry with reduced transfer factor (FeV1 78% predicted, FVC 90% predicted, TLCO 63% predicted). An echocardiogram was normal. Subsequent VATS-assisted lung biopsy showed brown pigment-laden macrophages in the small airways consistent with respiratory bronchiolitis interstitial lung disease (non-progressive, smoking related interstitial lung disease) [2]. She was treated with inhalers, salbutamol p.r.n., sibmcort 200/6/2 puffs b.d. and montelukast 10 mg o.d. In combination with smoking cessation, her respiratory symptoms and pulmonary function tests improved and her HRCT chest has remained stable to date.

Increasing global [3] and local experience with B cell depletion in antibody driven auto-immune disease suggested Rituximab as a further therapeutic option. Twenty-two months after initial presentation, she was treated with two infusions of 1000 mg Rituximab+100 mg methylprednisolone, 2 weeks apart. CD20 B cells were successfully depleted at 2 and 6 months post-Rituximab but the ANA remained strongly positive throughout.

Ten months post-Rituximab the patient continues to have severe, disabling Raynaud’s with intermittent digital ulceration. Addition of sildenafil 25 mg t.d.s. and switching from ramipril to losartan [4] has not been of benefit. Further, options such as low molecular weight heparin [5] and bosentan [6] are being considered.

There has only been one other case report of Rituximab treatment in a patient with severe Raynaud’s [7]. This patient had ANA-positive, mixed connective tissue disease with previous episodes of central nervous system involvement. Prior treatment