stem can result from static or dynamic subluxation of the cervical spine or from direct pressure by synovial pannus [2]. We present a case of periodontoid rheumatoid pannus formation in which symptomatic relief and regression of pannus (imaged by MRI scanning) was achieved following a short course of infliximab therapy.

A 65-yr-old female with a 33-yr history of rheumatoid arthritis presented with a 2 month history of severe intractable cervical spine (neck) pain and occipital headaches. Her peripheral arthritis was controlled on 10 mg of methotrexate. ESR was 11 mm/hr and CRP was < 7 mg/l.

Cervical spine X-rays showed marked osteoarthritis in the lower cervical spine. There was no instability on flexion and extension views, and in particular there was no atlanto-axial subluxation.

An MRI scan of her cervical spine showed that there was abnormal low-signal intensity material, which was seen anterior and superior to the odontoid peg. This was in keeping with pannus formation associated with synovial hypertrophy, which extended into the spinal canal on the left side indenting the thecal sac (Fig. 1A).

The patient subsequently received three infusions of 500 mg of methylprednisolone intravenously in an attempt to relieve her symptoms. However, there was no resolution of the symptoms and a subsequent MRI scan showed no reduction in the size of the pannus. There was extensive pannus formation around the odontoid peg, which extended into the spinal canal (Fig. 1B). The patient’s occipital headaches persisted despite methylprednisolone therapy and a left occipital nerve block. Pregabalin was ineffective in relieving her symptoms. Neurological examination remained unremarkable at all stages of her treatment. The patient was subsequently given three infusions of infliximab therapy at 5 mg/kg over a 6-week period. After the third infusion her symptoms of neck and occipital pain improved. A repeat MRI scan 4 months following the infliximab therapy revealed that the tissue planes around the odontoid peg were better defined when compared with the previous MRI scans with a significant reduction in the tissue bulk at this level (Fig. 1C).

Infliximab therapy should be considered early in the treatment of symptomatic cervical spine disease where rheumatoid pannus is shown to be causing neurological symptoms or compromise. Early treatment with anti-TNF therapy may have a significant impact on the development of rheumatoid myelopathy and prevent the need for surgery.
Diagnosis of PHL can often be complex. Ultrasonographic appearances of abdominal pain and nausea [7], with B symptoms of patients [6]. Treatment of RA. Recent studies suggest that the risk of lymphoma is not increased beyond that of the general population of RA patients. Methotrexate use and the development of lymphoma, there are reports of individuals developing lymphoma while taking methotrexate. A significant proportion of these are EBV positive and NHL often regresses following cessation of methotrexate [4, 5]. Anti-tumour necrosis factor (TNF) therapies have revolutionized the management of RA.NHL often occurring in RA are predominantly EBV positive and NHL often suggested that the risk of lymphoma may not be increased beyond that of the general population of RA patients [6].

Primary hepatic lymphoma (PHL) is rare; accounting for <1% of all extra-nodal lymphomas. Patients classically present complaining of abdominal pain and nausea [7], with B symptoms (fevers, night sweats and weight loss) present in 37–86% of the cases. Hepatomegaly and abnormal liver function tests are found in the majority. PHL may present as a solitary mass or multiple lesions, the pattern being of little or no prognostic value [8]. Diagnosis of PHL can often be complex. Ultrasonographic appearances may mimic metastases, abscess formation and liver cirrhosis, and CT scanning does not provide better results for similar reasons [9, 10]. Tissue diagnosis is therefore of paramount importance.

Although a rare cause of abnormal liver function, this case highlights the need for adequate investigation. PHL often presents with non-specific features and mimics a number of other conditions. Abnormal liver function in RA patients may not always be related to drugs. Tissue sampling is essential in the investigation and management of patients whose differential diagnosis lies between infection, malignancy and adverse drug reaction.

**Rheumatology key message**

- Abnormal liver function in RA may not always be attributable to drugs and should be comprehensively investigated.

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**Complete heart block after infliximab therapy**

SIR, we report the case of a 78-yr-old woman who developed complete heart block (CHB) following her third dose of infliximab.

She was diagnosed with RA RF-positive at age 50 and was treated sequentially with sulphasalazine, azathioprine, methotrexate and leflunomide. Each DMARD was discontinued either due to side-effects or lack of efficacy. She was then treated with etanercept from summer 2003 to October 2004. This had to be discontinued due to hypertension and headaches (which improved with stopping etanercept). Subsequently, she was treated for 12 months with adalimumab, which was ineffective (discontinued in December 2005).

Her RA continued to be active on prednisolone 10 mg once daily and in August 2006 she started infliximab (3 mg/kg) and methotrexate (7.5 mg once weekly). Her other medical problems were hypertension, osteoporosis, indigestion and nausea for which she was taking lisinopril, amiodipine, resindronate, omeprazole and...