have sacroiliitis on X-ray was HLA-B27 positive. It may be, however, that sacroilitis of the SI joint may be more common than previously thought. A single European study found that isolated pulmonary sarcoid was associated with HLA-B27 [10], making a true association between SpA and sarcoid possible, but this finding has not been replicated and the relatively high prevalence of the two conditions (1:1000 for AS and 0.04-64/1000 for sarcoidosis [7]) makes sporadic co-occurrence likely.

In conclusion, co-existence of SpA and pulmonary sarcoid is rare, but sacroilitis of the SI joint may be more common than previously thought. Treatment with TNF-α blockade may precipitate de novo pulmonary sarcoid and with the increasing use of these drugs for the treatment of SpA accurate diagnosis in patients who present with both sacroilitis and sarcoid is critical. The clinician should be aware that patients with SpA of sufficient severity to warrant treatment with anti-TNF agents may not report symptoms of pulmonary sarcoid due to limitation of their activity by musculoskeletal symptoms. We would therefore recommend that all AS patients undergo thorough assessment and monitoring of respiratory function prior to and during treatment with TNF-α blockers.

---

**Rheumatology key message**

- Reduced exercise capacity in AS may mask the symptoms of pulmonary sarcoidosis.

---

**Disclosure statement:** The authors have declared no conflicts of interest.

S. Levy1, V. Sandhu1

1Department of Rheumatology, St Georges Hospital, Tooting, London, UK

Accepted 7 August 2008

Correspondence to: S. Levy, Department of Rheumatology, Kings College Hospital, Denmark Hill, London SE5 9RS, UK.
E-mail: sarahlevy@doctors.net.uk

---


---

**FIG. 1.** Bone marrow trephine labelled with anti-CD20 showing hairy cells.
laboratory features may on occasions be indistinguishable from idiopathic scleroderma. The only unusual feature in this case is male gender, as 80% of the cases of SSc occur in women. The mechanism of interrelationship between scleroderma and malignancy has not been proven but most hypothesis favour imbalance of the immune system: it is postulated that a humoral or cell-mediated immune process initiated by the malignancy may be responsible for the development of scleroderma [2, 4, 5]. HCL is an indolent form of B-cell lymphoma. Hairy cells produce fibronectin and cytokines such as fibroblast growth factor, TGF-β and TNF-α. The first three have been deemed responsible for bone marrow fibrosis whilst the latter is thought to cause marrow inhibition [7]. Activated fibroblasts are recognized as the effector cells responsible for the fibrotic changes in scleroderma. Their activation and regulation results from complex cell–cell, cell–cytokine and cell–matrix interactions mediated by a variety of cytokines and growth factors [8]. TGF-β promotes extracellular matrix synthesis and myofibroblast differentiation and is implicated as a key driver of the activated scleroderma fibroblast phenotype [9]. Interestingly, TGF-β and other cytokines are produced in excess in HCL. Given that the interplay between a number of cytokines and growth factors is thought to underlie the pathogenesis of both conditions, it is reasonable, although purely speculative, to infer that both pathologies may have common pathogenic links.

Cladribine is a purine analogue with cytotoxic effects in proliferating and quiescent hairy cells [10]. Death of hairy cells will result in interruption of the production of TGF-β and other cytokines, which may explain why treatment of HCL halted the progression of scleroderma in our case. This shows parallelism with recent publications on the use of cladribine in systemic sclerosis and other disorders. Ann Intern Med 1995;122:60–2.

Sir, I read with interest the article by Adimulam et al. [1] on “NICE guidance does not tally with clinical practice—a district general experience”. They conclude that not all patients with fragility fractures have osteoporosis and thus may not need treatment. I feel that this conclusion is fundamentally flawed.

It is accepted that the clinical consequence of osteoporosis is a fragility or low-trauma fracture. These fractures are the reason for the morbidity and mortality seen in osteoporosis patients. Many studies have shown that a prior fragility fracture is an important risk factor for further fracture. Fracture risk is approximately doubled in the presence of a prior fracture, and these risks, in part, are independent of BMD [2]. For that reason, in the management algorithms for the treatment of osteoporosis, a prior fragility fracture can be used as an indication to start treatment, with or without a DXA measurement [3].

If we accept that a prior fragility fracture is a marker of established osteoporosis, its presence would therefore necessitate us to start treatment, regardless of the availability of DXA measurement, to prevent further fractures. In addition, the patients in Adimulam’s audit were also elderly (mean age of 79.8 yrs) who would all be at high risk of hip fractures, with all its consequent morbidity and mortality.

The authors mention that bone density may not be the perfect surrogate for bone fracture, with which I absolutely agree. However, the fact that the patients have already broken a bone would suggest that their bones are already fragile, regardless of the bone density, and thus require treatment, again regardless of their bone density.

Disclosure statement: The author has declared no conflicts of interest.

S. S. YEAP

Subang Jaya Medical Centre, Subang Jaya, Selangor, Malaysia.

Accepted 24 July 2008

Correspondence to: S. S. Yeap, Subang Jaya Medical Centre, No. 1, Jalan SS12/1A, 47500 Subang Jaya, Selangor, Malaysia. E-mail: yeapp@myjaring.net

