et al. [4] is a well-considered move in the standardization of capillaroscopic scoring systems.

International description of the patterns in terms of well-defined, simple and reliable parameters, including the definition of the distal row, is essential for research on the diagnostic significance in relation to organ involvement as well as response to therapy in connective tissue diseases, and subsequently for the interpretation of scoring of nail-fold capillary patterns in routine clinical practice.

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Comment on: A multicentre study on the reliability of qualitative and quantitative nail-fold videocapillaroscopy assessment: reply

Sir, we agree with Houtman [1] that there is a need for a simple scoring system for the assessment of nailfold images, based on reliable parameters. The purpose of our study [2] was therefore to gain more insight into the reliability of nailfold parameters using computer-based nailfold panorama mosaic images. We agree that (stereo)microscopy, at least until recently, has been more widely available in clinical practice than videocapillaroscopy. It is therefore reassuring and valuable to see that, at least in experienced hands, the inter- and intra-observer reliability of nailfold parameters using the stereomicroscope are in line with our study, although different statistical methods were used.

It is worth highlighting that in our study [2] some observers were experienced but others inexperienced (i.e. had no or very little previous experience with nailfold assessment). A key point in our study was the quantification (at high magnification) of abnormality across the whole nailbed, made possible with computerized software. The high magnification provides additional information and detail to that obtained using a stereomicroscope. Further studies are needed to further investigate the reliability and feasibility of the different imaging methods and a scoring system to be used for diagnostic and/or research purposes, although the likely selection of parameters has become clearer from recent studies.

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Comment on: Arthropathy with infiltrate IgG4-positive plasma cells in synovium

Sir, We read with interest the letter published in Rheumatology by Umekita et al. [1] regarding a case of
IgG4-related disease associated with arthropathy. As reported recently [2], a case of arthropathy with elevated IgG4 in the sera and abundant IgG4-positive plasma cell infiltration was observed without hyperplasia of the synovial lining cells. This is in contrast to RA, where a high concentration of serum IgG1 and dominant IgG1-positive plasma cells with synovial lining cell hyperplasia is often observed. The study observed no other organ involvement, including visceral organs, besides peripheral joints. Thus they concluded they had identified a novel case of IgG4-related arthropathy without other organ involvement [1]. However, it is sometimes difficult to detect multiple organs involved in disease pathogenesis during IgG4-related systemic disease because of a lack of symptoms or insidiousness.

Primary and metastatic malignant lesions can be observed easily by 2-[18F]fluoro-2-deoxy-D-glucose positron-emission tomography (FDG-PET), a highly useful imaging technique in these cases. Furthermore, FDG-PET is increasingly recognized as a useful tool for diagnosis, tissue localization and follow-up in inflammatory disorders including Takayasu’s arteritis and RA [3]. Because FDG-PET can be used to analyse the whole body, this sensitive technique can be used for the non-invasive assessment of multiple organ involvement in systemic inflammatory diseases, including IgG4-related disease [4]. The introduction of FDG-PET with computed tomography (FDG-PET/CT) for clinical use has shown it to be a superior technique that enables the accurate anatomical localization of specific areas in which increased signal intensity is observed by FDG-PET [4]. Although Umekita et al. [1] described FDG accumulation as observed only in multiple joints, other areas of accumulation, such as nasopharyngeal, cervical mediastinal and para-aortic lesions, and renal accumulation may also be observed in the FDG-PET image. Lymphadenopathy is also a common feature of IgG4-related disease [5, 6]. Most patients develop cervical, hilar, mediastinal and para-aortic lymph node swelling, though the size of the lymph nodes often does not exceed 2 cm in diameter [5]. We are concerned about the anatomical localization of cervical and mediastinal accumulation of FDG in the FDG-PET/CT imaging. Thus horizontal or coronal FDG-PET/CT imaging may provide such information and further clarify the results.

In IgG4-related diseases, various organ involvement may be concomitantly or sequentially observed in the pituitary gland, thyroid gland, salivary and lacrimal glands, lung, pancreas, liver, kidney, retroperitoneum, prostate, peripheral joints, lymph nodes and skin [5–9]. These symptoms may be asymptomatic and insidious, and in these cases only, biopsy specimens can indicate organ involvement. In renal diseases, tubulointerstitial nephritis (TIN) is the most frequent pathological form of IgG4-related disease in the kidneys. Nishi et al. [9] reported that in 37 cases of IgG4-related kidney disease, one-third of patients showed normal renal function in spite of the presence of TIN. In cases without renal dysfunction and abnormalities in urinalysis, only distinctive radiographic signals by contrast-enhanced CT may predict TIN [10]. In addition to a tumour-like lesion, wedge-shaped or patchy irregular contrast enhancement in the kidneys is a hallmark of IgG4-related kidney disease [9, 10], and should also be a concern.

Furthermore, as FDG-PET/CT can accurately visualize anatomical localities, FDG accumulation in the kidneys can be clearly discriminated between the renal parenchyma and pelvis. Indeed, the diffuse, intense uptake of FDG in the bilateral kidneys observed by FDG-PET/CT has been used to identify IgG4-related nephropathy [4, 10]. FDG-PET/CT images, but not FDG-PET images, should be presented to provide the anatomical distribution of FDG accumulation.

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References


Comment on: Arthropathy with infiltrate IgG4-positive plasma cells in synovium: reply

Sin, We would like to thank Taki et al. [1] for their interest in and comment on our manuscript reporting a case of arthropathy with infiltrate of IgG4-positive plasma cells in synovium [2]. We agree with their opinion that caution should be exercised when concluding that there were no active lesions except arthropathy in this patient. We actually evaluated this patient using [18F]fluoro-2-deoxy-D-glucose PET (FDG-PET) in combination with CT (Fig. 1). FDG accumulation was confirmed by the radiologists to exist in multiple joints, but not in other areas such as the nasopharyngeal, cervical mediastinal and para-aortic regions. FDG accumulation observed in areas of the face and neck in the FDG-PET without CT were due to lesions in the cervical vertebra and sternoclavicular joints. Accumulation of FDG-PET in the kidneys is usually observed because FDG-PET is excreted in the urine. There was nothing to suggest tubulointerstitial nephritis (TIN) in this case because urinary abnormalities, renal dysfunction and imaging abnormalities such as wedge-shaped or patchy irregular tumour-like lesions on contrast-enhanced CT were not observed. Furthermore, there was no diffuse FDG uptake in the bilateral kidneys on FDG-PET/CT [3]. It has been reported that positive RF and low levels of complement are frequently observed in IgG4-related TIN, but these were not observed in this case [4, 5]. Therefore renal involvement in this case was unlikely. However, histological confirmation by renal biopsy was not performed. In addition, we agree with the possibility that IgG4-related lesions other than arthropathy could occur in the future in this case. Careful long-term follow-up is necessary to determine the prognosis of this case.

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