was evaluated using whole blood targeting a portion of the gene HcP100. The method showed 89% sensitivity and 96% specificity for the diagnosis of histoplasmosis. Similar to the case described by Small et al. [8], evidence for infection by H. capsulatum came in our case only from isolation of the fungus from a remote site (blood), but not from the lesion itself. The response to specific antifungal therapy with itraconazole strongly supported the diagnosis of IPG in this case. Our experience suggests that any PG-like lesion without adequate response to antibiotic treatment and a failing corticosteroid trial should alert the physician to consider the anatomic location, make a detailed and thorough assessment of the pathology with staining for non-bacterial infections (considering atypical forms of vasculitis as the case) and systematically perform isolation studies of deep mycosis. We believe that the PCR technique for Histoplasma, despite not being validated through multicentre studies where a large number of samples could determine its specificity, can be useful in cases where the classical methodology (direct examination, culture and serology) produces inconclusive results.

**Rheumatology key message**

- Atypical pathogens should be suspected in vasculitic ulcer unresponsive to corticosteroid and antibiotic therapy.

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

**Supplementary data**

Supplementary data are available at Rheumatology Online.

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**References**


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**Successful desensitization to low-dose methotrexate**

Sir, A 57-year-old woman with RA was initially treated with prednisone for 4 months before MTX was commenced as a disease-modifying agent. After 5 weeks of MTX therapy, she developed an immediate reaction following a 20 mg dose which was characterized by generalized urticaria, angio-oedema, throat constriction and abdominal cramping. She developed similar reactions to LEF and SSZ. During this period, her dose of prednisone was maintained at 15 mg daily.

A desensitization protocol to MTX was formulated on the basis that it was the preferred disease-modifying agent especially if an approved biologic agent was to be used as part of her therapy. MTX is used as an immunosuppressive agent in low doses and as an antineoplastic agent in high doses. Anaphylactic reactions are rare and have been reported at various dosing levels.

However, the small number of desensitization protocols to MTX that have been published all target tolerance to high dose levels required in the treatment of malignancy. The initial doses administered in these protocols are usually ≥50 mg [1, 2]. In contrast, desensitization was performed to a low target dose of 25 mg in this patient. As it was not feasible to use oral suspensions of MTX, the protocol involved the slow i.v. administration of incremental doses of MTX (0.025, 0.25, 2.5 and 22.5 mg resulting in a cumulative dose of 25 mg) in the intensive care unit (Table 1). She ingested her daily dose of 15 mg of prednisone prior to the commencement of desensitization. The protocol was completed successfully and the following week she was able to tolerate a 25 mg oral dose of MTX given under medical supervision. She was then able to
This is the first case report of successful desensitization to low-dose MTX. This schedule may need to be amended for individual patients according to the target dose. This would involve as for our patient administering incremental doses in a logarithmic fashion at the same infusion rate. The patient was made aware that if MTX was ceased she would need to be desensitized again. This desensitization schedule provides clinicians with the option of using low-dose MTX in patients who have had a hypersensitivity reaction to the drug. Given the risk of anaphylaxis with desensitization, it is crucial that it is performed by clinicians who are experienced in such procedures and performed in settings where patients can be monitored and treated for anaphylaxis.

**Rheumatology key message**

- Desensitization to low-dose MTX is an option for patients with an autoimmune disease.

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**References**


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### Table 1

Desensitization schedule to low-dose oral MTX

<table>
<thead>
<tr>
<th>Stage 1, Day 0</th>
<th>1 ml of MTX 25 mg/ml in 999 ml of normal saline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concentration of MTX (mg/ml)</td>
<td>Dose of MTX (mg)</td>
</tr>
<tr>
<td>0.025 mg/ml</td>
<td>0.025</td>
</tr>
<tr>
<td>0.025 mg/ml</td>
<td>0.25</td>
</tr>
<tr>
<td>0.025 mg/ml</td>
<td>2.5</td>
</tr>
<tr>
<td>0.025 mg/ml</td>
<td>22.5</td>
</tr>
<tr>
<td>Total cumulative dose of 25 mg</td>
<td>Total infusion time of 7.5 h</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2, Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral MTX 25 mg</td>
</tr>
<tr>
<td>Patient observed for 6 h</td>
</tr>
</tbody>
</table>

Take her weekly dose of MTX at home without an adverse reaction.