RE hearing to baseline (determined through a new audiometry) and normalization of acute phase reactants. The patient was discharged with prednisone 30 mg/day and tapered the dosage of MTX to 12.5 mg/week, remaining asymptomatic after 6 months. Since the first description of CS, more than 220 cases have been described, 92 of them appearing atypically.[5] Unlike typical CS, the atypical variety is most commonly associated with systemic[6] manifestations and other autoimmune diseases, such as sarcoidosis, rheumatoid arthritis, relapsing polychondritis, juvenile idiopathic arthritis, Sjögren's syndrome and inflammatory bowel disease, among others.[7] Our case may raise doubts about the diagnosis, given the coexistence of several autoimmune[8,9] diseases. Psoriatic arthropathy could justify that the patient presented uveitis. Relapsing polychondritis can also present with hearing loss and vertigo, although generally it is a conductive hearing loss and vestibular dysfunction is not as similar to Meniere's. In this patient, the vestibular episodes were intense, with prolonged and bilateral sensorineural hearing loss, preceded by ocular involvement in less than a two year interval, and in the absence of specific complementary data, made us opt for the diagnosis of atypical CS, fulfilling the criteria established by Haynes et al.,[3] with 2 associated autoimmune disorders (psoriatic arthritis and relapsing polychondritis) and showing a good response to corticosteroid and immunosuppressive therapy, something relevant given the poor prognosis of deafness.

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Silvia Montes,[a,*] Samantha Rodríguez-Muguruza,[b] Viña Soria,[c] Alejandro Olivé[b]

[a] *Servicio de Reumatología, Hospital Universitario San Cecilio, Granada, Spain*
[b] *Servicio de Reumatología, Hospital Germans Trias i Pujol, Barcelona, Spain*
[c] *Servicio de Otorrinolaringología, Hospital Germans Trias i Pujol, Barcelona, Spain*

Corresponding author.
E-mail address: silvia.montes_@hotmail.com (S. Montes).

Usefulness of the Ankle-brachial Index as a Survey Method for Subclinical Vascular Disease in Patients With Rheumatoid Arthritis☆

Utilidad del índice tobillo-brazo como método de cribado de enfermedad vascular subclínica en pacientes con artritis reumatoide

To the Editor,

Rheumatoid arthritis (RA) is a systemic inflammatory disease, with a chronic and variable evolution, characterized by persistent and symmetrical synovitis of the peripheral joints. In recent years its natural history has changed thanks to advances in treatment, so comorbidities have become more important; in fact, increased mortality compared to the general population is primarily a result of diseases of cardiovascular origin,[1] with rates up to 50% or higher.

In RA underlying atherosclerotic disease is increased[2] secondary to chronic inflammation, which involves activation of T lymphocytes and macrophages, production of proinflammatory cytokines[3] (gamma interferon, tumor necrosis factor, IL-1 and IL-6). It is potentiated due to classic cardiovascular risk factors (CVRF), including the metabolic syndrome, which is more prevalent probably due to less physical activity because of joint pain and moreover, dyslipidemia follows a more atherogenic[4] pattern.

With all these data, we conclude that the RA is a situation with a high CVR, where cardiovascular morbidity is related to the disease activity, so its control could reduce the risk.[5] Therefore, this study proposes to detect subclinical CVD by measuring the ankle-brachial index (ABI).

We performed a descriptive cross-sectional study on 60 RA patients with no history of CVD, at the University Hospital of La Princesa, Madrid, selected consecutively in the rheumatology clinic during the 6 months when the study was carried out. Sociodemographic variables, analytical data, classic CVRF, duration of RA and immunomodulatory treatment were collected. ABI was defined as abnormal if less than 0.9.[6]

Of the 60 patients enrolled, 3 were men (5%) and 57 women (95%) with a mean age ± standard deviation of 53.75 years (53.75 ± 15.38, range 29–87). 38 had mild RA (63.3%), while 22 (36.7%) had important deformities. The time of disease progression was 9.14 years (9.14 ± 6.505, range 0.6–40), 58 patients (96.7%) were under immunomodulatory therapy, mostly with methotrexate (75%). The result of the ABI was similar in both lower limbs: 1.074 (1.074 ± 0.082, range 0.88–1.28) on the right and 1.077 (1.077 ± 0.088, range 0.92–1.27) on the left, with no significant differences between them. Only one patient (1.7%) had an abnormal ABI: a woman of 87 years, with hypertension, and RA for 12 years and using corticosteroids during virtually all this time; the ABI on the other extremity was 0.92. Fig. 1 shows the ABI results.

In our sample, there is an overrepresentation of women (19:1) with respect to other RA populations (3:1). However, the profile of CVR did not differ regarding the Spanish general population.[7] Only one pathological case was detected, much lower than other studies,[8,9] with rates of 20%–25%, although the frequency cutoff point considered as pathological was 1, rather than the value of 0.9 currently accepted. However, in another publication with the same cutoff,[10] the prevalence was 10%, although in their sample the mean age, duration of RA and, above all, the prevalence of cardiovascular

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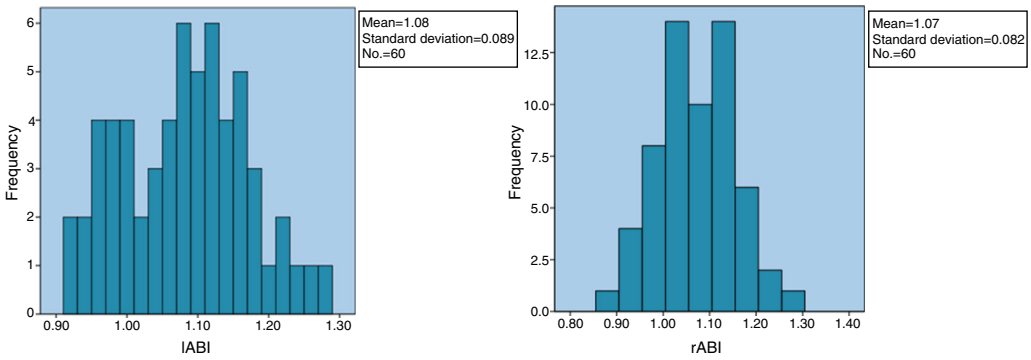

Fig. 1. Results of the ABI on the left and right lower extremities.

risk factors (especially diabetes and dyslipidemia) were superior. Other possible factors involved could be the adequate control of the disease, since only 3.3% of patients had no specific treatment and the value of the acute phase reactants was normal.

A major limitation to the study was accessibility, as the ABI was performed after the patient visit, so many of the patients excluded were those who refused to participate, claiming physical difficulty to go and get tested, which may have been a selection bias, having lost the sickest patients.

In conclusion, based on our results we do not consider routine ABI testing justified in asymptomatic patients with RA from a cardiovascular point of view.

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Cristina Marcos de Frutos, Daniel Abad Pérez,*
Carmen Suárez Fernández

Servicio de Medicina Interna, Hospital Universitario de La Princesa, Madrid, Spain

Corresponding author.
E-mail address: danielabadperez@hotmail.com (D. Abad Pérez).

Etiology of sicca syndrome in a consecutive series of 199 patients with chronic fatigue syndrome

Etiología del síndrome seco en una serie consecutiva de 199 pacientes con síndrome de fatiga crónica

Dear Sir,

Chronic fatigue syndrome (CFS) is a heterogeneous and multisystemic disorder of unknown pathogenesis and etiology. It is characterized by prolonged generalized and abnormal fatigue post-exercise (98%), recurrent headache (90%) and problems of concentration and memory (85%) that have lasted for at least 6 months. It is accompanied by such other symptoms as tender lymph nodes (80%), musculoskeletal pain (75%) and psychiatric problems (65%).[1,2] The prevalence of CFS is estimated to be between 0.5 and 2.5%, predominantly in women (4:1).[1,2] Many patients with CFS also complain of sicca symptoms in up to 30–87%, and are more likely to have thyroid disorder and sleep disruption;[2,3] that may suggest an underlying role of the immune system in these patients. Primary Sjögren' syndrome (PSS) is a systemic autoimmune disease, that presents chronic exocrine glands hypofunction leading to xerostomia and/or xerophthalmia, and extraglandular involvement, of which autoimmune hypothyroidism (AIHT) is the most common autoimmune disease developed[4]. Patients with PSS, also experience CFS-like musculoskeletal and neurocognitive symptoms more than 50%, and the two disorders share some similar immunologic defects.[4] The purpose of this study was to determine the causality of sicca symptoms in 199 consecutive patients diagnosed as having CFS, and the possible association with PSS, although few studies that have examined this association (between 2010 and 2012 in our chronic fatigue unit of Joan XXIII University Hospital) according to the Fukuda' criteria of 1994. One hundred sixty-seven patients (84%) were women. The age of onset of symptoms was 41 ± 10 years. Mucosal sicca symptoms were complained by 160 patients (80.4%): 11/160 (6.8%) patients were diagnosed with PSS (9 patients were incomplete PSS and 2 patients were