LETTER TO THE EDITOR

(J Bangladesh Coll Phys Surg 2010; 28: 132-133)

A case report regarding 'Yellow Nail Syndrome' was published in Jan,2010 Vol. 28, No 1: 49-52 in the Journal of Bangladesh College of Physician and Surgeons.

To the editor in chief: we have gone through the case report and we have few important comments on this report:Yellow nail syndrome is a triad of deformed yellow nails, lymphoedema and pleural effusion.[1] This is an infrequently reported clinical entity. The three separate varities may manifest in widely varying times. [2]Patients may not present with the 'classical triad of syndromes. Age of onset varies and has been reported from antenatal to 65 years. [3]The basic abnormality in this syndrome appears to be ' hypoplasia of the lymphatic vessels which is responsible for lymphoedema, nail change and pleural effusion. [4]Respiratory manifestations also may include allergic rhinosinusitis and bronchiectasis and lower respiratory tract infections. Yellow nails are found in 89%, lymphedema in 80% and pleural effusion in 36%. These three findings are concurrently seen in only one third patients. [5]The diagnosis is made when patients has chronic pleural effusion in conjunction with yellow nails and lymphedema. Diagnosis may be difficult or missed as patients may not present with all the features of the syndrome simultaneously or present with each aspect of the syndrome in different departments.Increasing awareness of this syndrome and close scrutiny of the nails in patients having idiopathic and recurrent pleural effusion and lymphedema of the legs will avoid diagnostic delay and other unnecessary treatment modalities.

References:

1. Light RW. Pleural effusion. In: Murray JF, Nadel JA, editors. Text book of respiratory medicine, 2nd edition. Philadelphia: WB Saunders: 1994 p. 2164-92.
2. Beer DJ, Pereira W Jr. Snider GL, Pleural effusion associated with primary lymphedema: a perspective on the yellow nail syndrome. Am Rev Respir dis 1978; 117; 595-599
3. Nakielna EM, Wilson J, Ballon HS Yellow-nail syndrome: report of three cases Can MedAssoc J. 19 Jul apt 15(l):46-8
4. Light RW. Pleural Diseases, Philadelphia, Lippincot Williams and Wilkins, 2001.
5. Nordkild P, Kromann-Anderson H, Struve-Christensen E : Yellow nail syndrome. The triad of yellow nails, lymphedema and pleural effusion: a review of the literature and case report.

Dr. Rukhsana Parvin
Assistant Professor of Medicine
Enam Medical College

Author's Reply

Many thanks for asking for my comments. The reply is perfect complimentary statements. No reply from the author is needed. The letter can be published as it is !

Dr. Md. Ridwanur Rahman
Prof. & Head, Dept. of Medicine
Shaheed Suhrawardy Medical Colleges Hospital
Dhaka

"Medical Treatment of Rheumatoid Arthritis: A review" of the Journal of Bangladesh College of Physicians and Surgeons, January 2010, volume 28, no. 1

To the Editor-in-Chief: I have read with interest the review article titled "Medical Treatment of Rheumatoid Arthritis- A review". I would like to draw your attention to the new advancement that has occurred in the field of Rheumatoid Arthritis in recent past. It has long been known that TNF, IL-1, IL-6 and many other cytokines are closely related with the pathogenesis of RA. IL-6 promotes inflammatory events through the expansion and activation of T cells and the differentiation of B cell.[1] Severe RA is commonly associated with thrombocytosis, hypergamma-globulinemia, and elevated erythrocyte sedimentation rate (ESR) and CRP levels. Such abnormalities tend to rise in parallel with plasma and synovial levels of IL-6.[2] Consistent with these data, therapeutic studies in which the effects of IL-6 are blocked have noted improvements in clinical and laboratory variables. Tocilizumab is a novel

antibody therapy that competitively inhibits the binding of IL-6 to its receptor. Inhibiting the entire receptor complex prevents IL-6 signal transduction to inflammatory mediators that summon B and T cells.[1,3]

A Phase II, double-blind trial was conducted with 359 European patients who had active RA despite methotrexate therapy. The best results for monotherapy were seen with tocilizumab 8 mg/kg, with a 63% ACR20 response, a 41% ACR50 response, and a 16% ACR70 response; however, when tocilizumab was combined with methotrexate, the ACR responses improved (74%, 53%, and 37%, respectively), approximately twice the responses seen with methotrexate plus placebo.[4] The Study of Active Controlled Monotherapy Used for Rheumatoid Arthritis, An IL-6 Inhibitor (SAMURAI), a Phase III study, compared the effects of Tocilizumab 8 mg/kg with conventional disease-modifying anti-rheumatic drugs (DMARDs) on the progression of structural and joint damage over 52 weeks of treatment. After treatment, markers of disease activity were reduced: joint spaces had narrowed less, and ACR20, ACR50 and ACR70 responses significantly improved in the tocilizumab group compared with the DMARD group. Hence, it appears that tocilizumab also has a benefit for patients in terms of radiographic progression of disease.[5]

Since IL-6R inhibition has a distinct mechanism of action, some patients who do not respond to anti-TNF agents or who respond partially may be expected to respond to Tocilizumab. On January 8, 2010 the US FDA approved tocilizumab for the treatment of adult patients with moderate to severely active rheumatoid arthritis who have had an inadequate response to one or more TNF blockers. Tocilizumab is now currently available in Bangladesh and it will further enrich the armory of Internists and Rheumatologists for the management of RA.

References:

1. Naka T, Nishimoto N, Kishimoto T. The paradigm of IL-6: from basic science to medicine. *Arthritis Res*. 2002; 4(suppl 3):S233-42.
2. Papanicolaou DA, Wilder RL, Manolagas SC et al. The pathophysiologic roles of interleukin-6 in human disease. *Ann Intern Med*. 1998; 128:127-37.
3. Hirano T. Interleukin 6 and its receptor: ten years later. *Int Rev Immunol*. 1998; 16:249-84.
4. Maini RN, Taylor PC, Szechinski J et al. Double-blind randomized controlled clinical trial of the interleukin-6 receptor antagonist, tocilizumab, in European patients with rheumatoid arthritis who had an incomplete response to methotrexate. *Arthritis Rheum*. 2006; 54:2817-29.
5. Nishimoto N, Hashimoto J, Miyasaka N et al. Study of Active Controlled Monotherapy Used for Rheumatoid Arthritis, An IL-6 Inhibitor (SAMURAI): evidence of clinical and radiographic benefit from an X-ray reader-blinded randomized controlled trial of tocilizumab. *Ann Rheum Dis*. 2007; 66:1162-7.

Dr. Md. Azizul Haque
Assistant Professor, Department of Medicine,
Rajshahi Medical Colege
Email:drazadbd@gmail.com

Author's Reply

I thank Dr. Md. Azizul Haque for his interest in my article. I was delighted to read his letter giving information about a very recent advancement in the medical treatment of RA with Tocilizumab. Tocilizumab, a humanized anti-IL 6 receptor, after phase I I I studies, has been very recently (January 8, 2010) approved by US FDA and it is now available in Bangladesh. I reviewed the medical treatment of RA including the biological agents available at the time of submission (several months ago) of the manuscript of this article, although details of each of these novel agents were not given due to lack of space. However, I gladly accept the additional information he has provided.

Dr. A.H.M. Feroz
Associate Professor of Medicine
Shaheed Suhrawardy Medical College, Dhaka