ESIM SAAS-FEE 2014

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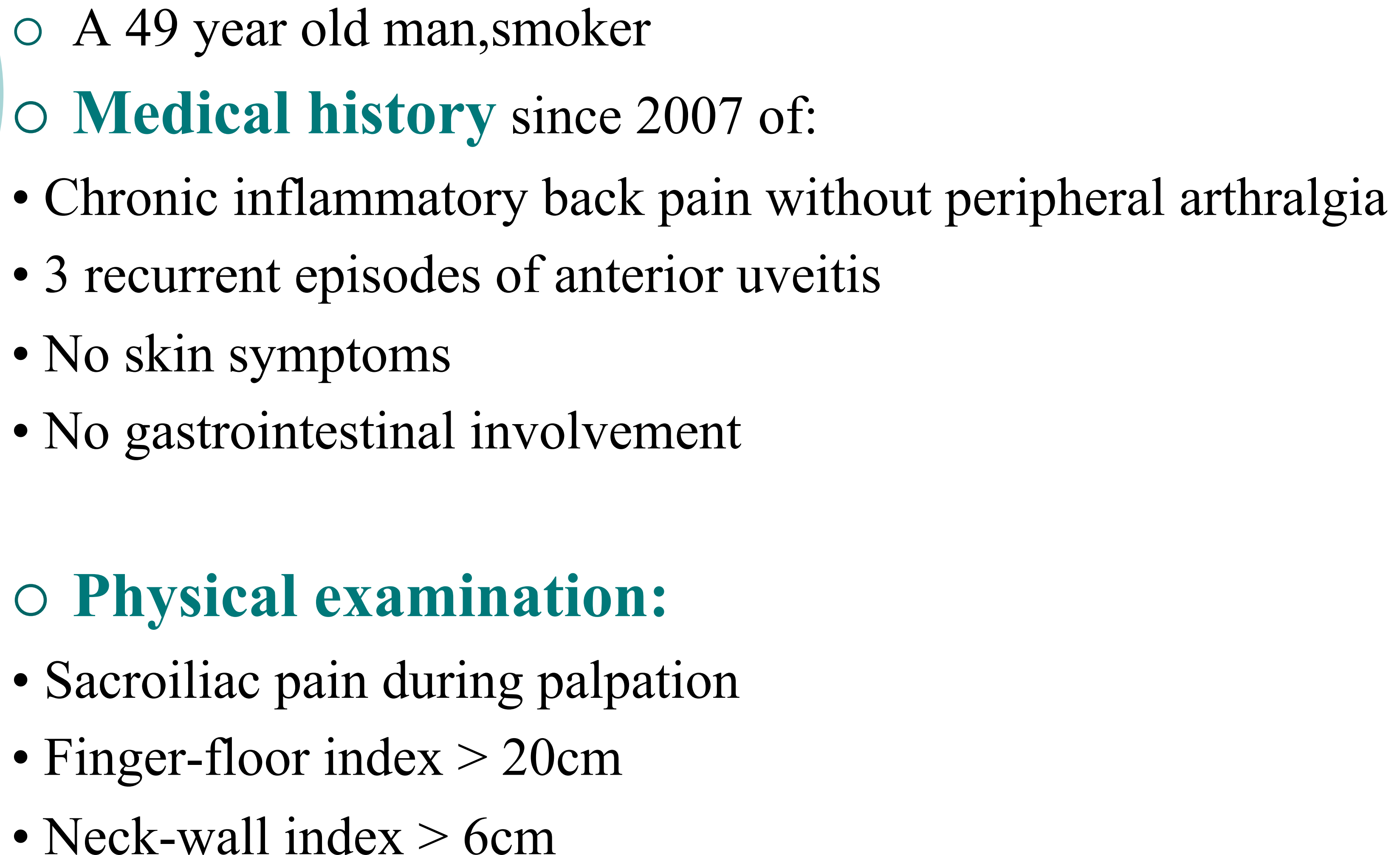
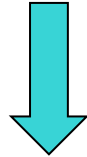

A 49 year old man,smoker
Medical history since 2007 of:
• Chronic inflammatory back pain without peripheral arthralgia
• 3 recurrent episodes of anterior uveitis
• No skin symptoms
• No gastrointestinal involvement
Physical examination:
• Sacroiliac pain during palpation
• Finger-floor index > 20cm
• Neck-wall index > 6cm

Paraclinical investigations:

- HLA B27: positive
- Sacro-iliitis in MRI

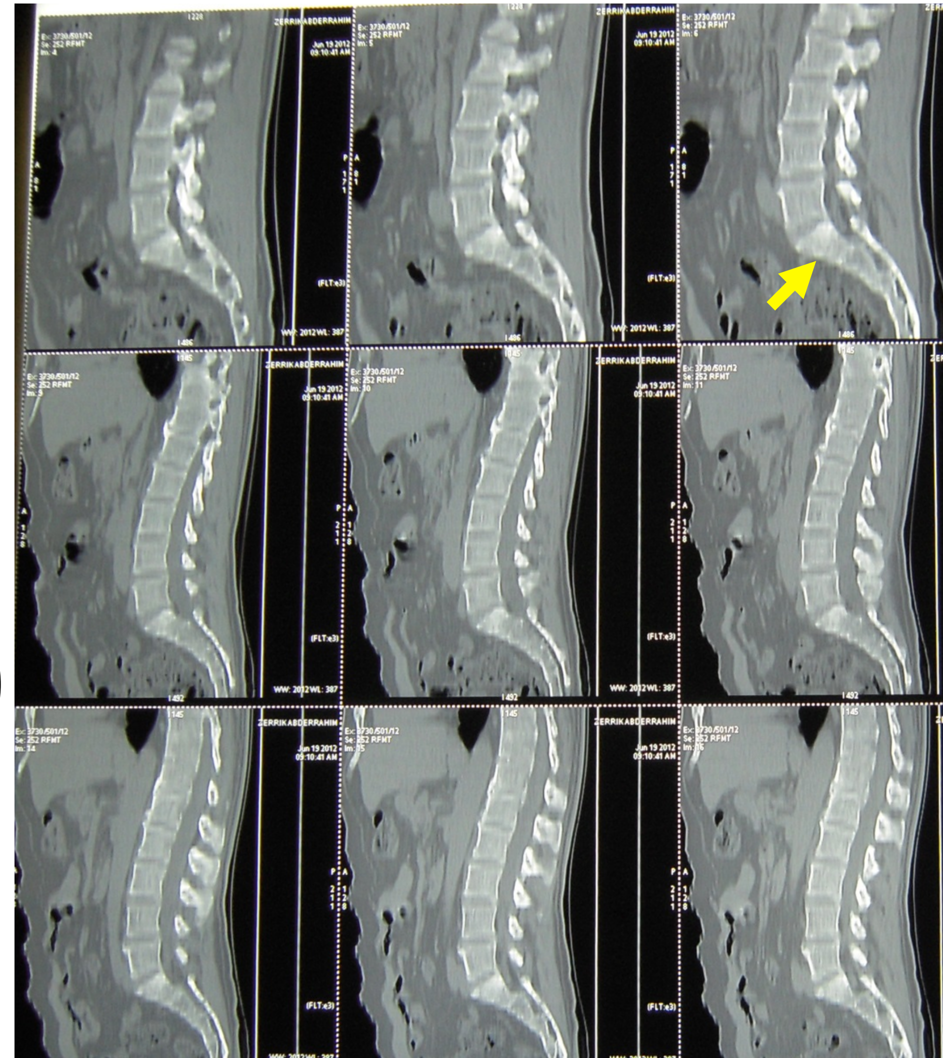


Refering to **ASAS criteria** diagnosis was made:

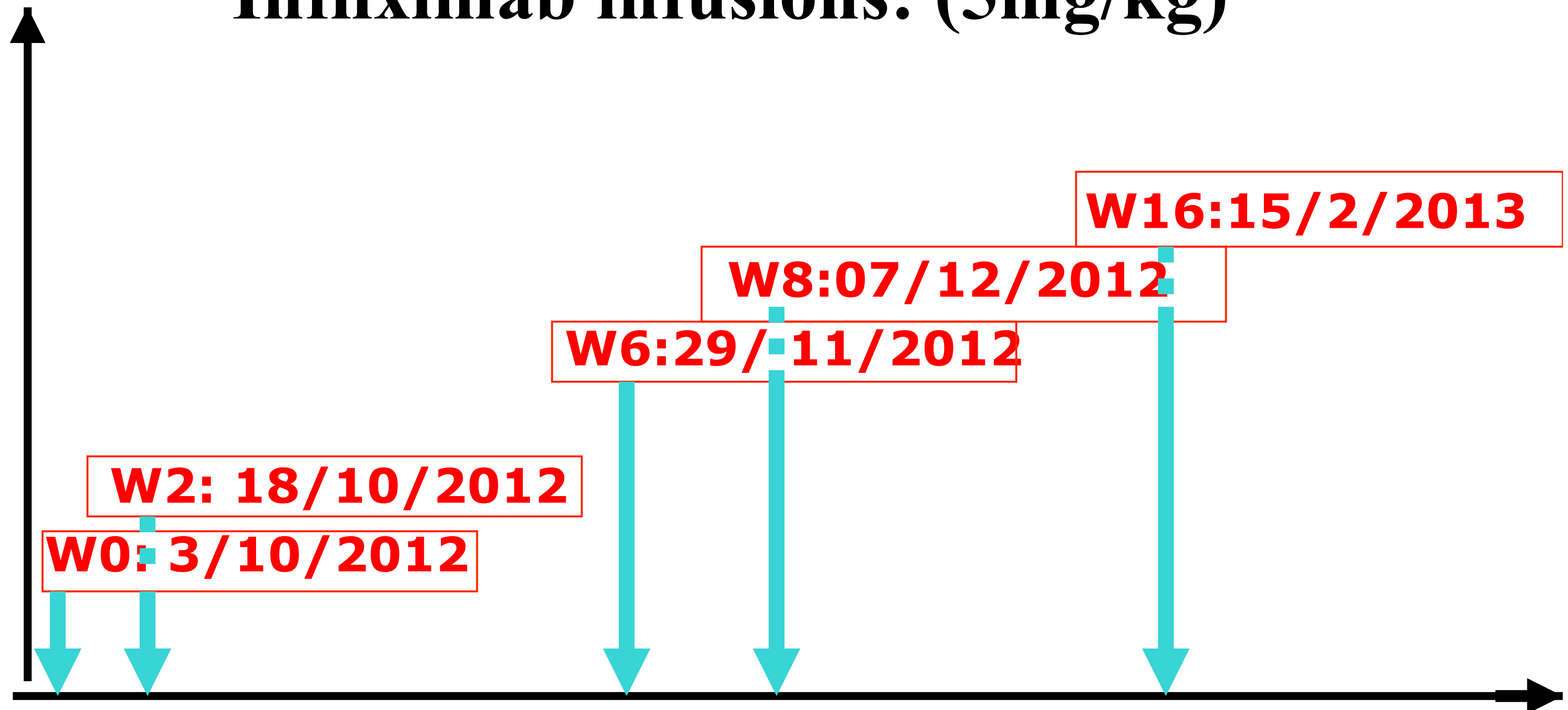
Ankylosing spondylitis with

◊ Ocular involvement

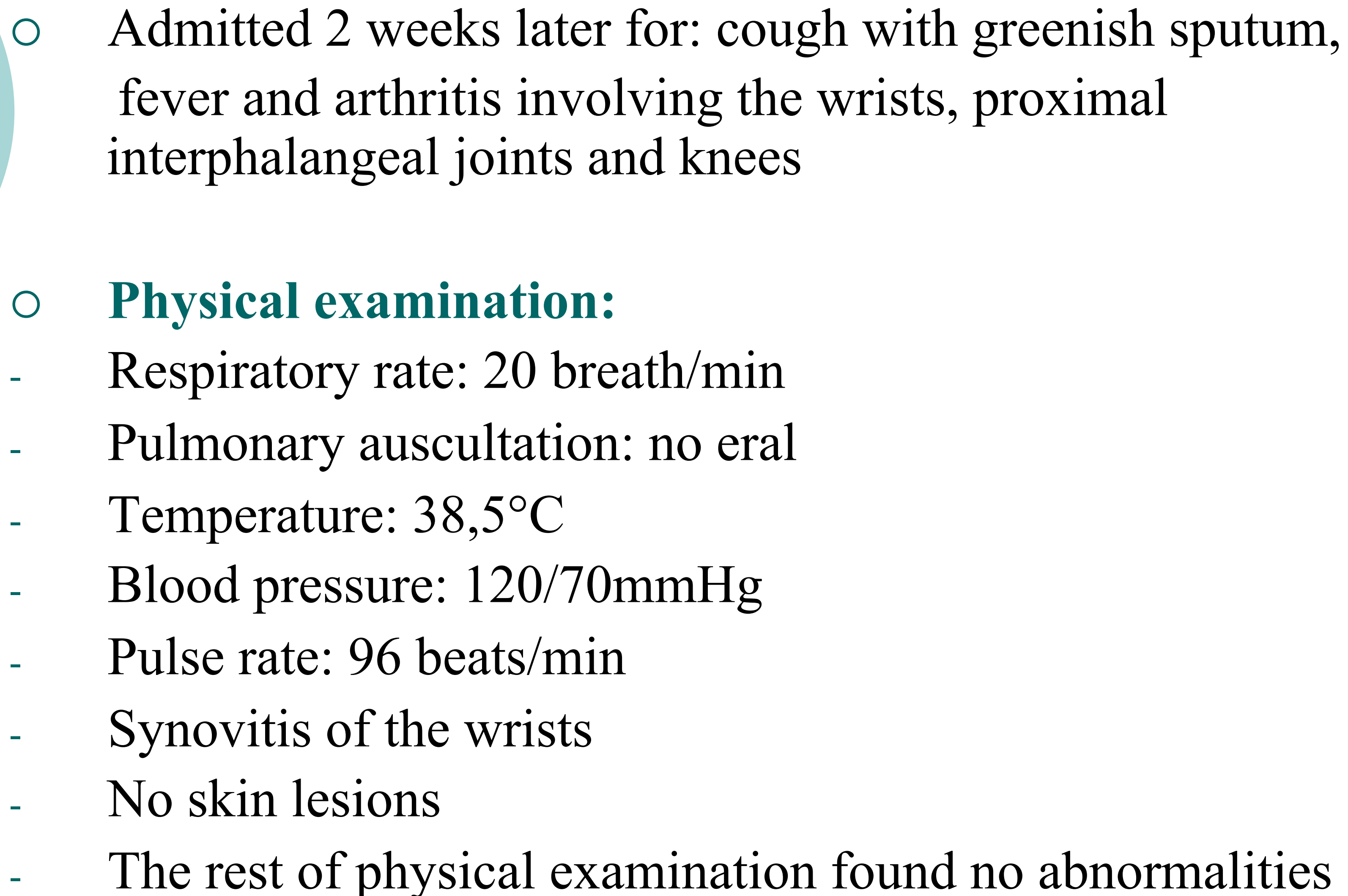
◊ Refractory axial damage despite NSAIDs



Therapeutic decision:



- **Before Biotherapy: tests recquired were normal**
- **Evolution: favorable**



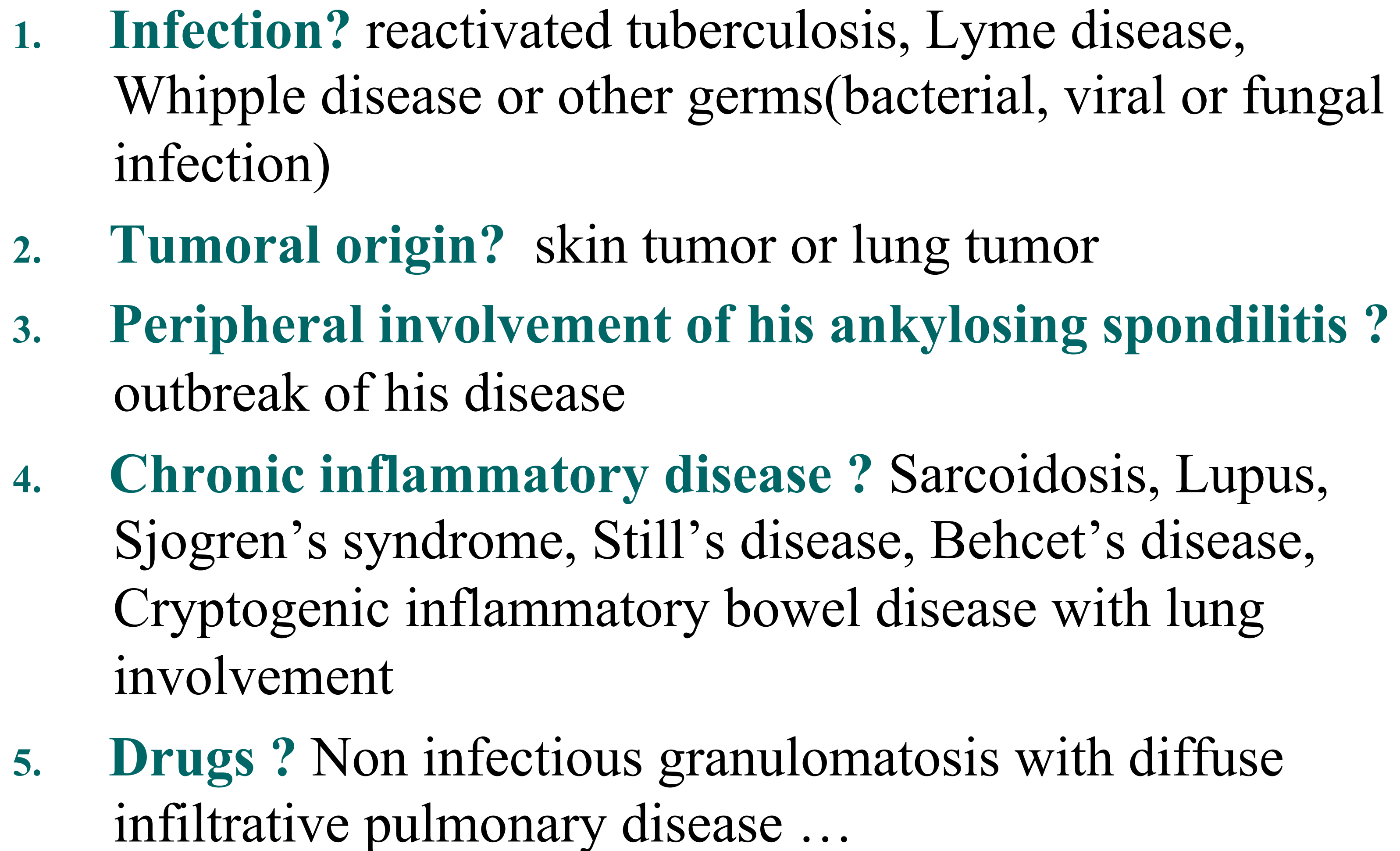
- Admitted 2 weeks later for: cough with greenish sputum, fever and arthritis involving the wrists, proximal interphalangeal joints and knees

- **Physical examination:**

- Respiratory rate: 20 breath/min
- Pulmonary auscultation: no eral
- Temperature: 38,5°C
- Blood pressure: 120/70mmHg
- Pulse rate: 96 beats/min
- Synovitis of the wrists
- No skin lesions
- The rest of physical examination found no abnormalities

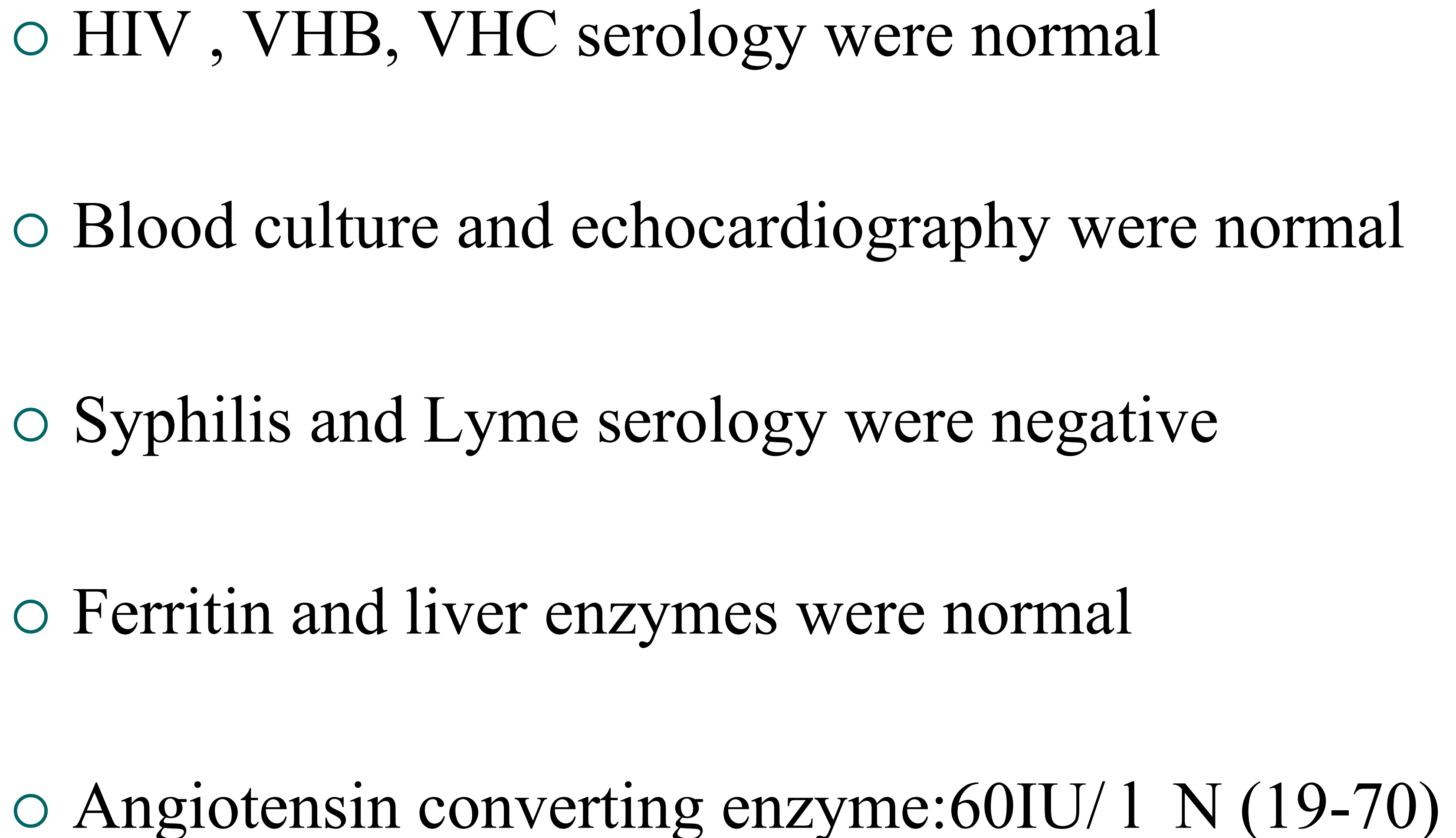
What are your hypotheses for the diagnosis?

- Ankylosing spondilitis treated with TNFα antagonist drugs + fever + cough + arthritis in peripheral joints

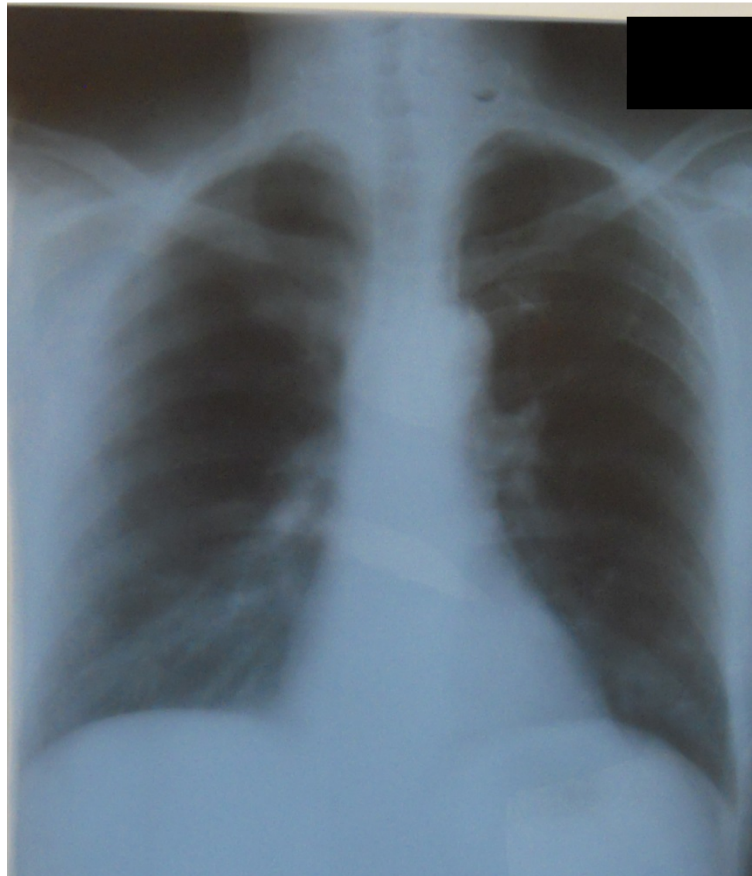

1. Infection? reactivated tuberculosis, Lyme disease, Whipple disease or other germs(bacterial, viral or fungal infection)
2. Tumoral origin? skin tumor or lung tumor
3. Peripheral involvement of his ankylosing spondilitis ? outbreak of his disease
4. Chronic inflammatory disease ? Sarcoidosis, Lupus, Sjogren’s syndrome, Still’s disease, Behcet’s disease, Cryptogenic inflammatory bowel disease with lung involvement
5. Drugs ? Non infectious granulomatosis with diffuse infiltrative pulmonary disease …

Laboratory tests:

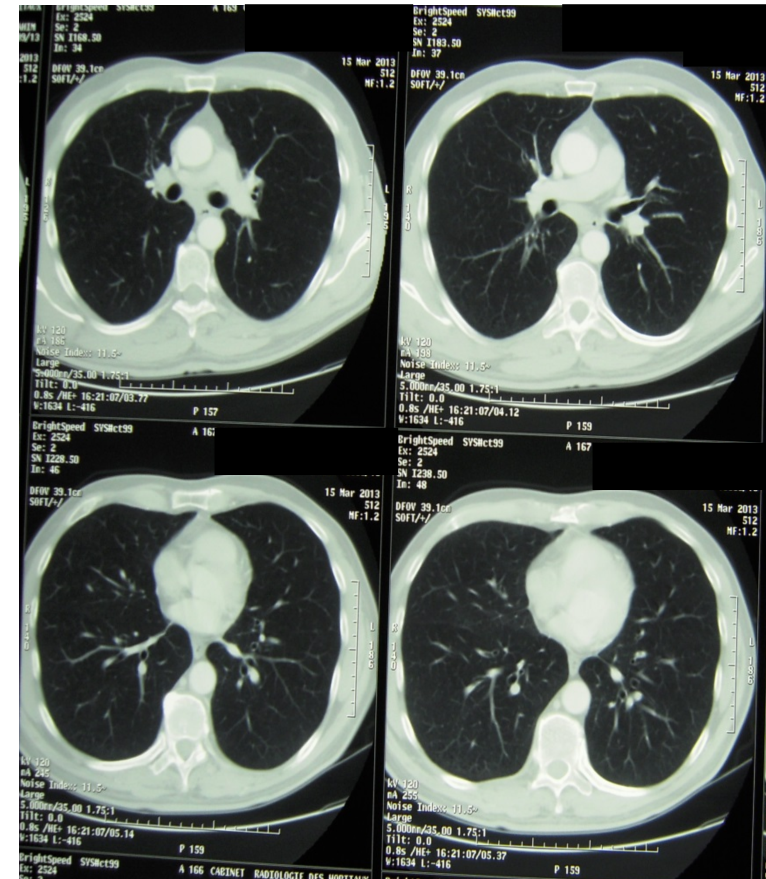
- C reactive protein: 36mg/l
- Sedimentation rate: 50mm
- White blood cell: 8000/mm³ (Neutrophils: 4200/mm³, lymphocytes: 3000/mm³), Platelets count : 270000/mm³, Haemoglobin: 13g/dl
- Sputum examination: sterile bacterial, tuberculous and fungal cultures
- QuantiFERON test was negative, mantoux test=20mm
- Urine culture was sterile, joint fluid was inflammatory and sterile without crystalline deposit


HIV , VHB, VHC serology were normal
Blood culture and echocardiography were normal
Syphilis and Lyme serology were negative
Ferritin and liver enzymes were normal
Angiotensin converting enzyme:60IU/ l N (19-70)

Imaging:

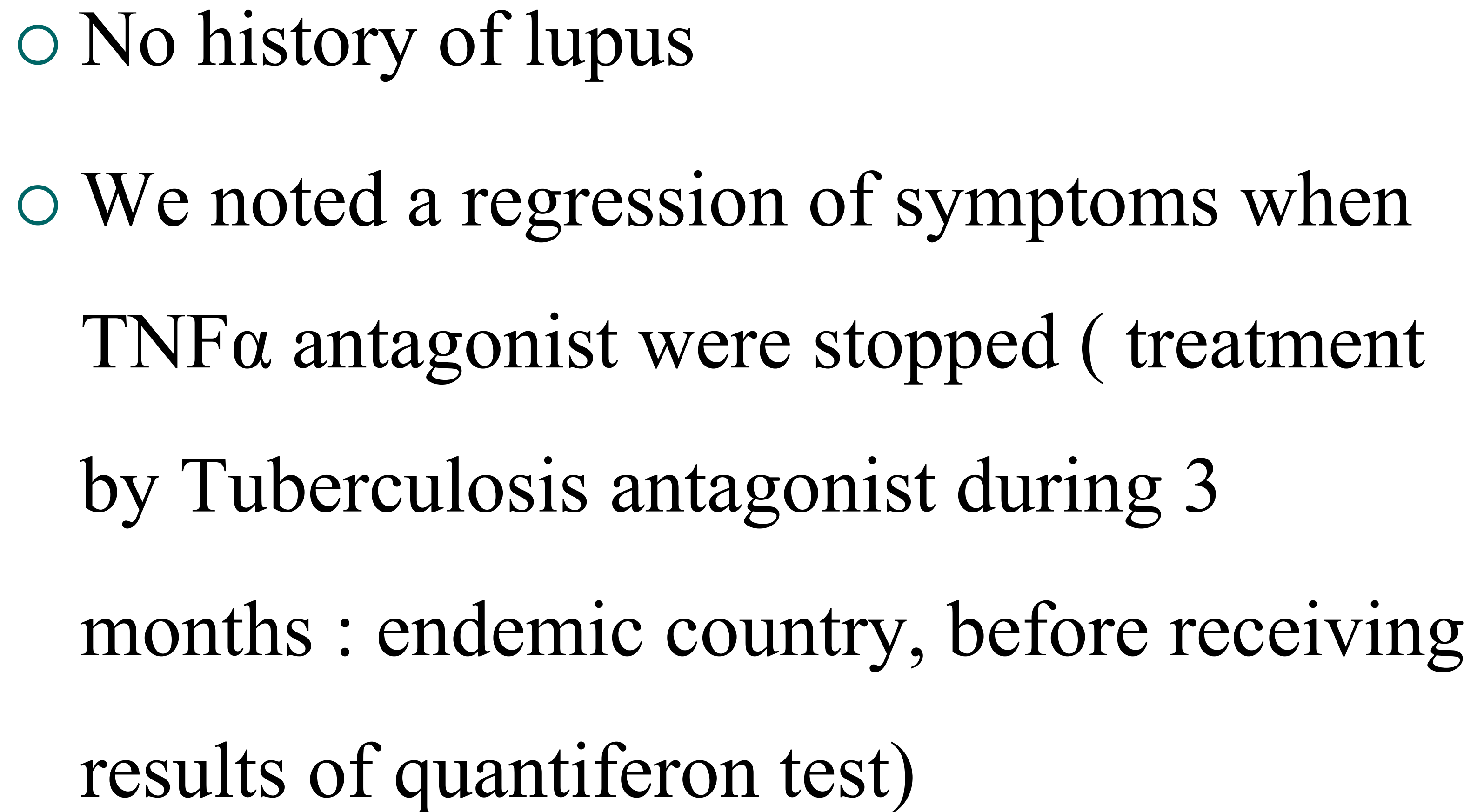


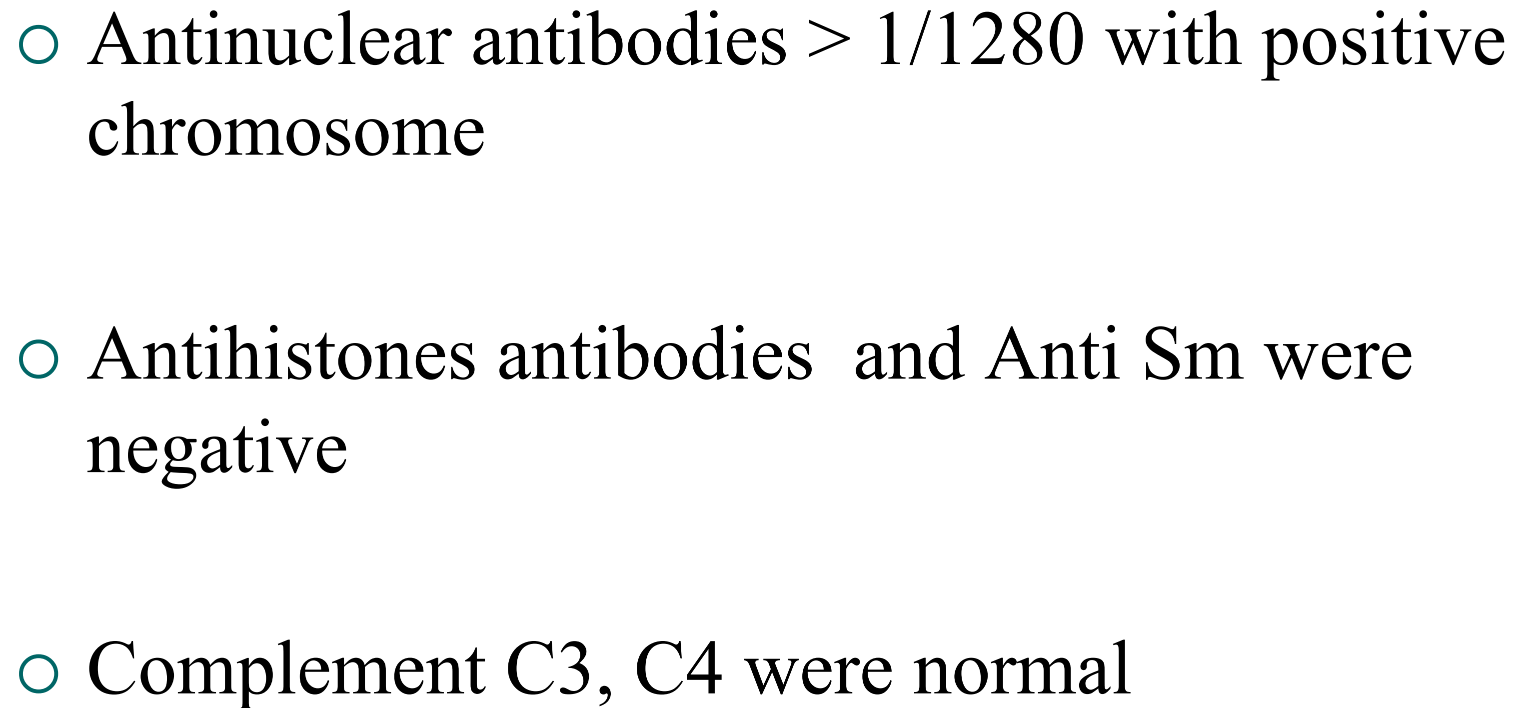
Bronchial syndrome on the right basal lobe



Subcentimeter mediastinal lymphadenopathy

Diagnosis?


No history of lupus
We noted a regression of symptoms when TNFα antagonist were stopped (treatment by Tuberculosis antagonist during 3 months : endemic country, before receiving results of quantiferon test)

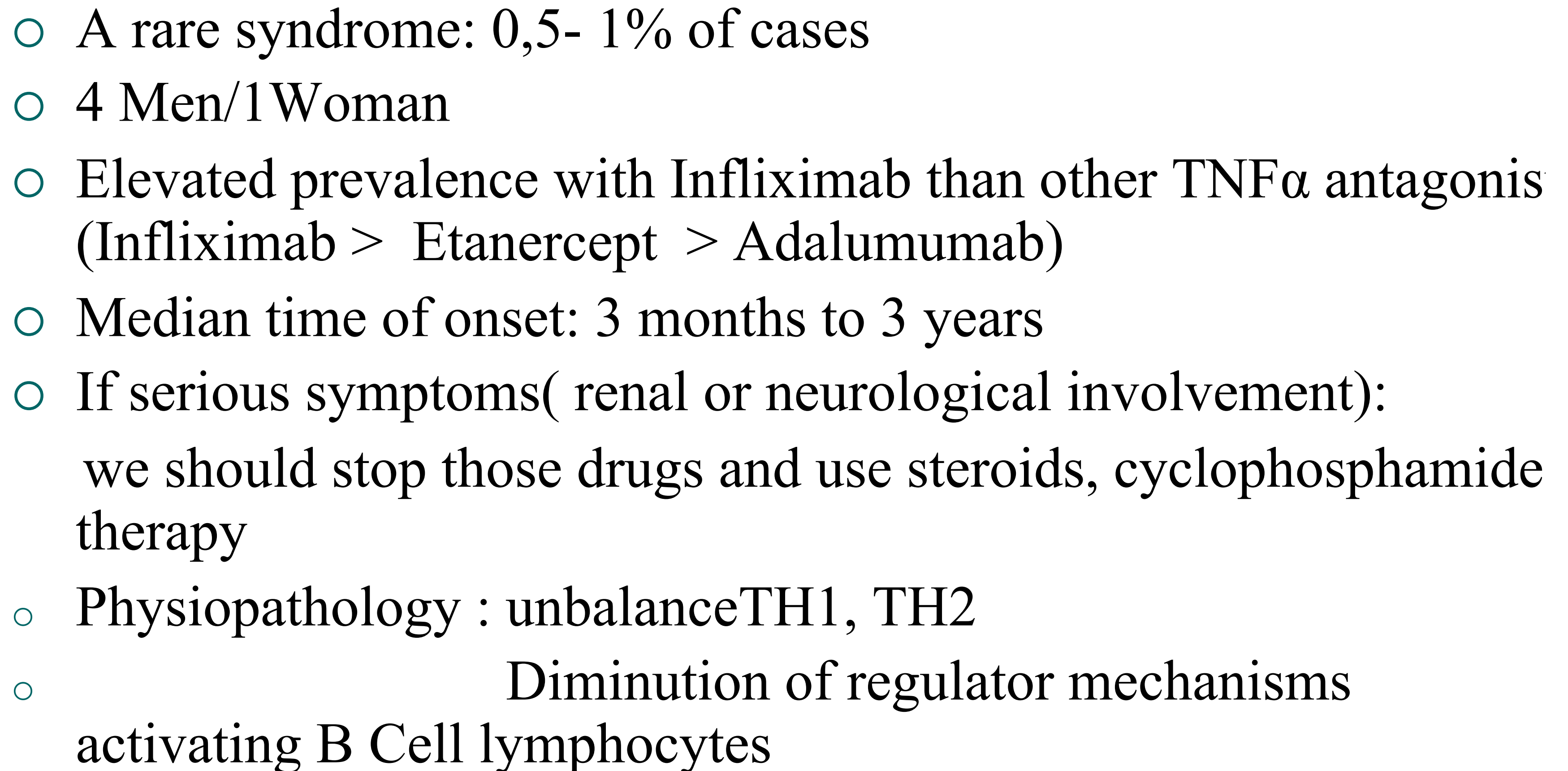


- Antinuclear antibodies > 1/1280 with positive chromosome
- Antihistones antibodies and Anti Sm were negative
- Complement C3, C4 were normal

Diagnosis TAIL:TNF alpha antagonist induced lupus like syndrome

Diagnosis criteria:

- One or more symptoms compatible with SLE
- Adequate and ongoing exposure to anti TNF drug
- No prior history of SLE
- Resolution of symptoms on cessation of the suspected precipitating drug
- Presence of ANA or antihistone antibodies



- A rare syndrome: 0,5- 1% of cases
- 4 Men/1Woman
- Elevated prevalence with Infliximab than other TNFα antagonis
  (Infliximab > Etanercept > Adalumumab)
- Median time of onset: 3 months to 3 years
- If serious symptoms(renal or neurological involvement):
  we should stop those drugs and use steroids, cyclophosphamide therapy
- Physiopathology : unbalanceTH1, TH2
- Diminution of regulator mechanisms activating B Cell lymphocytes

In our case:

- Infliximab was switched to Etanercept with favorable evolution
- Follow-up: 7 months

Conclusion :

- Regular clinical monitoring is required during treatment with TNF antagonist drugs, in order to not disregard induced lupus

- In our practice, iatrogenic causes: most be evoked

Thank you