LETTERS

Beclomethasone dipropionate inhalation treatment for chronic hoarseness in rheumatic disease

To the Editor:

Patients with rheumatoid arthritis (1), juvenile arthritis (2), and systemic lupus erythematosus (3) occasionally develop hoarseness due to local disease involvement in the vicinity of the vocal cords. Local pathology can range from proliferative granulation tissue, to nodules, to cricoarytenoid arthritis. In the past few years, we have seen 3 patients whose hoarseness has been controlled by periodic oral beclomethasone dipropionate (BDP) inhalation.

Patient 1. A 20-year-old white woman, a nonsmoker with a longstanding history of seronegative polyarticular juvenile arthritis treated with 10 mg oral prednisone every morning, developed progressive hoarseness over a period of 6–8 months. This interfered with her daily personal and business activities. Several otolaryngologic evaluations revealed only slight erythema of her vocal cords. She was begun on a regimen of oral BDP inhalations, started at 2 puffs 4 times daily. The hoarseness virtually disappeared within 2 weeks. The BDP was slowly tapered over a few months. She has been similarly treated on 2 or 3 other occasions over the past several years, for similar bouts of chronic hoarseness.

Patient 2. A 22-year-old black woman, a nonsmoker with longstanding systemic lupus erythematosus treated with 10 mg oral prednisone every morning, developed severe, progressive hoarseness over several months. Otolaryngologic evaluation revealed large, soft, friable tissue masses located posteriorly over her vocal cords; they were thought to resemble granulation tissue. No biopsy was obtained for fear of acute obstruction. It was believed that a tracheostomy would be necessary for further diagnostic evaluation. The patient refused this, and was started on a regimen of oral BDP inhalation, 2 puffs 4 times daily. Her symptoms markedly improved over 1 week, and the BDP was slowly tapered. The patient has refused repeat otolaryngologic evaluations.

Patient 3. A 54-year-old white man with longstanding systemic lupus erythematosus, treated with 10 mg oral prednisone every morning, developed symptoms of progressive hoarseness and upper airway obstruction. Otolaryngologic evaluation revealed a large posterior mass of presumed granulation tissue overlying the vocal cords. The appearance was similar to that in patient 2. Again, biopsy was not performed for fear of obstruction. Two single intravenous doses of 1 gm methylprednisolone succinate, given 3 days apart, did not alter his symptoms. Three days after the last intravenous administration of bolus, oral BDP inhalation was begun as in the above cases. Symptoms began to abate in 24 hours, although this could have been a response to the previous bolus therapy.

We believe that oral beclomethasone dipropionate inhalation is a useful therapeutic adjunct in selected cases of chronic hoarseness in rheumatic disease patients. Clearly, an initial otolaryngologic evaluation is advisable. Therapy with intermittent BDP is associated with minimal toxicity, particularly when compared with other pharmacologic options in patients with connective tissue diseases.

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Seronegative rheumatoid arthritis and B7–CREG: disparate results

To the Editor:

The existence of patients who meet the criteria for the diagnosis of rheumatoid arthritis (RA) (1), but are seronegative, has long been recognized. These patients tend to have a less aggressive disease than their seropositive counterparts. Clinical, immunologic, and immunogenetic studies have recently been reported suggesting further differential features between seropositive and seronegative RA (2–6).

A report by Wellborne et al (7) of an increased frequency of the X antigen (a public determinant common to the B specificities 7,22,27,40,42; commonly referred to as B7–CREG) in a group of 23 patients with seronegative RA, compared with their local controls, prompted us to further analyze the immunogenetic characteristics of our patients with seronegative RA. We have previously reported that the B7–CREG occurred in both whites and blacks with RA, in frequencies comparable with the controls. Furthermore, RF positivity was present with comparable frequencies in both CREG positive and CREG negative individuals (8).

We have typed 38 whites and 22 blacks with well-defined seronegative RA (4,6) and have found that the frequency of B7–CREG in our black and white patients (Table 1) is comparable with the frequency in the black and white local control populations. Similar analysis of our seropositive black and white RA patients (data not shown) also failed to reveal any difference in the frequency distribution of the B7–CREG antigens. Thus, we have been unable