Human T cell leukemia/lymphoma virus type I DNA and polymyositis/dermatomyositis: comment on the article by Sherman et al

To the Editor:

In their recent article, Sherman et al showed an association between human T cell leukemia/lymphoma virus type I (HTLV-I) and polymyositis in patients from Jamaica, an endemic area for HTLV-I infection (1). The case of their patient MR was of great interest because he had negative serologic results for HTLV-I.

We have previously reported the case of a female polymyositis/dermatomyositis patient from France who was HTLV-I seronegative but in whom HTLV-I DNA sequences were detected in peripheral blood lymphocytes, by gene amplification utilizing the polymerase chain reaction (PCR) assay (2). The search for a possible HTLV-I infection in this patient was prompted by the presence of certain unusual features which have been previously noted in HTLV-I-seropositive patients. She had an intense CD8+ lymphocytic alveolitis, a pulmonary manifestation observed in patients with HTLV-I-associated myelopathy (3). She also reported xerostomia and xerophthalmia. Findings of a Schirmer’s test were positive, and rose bengal staining of the conjunctiva was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal. Biopsy of the minor salivary glands demonstrated an interstitial lymphplasmacytic infiltration with dilatation of the ducts. The duct of the epithelium was abnormal.

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American College of Rheumatology preliminary definition of improvement in rheumatoid arthritis: comment on the article by Felson et al

To the Editor:

We read with great interest the article by Felson et al regarding the American College of Rheumatology (ACR) preliminary definition of improvement in rheumatoid arthritis (RA) (1). We share the authors’ opinion that the topic of assessing and analyzing individual treatment response in RA clinical trials is very important. We fully agree that the use of a single measure for improvement increases the power of a trial, and that we should aim for standardization of a definition for improvement since this makes it possible to compare different trials.

In their study, Felson et al selected a definition of improvement based on 1) correspondence with rheumatologists’ impressions about the improvement of “paper” patients (n = 43), 2) the most powerful discrimination between active treatment and placebo (or less active) treatment, and 3) ease of use/credibility. Although we appreciate the method used to select this definition, we would like to make some minor comments.

First, to what extent do rheumatologists’ impressions of paper patients for whom only 7 variables at 2 time periods are described reflect the impressions of rheumatologists in daily clinical practice? Does the selection of paper patients “near expected thresholds for improvement (20–45% improvement in at least 3 outcomes)” not implicate bias by using a predetermined definition of improvement? Second, is the difference between placebo and active treatment identified with the improvement definition a clinically relevant difference? Is there an association with outcome measures in RA, such as radiographic progression and functional capacity? Is the measure sensitive to detect smaller differences between two active treatments?

Recently, we developed response criteria based on the Disease Activity Score, using a different approach (2). During the European League Against Rheumatism (EULAR) meeting in Amsterdam (June 1995), these re-
The ACR improvement definition incorporates all of the core set measures, and the core set measures were selected because they correlate with gold standard measures such as radiographic progression and functional capacity (1). Furthermore, the core set actually includes measures of functional capacity. Therefore, we are confident that the ACR definition of improvement correlates with both radiographic deterioration and functional status. Conversely, failure to improve is likely to portend worse functional status and radiographic deterioration. Nonetheless, both of these need to be confirmed in prospective studies.

In contrast to the assertion by van Gestel and van Riel, the ACR criteria were tested against comparative trials and effectively differentiated between effective second-line drugs in RA (see Figure 2 of ref. 3). They also have been shown in a recent published trial (4) to discriminate well between patients treated with combination therapy and those receiving single second-line drug therapy, suggesting that, with the use of the ACR improvement criteria, one can detect small but important clinical differences between effective regimens.

Van Gestel and van Riel list 3 important differences between the EULAR and the ACR definitions of improvement on which I would like to expand, and I will also list additional differences. First, the ACR improvement definition was constructed to correspond to clinicians' impressions of improvement, whereas the EULAR response criteria were constructed based on decisions about starting and stopping second-line drugs, decisions that are not always related to improvement.

Second, the ACR criteria use all 7 measures incorporated into the ACR/EULAR/WHO core set of measures for disease activity, a group of measures agreed upon by the EULAR group. Nonetheless, the EULAR response criteria use the Disease Activity Score (DAS) index, which focuses...