To the Editor:

I read the article by Pillemer et al with great interest (1). The authors conclude that in their controlled trial of dehydroepiandrosterone (DHEA) versus placebo in 28 patients with Sjögren’s syndrome (SS), no evidence of DHEA efficacy was demonstrated. However, no evidence is not equal to no efficacy. This trial is underpowered to detect efficacy under the reasonable assumption that efficacy of DHEA is similar in SS to the efficacy of DHEA in systemic lupus erythematosus (SLE).

In a trial reported by Petri et al (2) the response rates were 45% in the group receiving placebo, and 59% in the group receiving DHEA, a difference that reached clinical significance with ~150 patients in each group. The trial by Pillemer et al had response rates with a similar numerical difference, 36% in the placebo group, and 50% in the group receiving DHEA, but with 14 patients in each group, this difference is not statistically significant. Pillemer et al also noted that a statistically significant difference was seen in only 1 outcome parameter – dry mouth symptoms. A more positive view of the results would be that statistical significance was achieved, albeit for only 1 parameter, despite the small sample size. Moreover, Pillemer et al downplay this improvement by emphasizing that the difference in dry mouth symptoms was only 9%, and not clinically meaningful. However, the change was 9 mm on a visual analog scale from a baseline of 25.4 mm, representing an improvement of 35%. I submit that this may well be important at the individual patient level. Incidentally, the first controlled trial of DHEA in SLE (3) had exactly the same number of patients as the study by Pillemer et al, and that first study also achieved statistical significance in only 1 parameter. Finally, it may be worth considering that based on the published results of tumor necrosis factor α antagonists in rheumatoid arthritis, a sample size of 14 patients per group in a 2-armed trial would in many cases not have been sufficient to detect a statistically significant difference between such agents and placebo.

I applaud Pillemer et al for having performed their important study, but suggest that their negative findings are, unfortunately, inconclusive regarding the question of potential efficacy of DHEA in SS.

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Pilot clinical trial of dehydroepiandrosterone for Sjögren’s syndrome: comment on the article by Pillemer et al

To the Editor:

I read with interest the article by Pillemer and coworkers (Pillemer SR, Brennan MT, Sankar V, Leakan RA, Smith JA, Grisius M, et al. Pilot clinical trial of dehydroepiandrosterone [DHEA] versus placebo for Sjögren’s syndrome. Arthritis Rheum 2004;51:601–4) regarding the possible treatment of fatigue associated with Sjögren’s syndrome (SS) with dehydroepiandrosterone (DHEA). In their trial, treatment with DHEA was compared with placebo in 14 patients and 14 controls over a period of 24 weeks. No benefit of DHEA was detected. Although the patients were carefully selected and several tests were carried out at the start, one test of major importance, the baseline serum concentration of DHEA, was unfortunately omitted. I be-
lieve it would also have been helpful if the serum levels of DHEA had been monitored during the followup period. According to the article, the patients were not asked whether they had previously used DHEA in any form. Taking into account the relatively small number of patients included, these pieces of information would have permitted more reliable evaluation of the results. Although the final conclusion is certainly correct, that patients with SS should avoid using unregulated DHEA supplements, it cannot be based on the results this study.

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Discoid lupus erythematosus after tattoo: Koebner phenomenon

To the Editor:

A 27-year-old African American woman with a diagnosis of systemic lupus erythematosus manifesting as discoid skin lesions and joint pain presented with new discoid lesions on her lower back. She had obtained a tattoo on her lower back one year earlier. One week later she noticed circular, raised lesions superimposed on the tattoo, which progressively increased in size. At the time of presentation, she was taking prednisone (40 mg/day) as prescribed by her primary care physician. She had previously taken hydroxychloroquine but had discontinued the medication a year and a half prior. Her serologies were positive for antinuclear antibodies (1:640 in homogenous pattern), double-stranded DNA antibodies (1:160), and anti-SSA antibodies. Complement C3 level was 64 mg/dl (normal 86–184 mg/dl). Tests for hepatitis were obtained and showed no hepatitis B surface antigen, but the patient tested positive for antihepatitis B surface antibodies and antihepatitis B core antibodies. She had no history of blood transfusions or intravenous drug abuse. Hepatitis status at the time of delivery of her youngest child (6 years previously) was negative.

The appearance of the discoid lesions superimposed on the tattoo is shown in Figure 1. Koebner phenomenon is the induction of skin changes that are at the site of non-specific trauma, of a type spontaneously present elsewhere. Koebner phenomenon is usually associated with psoriasis, lichen planus, plantar warts, molluscum contagiosum, and active eczema. As early as 1926, external irritants were reported as a causative factor in discoid lupus (1). Kern and Schiff reported cases of discoid lupus in scars (2,3). Koebner phenomenon in tattoos has also been reported to be associated with discoid skin lesions (4), as have intramuscular injection (5) and burn scars (6).

Even though it is documented in the medical literature that trauma exacerbates and induces the onset of discoid lupus, it receives negligible attention during patient education on prevention and management of discoid lesions. Not only did this patient develop new skin lesions after receiving the tattoo but she also acquired hepatitis B after receiving the tattoo, limiting her further treatment options. Prevention of inducible trauma should be especially emphasized in patients with discoid or systemic lupus erythematosus.

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The 3-way stopcock: a useful adjunct in the practice of arthrocentesis

To the Editor:

The art of arthrocentesis is an essential element in every rheumatologic practice. Diagnostic aspirations retain a central position in the recognition of microcrystalline arthritides and septic arthritis. Therapeutic arthrocenteses relieve the discomfort of high-pressure effusions, permit effective debulking of large fluid collections, and provide essential access for articular administration of corticosteroids. All of these facts are axiomatic.

In practice, however, arthrocentesis is sometimes more challenging than it is in theory. One practical problem lies in the need for more than one syringe. Large effusions may require syringe changes even when the (in our hands)