Treatment of coincident seronegative arthritis and hidradenitis suppurativa with adalimumab

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Article Outline

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To the Editor: Fifteen reported cases link acne conglobata with hidradenitis suppurativa (diseases part of the follicular occlusion triad) and arthritis, in which nonsteroidal anti-inflammatory drugs, systemic steroids, penicillamine, methotrexate, sulphasalazine, and infliximab have been noted effective.1

In this case, a 41-year-old morbidly obese African American male with arthritis, hidradenitis suppurativa, and a history of cystic acne with keloid formation was treated with adalimumab. The patient had developed hidradenitis 15 years before presentation and arthritis 8 years before presentation. He had a history of nodules and ulcers on his legs clinically diagnosed as pyoderma gangrenosum. He complained of frequent bowel movements that did not, upon investigation, relate to infection or inflammatory bowel disease. For the 6 months leading up to his consultation, he had been treated with 600 mg of hydroxychloroquine, isotretinoin 40 mg twice daily (120 mg/d), and 10 mg of methotrexate dosed every 12 hours in 3 doses weekly (30 mg/ wk) without effect.

Physical examination revealed flocculent axillary nodules and knee effusions. Laboratory examination demonstrated a white blood cell count of 13,000/loc; a total protein of 5.9 g/dl; a normal rheumatoid factor; an erythrocyte sedimentation rate of 100 millimeters per hour; normal complements levels; and no anemia. A bone scan revealed increased uptake in the bilateral patellae and proximal tibias likely caused by degenerative changes and, less likely, by osteomyelitis. There were multiple foci of increased uptake in the right costal cartilage. There was increased uptake in both patellae and proximal tibias because of degenerative changes or osteomyelitis. There was an increased uptake in the mid-thoracic spine and sternum.

Diagnoses entertained for this patient included the SAPHO (synovitis, acne, pustulosis, hyperostosis and osteitis [or osteomyelitis]) syndrome or the follicular occlusion triad with associated arthritis–disease entities likely on a continuum rather than wholly distinct. The later seemed more likely because hidradenitis was his most significant and protracted cutaneous symptom and his radiographic finding did not clearly show osteomyelitis. The former diagnosis, however, could not be ruled out.

The patient stopped taking methotrexate, plaquenil, and isotretinoin and began taking adalimumab 40 mg every other week, and after 2 months noted improved ambulation and decreased axillary flocculence of the axillary nodules. One month later, the patient stated that his condition was worsening, so the adalimumab was increased to 40 mg weekly. Over the following months, pain and edema decreased. When an insurance issue prevented adalimumab use, pain and swelling returned; when adalimumab was re-administered, symptoms abated.

Because adalimumab, a human monoclonal tumor necrosis factor alpha (TNFα) antibody is approved therapy for rheumatoid and psoriatic arthritis, adalimumab's use for the treatment of arthritis with etiologically consistent and coincident inflammatory dermatosis has a therapeutic basis. Infliximab has been effective against combinations of hidradenitis and arthritis (eg, the SAPHO syndrome2, 3) and etanercept has been used to treat hidradenitis.4 In numerous anecdotal reports in the literature, adalimumab has been used off-label to effectively treat a variety of disorders including Crohn's disease, sarcoidosis, severe, recalcitrant, major aphthous stomatitis, recalcitrant acrodermatitis continua of Hallopeau, adult-onset Still's disease, psoriasis, Takayasu's arteritis, subcorneal pustular dermatosis, ulcerative colitis, ankylosing spondylitis, orbital myositis, pyoderma gangrenosum, and psoriatic onycho-pachydermoperiostitis.5

This report constitutes a case involving the off-label use of adalimumab. In any case, adalimumab seemed to help treat this patient's disease and is a therapy that could aid patients with dermatoses of the follicular occlusion triad associated with arthritis.

References


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The author has no conflicts of interest to disclose.

Pit: 50190-6820(06)00054-5
doi:10.1016/j.jaad.2006.01.024

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