

a process leading to cell clearance. However, as CD14 and CD36 are known to play a part in different biological processes, the demonstration of these multifunctional adhesion molecules on Reiter cells is not a definitive evidence concerning their role for apoptotic cell clearance in the synovial fluid. Additional functional investigations are required to establish the exact role of CD14 and CD36 in the clearance of the PMN in synovial effusions.

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ENRICO SELVI
STEFANIA MANGANELLI
RENATO DE STEFANO
ELENA FRATI
ROBERTO MARCOLONGO
*Institute of Rheumatology, Loc Le Scotte
University of Siena, 53100 Siena, Italy*

Correspondence to: Dr Selvi

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Non-periodic leg pain in patients with familial Mediterranean fever

Familial Mediterranean fever (FMF) is characterised by recurrent bouts of fever and peritonitis, pleuritis, arthritis or erysipelas-like skin disease. Between the episodes, FMF patients are free of symptoms and appear healthy.¹ However, interestingly we observe leg complaints after prolonged standing or sitting, or both, in FMF patients, who usually experience these painful manifestations during evenings or after long distance bus trips. Thus we conducted a questionnaire study on 40 FMF patients (age, mean (SD); 21.6 (2.7) years; F: M, 2: 38) and 180 healthy male subjects (age, 21.3 (0.2) years) to ascertain the frequency of these complaints, and some of FMF patients were also included in a test to

Table 1 Questionnaire on lower extremity complaints

A Have you ever had foot or leg pain events after prolonged standing and/or bus travel lasted more than six hours? If the answer is yes, B Has it been existed since childhood or adolescence? Does it occur after almost every period of prolonged standing or sitting? Does it occur mostly bilateral? Does it persist at least 30 minutes after rest? If all of the answers are yes, then the case was considered to be positive.
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provoke these symptoms. Table 1 shows the questionnaire. Positive cases were also questioned for the presence of swelling or redness during these painful periods, and whether these complaints followed by an episode.

Although 14 of the 180 healthy subjects responded positively to the first question (question A), none of them were considered to be positive after further questions (questions B). All FMF patients reported foot or leg pain after prolonged standing periods (first part of question A). They described that, at the onset, the pain was merely confined to the soles, however other sites (the ankles, the calves, the knees or even the thighs) were involved in an additive manner as the intensity of pain increased unless resting ensued. Thirty six FMF patients have experienced foot pain (with or without subcutaneous swelling) during or after long distance bus travelling and they also described an area of redness, which typically located on the swollen region on those occasions. Thirty five patients defined a period of fatigue accompanied a low grade fever subsequent to the episodes with severe lower extremity symptoms.

In provocation test, 30 volunteer male FMF patients (age, 21.2 (1.8)) without proteinuria and 30 volunteer male healthy subjects (age, 21.1 (0.8)) were kept in an upright position (standing, walking or dependent sitting) for six hours. At the beginning, all participants were symptom free and none of them had any other disorder that may cause foot pain. Thirteen FMF patients were receiving colchicine treatment. Bilateral ankle and mid-foot circumferences were measured from the marked points at the onset and the termination of the test. The mean change in circumference per measurement site (mean (SD)) was 3.0 (2.7) mm and 1.3 (1.5) mm in the patient and the control group, respectively. Although the comparison was statistically significant ($p=0.014$; Mann-Whitney U), we think that our method was not reliable to detect those small changes precisely.

At the end of the provocation test, none of the healthy controls had lower extremity pain or tenderness. Apart for one patient, all FMF patients had intense foot or calf pain, which interfered with walking. Tenderness was so profound that it could be elicited even by a gentle touch. Widespread tenderness was detected in 12, whereas localised tenderness was detected in 17 of the patients. Although swelling was not noticed in anyone, focal erythematous areas (not erysipelas) were seen in five patients. After five hours of resting, palpation showed that tenderness was sustained (14 widespread and 16 localised). A localised pain and tenderness was also developed in the symptom free patient. Colchicine use did not change the results of provocation test ($p=0.240$; Fisher's test).

Although leg pain induced by exercise or prolonged standing has already been discussed in FMF patients,² we are unaware of any report about leg pain and swelling

episodes after prolonged sitting in these patients. Increased hydrostatic pressure in the lower extremities may be the main factor responsible for those symptoms experienced during bus trips.

It was suggested that FMF is related to catecholamine metabolism as metaraminol infusion may provoke an acute episode,³ and episodes may be prevented by prazosin hydrochloride, as reported recently.⁴ Leucocytes may need adequate perfusion (driving) pressure to pass through capillaries in microcirculation.⁵ These findings raise the possibility that catecholamines may increase the hydrostatic pressure of capillary bed, which may be an inciting factor for episodes.

Our findings show that an inflammatory activity involving lower extremities occurs after prolonged standing and sitting periods in FMF patients. We think that genetically low level of inhibitory activity (that is, mutated pyrin) may not be able to compensate the inflammatory reaction that is probably initiated in a stressful microenvironment caused by not only microtrauma,⁶ but also increased hydrostatic pressure.

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A DİNÇ
*Division of Rheumatology, Department of
Internal Medicine, Gülhane School of Medicine,
Ankara, Turkey*

Correspondence to: Dr Dinç, GATA Romatoloji Bilim Dalı, Etlik, 06010 Ankara, Turkey

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CORRECTION

Subclinical gut inflammation in spondyloarthropathy patients is associated with upregulation of the E-cadherin/catenin complex (P Demetter et al. *Ann Rheum Dis* 2000;59:211-16)

We regret that the references in this article are incorrectly numbered. Owing to the splitting of reference 7, references numbered from 9 onwards in the text are listed as 10 onwards in the reference list.