Anticentromere antibody positive Ackerman's Syndrome with Granulomatous Anterior Uveitis

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Ackerman's Syndrome (AkS) has been an issue of increasing number of reports in the last decade, which had focused its heterogeneous expression. Granulomatous anterior uveitis and its association with anticentromere antibodies (ACA) has not been previously reported[1-3].

A 65 year-old man presented with a 6-month history of skin lesions, polyarthritis and weight loss. He had asymptomatic annular erythematous plaques on lateral aspects of the trunk (Figure 1a), back, arms and thighs which were histologically an inflammatory perivascular and periglandular infiltrate within the *dermis*. The arthritis was symmetrical non-erosive and involved shoulders, elbows, wrists and hands. Inflammatory markers were elevated in association with mild anemia and positive ANA (>1:640). HIV, Hepatitis, Lyme disease, Syphilis, Tuberculosis, Sarcoidosis and solid and hematological cancers were excluded. Topical betamethasone, oral prednisolone (15 mg/day) and methotrexate (20 mg/week) were ineffective. Two years later he developed severe Raynaud's phenomenon with a digital ulcer. ACA became positive in two determinations (240 U/mL) and megacapillaries appeared in nailfold capillaroscopy. Cardiac and lung involvement were excluded. The patient was treated with three consecutive infusions of methylprednisolone (500 mg) followed by prednisolone (30 mg) tapered down and subcutaneous methotrexate (25 mg/week) and hydroxychloroquine (400 mg/day). Skin and arthritis improved in 3 months (Figure 1a, b, c). Six months later he was diagnosed with an anterior granulomatous uveitis of the right eye during a routine ophthalmology examination for his previous Glaucoma. Large mutton fat keratitic precipitates and raised intraocular pressure (28 mmHg) were found. Infection by Herpes simplex, Varicella zoster, Epstein-bar, Cytomegalovirus, Toxoplasma gondii and Syphilis were ruled out by serum serology and Tuberculosis by chest Rx-ray, Mantoux and IGRA test. He was treated with topical dexamethasone and tropicamide; cyclosporine (100mg/ /day) was added and prednisolone was kept in 2,5 mg/day due to uncontrolled Glaucoma. The uveitis resolved in 12 days and cyclosporine was stopped after 10 months. The patient is in actual remission for two years with methotrexate and hydroxychloroquine.

Since the classical description of the "rope sign" by Ackerman in 1993 the syndrome has been associated with variable skin lesions[1-3] and variable time of occurrence of arthritis[1]. It suggests that manifestations may not be fully known. Uveitis has been described in AkS[2]. Granulomatous type typically presents with insidious and minimal pain and tends to chronicity[4,5]. Its occurrence always demands a careful investigation of infectious and inflammatory causes, being unlikely as an isolated manifestation[6]. In our patient, uveitis occurred under immunosuppressive agents, which could suggest an underlying infection presenting as inflammatory eye disease (ruled out). Steroids were tapered in 9 months due to uncontrolled Glaucoma and the occurrence of uveitis at this time could be related to such taper, thus representing a possible flare of systemic disease. Granulomatous uveitis has been published in patients with CREST disease[7] but neither in AkS.

This is the first report of an ACA positive patient with AkS with severe Raynaud's phenomenon and a digital ulcer, to our knowledge. Raynaud's is not universally described but is thought to occur in patients with high titers of ANA[1,3]. Some patients with AkS are reported to have autoantibodies[1]. It seems that our patient has a different phenotype concerning his immunological profile. Case reports described the use of steroids and several immunosuppressive agents with variable success rate[1-3]. We believe hydroxychloroquine in association with methotrexate and cyclosporine had a role in our patient's remission as previously reported[3].

In conclusion, autoimmune mechanisms and a constellation of symptoms in AkS are yet to be clarified. Ophthalmological evaluation should be done in pa-

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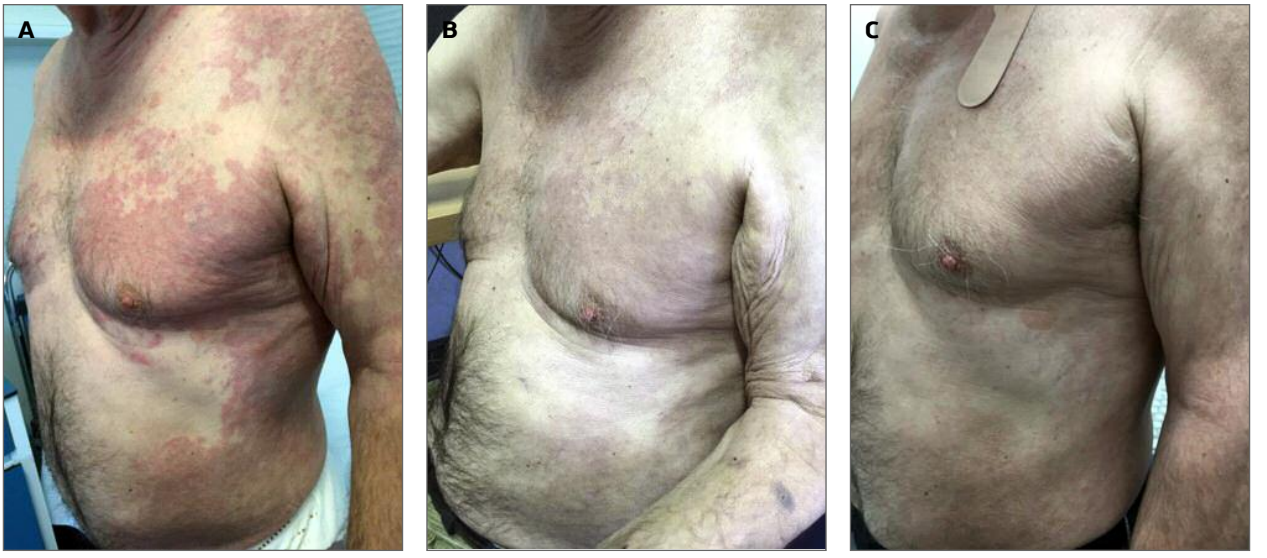

FIGURE 1. Evolution of cutaneous lesions treated with methotrexate, hydroxychloroquine and systemic steroids. **A)** Initial presentation of the dermatosis; **B)** Evolution of the dermatosis in a 3-week time; **C)** Evolution of the dermatosis in a 3-month time

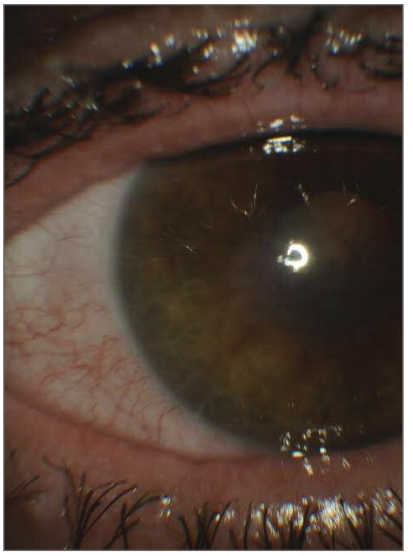

FIGURE 2. Anterior segment image assessment of mutton fat keratic precipates of anterior granulomatous uveitis

tients even when they are asymptomatic. This is the first description of ACA positive AkS with granulomatous anterior uveitis.

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REFERENCES

1. Busquets-Pérez N, Narvaez J, Valverde-García J. Interstitial granulomatous dermatitis with arthritis (Ackerman syndrome). J Rheumatol. 2006 Jun;33(6):1207-9
2. Narayan N, Marguerie C. A Case of Interstitial Granulomatous Dermatitis with Arthritis. Rheumatol. 2014 Abstracts;53 (suppl 1):66
3. Corley AB, Fox A. Erythematous Annular Plaques in a Woman with New Onset Arthritis. J Women's Health Care 2014; 3:2
4. Sharma S. Ophthaproblem – Granulomatous uveitis. Can Fam Physician 1996 Dec;42:2349, 2356
5. Martenet AC. Uveitis in connective tissue disorders. Trans Ophalmol Soc UK 1981;101:376-9
6. Llopis M, Calonge M, Maza M, Castillo J, Pinazo R, Arévalo J. Uveítis e Escleritis – Diagnóstico e Tratamiento. Sociedad Española de Oftalmología 2014.
7. Courttade M, Gicquel JJ, Mercie M, Vabras B, Dighiero P. Granulomatous uveitis and CREST syndrome: a case study. J Fr Ophtalmol. 2004 Oct;27(8):918-20