tion factors, including NFkB [3]. It is also widely recognized that cell differentiation and proliferation, cytokine expression, and programmed cell death (apoptosis) are determined by oxidant stimuli [3]. Undoubtedly, these phenomena have exceptional significance in autoimmune and atherosclerotic diseases. In addition, several biochemical parameters, mentioned by the author, that influence plaque progression and stability (adhesion molecules, matrix metalloproteinases) can be up regulated by oxidative stress [3]. Finally, the importance of nitric oxide (NO) in maintaining vascular integrity cannot be ignored [2,3]. It is highly possible that oxidative stress accompanying rheumatic diseases reduces NO bioavailability and further deteriorates endothelial function. Notably, the reactive nitrogen species formed accelerate atherosclerotic and inflammatory processes.

In conclusion, we believe that the study of the complex interrelation between oxidative stress and inflammation could further elucidate the biochemical basis of accelerated atherosclerosis observed in rheumatic diseases. There is experimental evidence mainly from basic research that various antioxidants are able to favorably affect both conditions [3]. It remains to be seen whether or not these antioxidant interventions become clinically relevant.

References


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Association of Shulman’s syndrome and morphea: a case report

1. Introduction

Fasciitis with eosinophilia (FE), or Shulman’s syndrome, is a rare disease characterised by swelling and indurations of the extremities and hypereosinophilia. We report here a case of FE with morphea in which diagnosis was unfortunately delayed.

2. Case report

Mrs. F.D., 32 years old, was admitted with the initial diagnosis of superficial thrombophlibitis of both the upper limbs. She gave no past history of any significant illness. Since 5 months (3 months after the delivery of her seventh child), she felt numbness in the third and fourth fingers of the left hand, accompanied by the appearance of hot rashes on both the arms and she suffered from pain on the left shoulder. Two months later, she underwent left median nerve decompression for carpal tunnel syndrome, but she showed no improvement. Then, she developed extensive swelling on the entire left upper limb with the appearance of a violet-coloured painful dilatation of veins in both the arms. Later on, she had arthralgia in her knees. She also had occasional fever and showed weight loss. She gave no history of Raynaud phenomenon, ophthalmic, digestive, dysphagia or urinary problems.

On clinical examination, the patient seemed tired. Both the arms were swollen with tender dilated veins; the skin was indurate as a cartoon with morphea-like features on the upper part of left forearm. She had restricted flexion and extension of the fingers, all movements of the shoulders were considerably limited and painful, and the flexion of the knees was also painful. She had no lymphadenopathy, abdominal masses, or aphthosis. The cardio-pulmonary system was normal.

The laboratory findings revealed WBC: 7100 mm$^{-3}$; PMN: 60.4%; L: 25.9%; eosinophils: 6.2%; RBC: 4,400,000 mm$^{-3}$; haemoglobin: 11.7 g/100 ml; Pt: 349,000 mm$^{-3}$; ESR: 171 h; CRP: 82.7 mg/l (0–6). Prothrombin time: 100%; PTTK: 27 (25–36). Glucose, Creatinine, Urea, GPT, GOT, protein electrophoresis, ANA, C3: all were normal. TSH: 4.3 (0.2–4.2); T4: 0.9 (1–1.8). Stools examination showed cysts of Giardia.