Letter to the Editor

The use of etretinate in psoriatic arthropathy

Sir,

Psoriatic arthropathy is an uncommon condition among the Mongoloid race, since the prevalence of psoriasis is well under 1% in the Mongoloid race in the Far East (Yip, 1984).

We would like to report a case of severe psoriatic arthropathy non-responsive to non-steroidal anti-inflammatory drugs, but which was controlled by a limited course of etretinate.

A 36 year old Chinese male presented with a generalized skin rash and severe symmetrical polyarthritis involving the shoulders, elbows, wrists, hands, knees and feet. Psoriasis was diagnosed 8 y before presentation and polyarthritis developed 5 y ago, but was of a mild form. The polyarthropathy had been treated with a variety of nonsteroidal anti-inflammatory drugs without success.

On examination he was febrile (38°C); there was widespread psoriasis involving the scalp, trunk and limbs. All the peripheral joints were hot, tender and swollen. In addition the movements of the hips and neck were also restricted by pain.

Investigations including radiology were unremarkable apart from an ESR of 105 mm/h.

Etretinate was started as the skin lesions were not responsive to local treatment, at a dose of 10 mg b.i.d. The skin condition improved within 2 d, as did the arthritis and fever 2 d after the dose was raised to 10 mg/d. No adverse effects of etretinate, in particular no hepatic and renal insufficiency developed in the 20 d following its administration.

Etretinate was stopped after a 40 d course, and the patient remained well for a further observation period of 60 d.

The mechanism of action of etretinate is unclear, but may improve the polyarthritis by acting as an immunostimulant (Micksche *et al.*, 1977; Felix *et al.*, 1975; Lotan, 1980). The main drawback to the use of etretinate in the rheumatic diseases is its toxicity; precluding long term use.

This dramatic response contrasts with the experience of Hopkins *et al.* (1985) in a double-blind controlled trial of etretinate and ibuprofen in psoriatic arthritis, where although etretinate was considered to be more efficacious than ibuprofen, improvement was not noted until the 12th to 24th week of treatment.

Thus there may be an ethnic difference in the response to etretinate. Results from a clinical trial of etretinate in Chinese patients recently started in Hong Kong should elucidate this point.

With monitoring of hepatic and renal functions and triglyceride levels, etretinate appeared to be very effective in dealing with acute exacerbations of arthropathy and long term administration was not necessary in this case. If a less toxic derivative possessing similar properties is found, then such a compound may have a place in the long term treatment of psoriatic or other arthropathies.

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