

Table 1
Total cholesterol, HDL-cholesterol and triglyceride levels.

	Triglyceride (mmol/L), [Normal value 0.68–1.88 mmol/L]	Total cholesterol (mmol/L), [Normal value 3.9–5.2 mmol/L]	HDL (mmol/L), [Normal value 0.75–1.85 mmol/L]
September 2004	5.73	4.6	0.58
February 2007	11.76	7.6	0.63
June 2007	9.75	6.1	0.68
September 2007	17.81	6.9	0.66
January 2008	20.60	6.7	0.53
March 2008	5.25	2.7	0.51
June 2008	4.92	2.5	0.50

apy we have no plausible explanation for the abnormal lipid profile.

The results obtained after etanercept treatment in our patient illustrate the complexity of effects of TNF superfamily on lipid metabolism. Research on the effects of anti-TNF therapy on lipid profile is scarce and encompasses only case reports and small studies which are either too small or too brief. Further long term prospective studies are needed, firstly to confirm the modulation of lipoprotein plasma concentrations with anti-TNF therapy, and secondly to identify which anti-TNF formulation has a more pro-atherogenic effect.

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5 January 2009

Available online 19 March 2009

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doi:10.1016/j.jbspin.2009.01.002

Role for the central motor system in fibromyalgia: Pain resolution after pontine infarction

Keywords: Fibromyalgia; Pontine Infarction; Central Motor System, modification

A 50-year-old woman was diagnosed with fibromyalgia in 2002 upon evaluation for diffuse muscle pain, chronic fatigue, headaches and sleep disturbances. Several investigations were performed, with normal findings. Her treatment consisted of pregabalin 125 mg, clonazepam 0.5 mg and dosulepin 50 mg/day. On June 11, 2008, she experienced the sudden onset of left hemiplegia without sensory loss. Computed tomography of the brain showed an infarction in the right side of the pons along the pyramidal tract (Fig. 1). Magnetic resonance imaging was contraindicated by a history of claustrophobia.

On June 23 2008, she was admitted to the rehabilitation unit. The Toulouse motor scale (TMS) score [1] was 80/100 and the functional independence measure (FIM) was 87/126. During her stay, findings were normal from three separate assessments of sensitivity to touch, prick, temperature, joint position and movement. At discharge from the rehabilitation unit after 2 months, the TMS score was 95/100 and the FIM was 125/126. She had persistent pyramidal tract signs on the left with myotatic hyperreflexia, ankle clonus and mild exertional spasticity. After the pontine infarction, the muscle pain resolved completely in the left half of the body despite the excellent level of motor function recovery and the muscular efforts required by the rehabilitation program. The muscle pain persisted on the right.

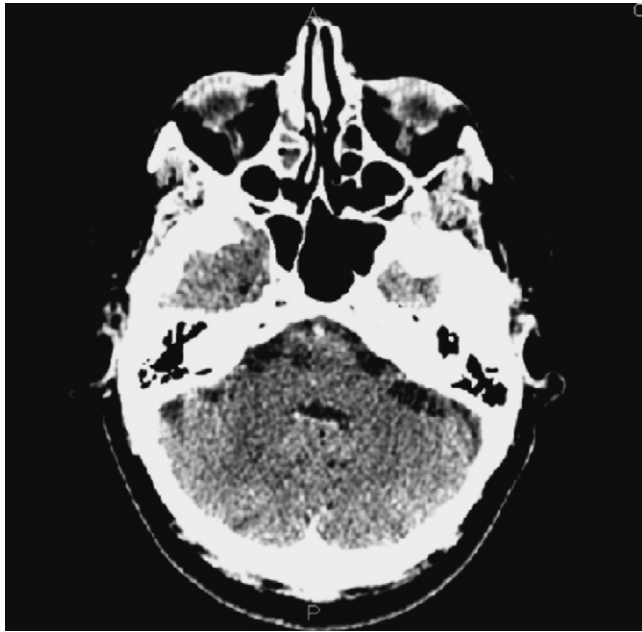


Fig. 1. Computed tomography, axial section through the pons: infarction seen as a hypodense zone in the right part of the pontine protuberance, at the site occupied by the pyramidal tract.

She returned to work on October 8, 2008. On November 15, her neurological evaluation was unchanged compared to the previous visit. On the right, pressure on eight of nine fibromyalgia points caused pain and flinching; whereas, on the left six points were slightly tender (discomfort without flinching). At the arms, the blood pressure cuff caused pain (visual analog scale pain score of 5/10) at 170 mmHg on the right and 220 mmHg on the left; corresponding figures at the legs were 120 and 220 mmHg.

The pathophysiology of fibromyalgia is complex and multiple factors are probably involved. A role for the central nervous system has been documented by studies showing central pain sensitization and hyperexcitability [2–4]. Recent data suggest impaired sensorimotor control or abnormalities in the motor system [5–7]. Our case-report supports a role for the central motor system. The infarction visualized by computed tomography seemed confined to the pyramidal tract, with no involvement of sensory pathways. The patient had isolated motor deficits. Thus, the resolution of the muscle pain on the paralyzed side was unexpected, as sensory function remained normal. Neither the spasticity nor the substantial muscular exertion required by the rehabilitation program exacerbated the muscle pain. Our case-report supports a role for a functional abnormality in motor control, which may be either primary or secondary to defective sensorimotor control. This functional abnormality may increase motor activity above the level required to maintain posture or to perform a movement, resulting in chronic muscular overload and in fatigue. The pyramidal tract involvement in our patient may have lowered this abnormally high level of central motor activity, leading to resolution of the muscle pain in the left side of the body.

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21 January 2009

Available online 29 September 2009

doi:10.1016/j.jbspin.2009.01.012

Intravenous immune globulins to treat eosinophilic fasciitis: A case report

Keywords: Eosinophilic fasciitis; Shulman syndrome; Eosinophilia; Immunoglobulins

1. Introduction

Eosinophilic fasciitis or Shulman's syndrome was first described in 1974 as a syndrome of diffuse fasciitis with high peripheral eosinophil counts [1]. This rare condition usually responds to glucocorticoid therapy. In patients with glucocorticoid-resistant or dependent disease, immunosuppressant therapy may be considered. We report the case of a glucocorticoid-dependent patient who experienced a partial response to methotrexate therapy followed by a full response to intravenous immune globulin (IVIg) therapy.

2. Case report

A 39-year-old male was admitted for swelling and induration of the hands and feet with severe functional impairment. He