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CORRESPONDENCE

Infliximab treatment in a patient with rheumatoid arthritis and pulmonary fibrosis

To the Editors:

Infliximab is a chimeric human-mouse anti-tumour necrosis factor-α (anti-TNF-α) immunoglobulin G monoclonal antibody that binds the soluble and transmembrane forms of TNF-α. Its efficacy in the treatment of chronic inflammatory diseases, such as rheumatoid arthritis (RA) and Crohn′s disease, is well documented [1, 2], and recent reports indicate a possible use in the treatment of psoriasis, giant cell arteritis, spondyloarthropaties and sarcoidosis [3–6].

As conventional treatments of idiopathic pulmonary fibrosis and lung fibrosis associated to RA are not effective, it is interesting to refer the efficacy of TNF-α inhibitor therapy in a patient affected by interstitial lung disease and RA (diagnosis performed according to the American College of Rheumatology classification criteria [7]). The patient was a 70-yr-old female, nonsmoker, refractory to azathyoprine and steroids. As recommended for RA [2], Remicade $3 mg \cdot kg^{-1}$ was administered at time 0, after 2–6 weeks, then every 8 weeks, and it was associated with methotrexate ($10 mg \cdot week^{-1}$) and folic acid supplementation. The treatment was well tolerated and after the second infusion, joint symptoms improved dramatically, with a substantial reduction in morning stiffness, inflammatory index (C-reactive protein and erythrocyte sedimentation rate) and number of tender joints. During the treatment arterial oxygen tension and carbon dioxide arterial tension remained stable in the normal range. High-resolution computed tomography scan of the chest, that showed bibasilar mantellar fibrosis with honeycombing, was unchanged after 3, 6, 12 and 15 months of therapy.

Before starting Infliximab, lung function tests (LFT) showed a restrictive pattern with a progressive worsening of vital capacity (VC) and transfer factor of the lung for carbon monoxide ($T_{L,Co}$). After 15 months of Infliximab, there were increases of 17% in $T_{L,Co}$ (65% of theoretical value at time 0 and 82% after 15 months of Infliximab) and 11% in VC (73% at time 0 and 84% after 15 months of therapy), and a stabilisation of forced expiratory volume in one second (73% of the predicted value at time 0 and 76% after 15 months of therapy).

These results indicate that Infliximab may have positive effects in the treatment of rheumatoid arthritis associated with interstitial lung disease, as also reported by VASSALLO *et al.* [8], who treated a patient with rheumatoid arthritis and lung fibrosis for 1 yr with anti-tumour necrosis factor-α. These two reports suggest that Infliximab (with or without methotrexate [8]) may be a therapeutic option for the treatment of pulmonary fibrosis associated with rheumatoid arthritis.

E. Bargagli*, M. Galeazzi#, P. Rottoli*
*Respiratory Diseases Section, and #Rheumatology Section, Dept of Clinical Medicine and Immunology, Siena University, Siena, Italy.

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Nasal *versus* full face mask for noninvasive ventilation in chronic respiratory failure

To the Editor:

I read with interest the study by WILLSON *et al.* [1] published recently in the *European Respiratory Journal*. The paper was focused on interfaces, which are one of the most important issues in treating patients with chronic respiratory failure. The study was set up to compare nasal mask (NM) with full face mask (FFM) ventilation, in terms of sleep quality, gas exchange and tolerability. In addition, the authors tried to investigate any differences in pressure settings between the