

Sjögren's Syndrome and the Skin

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The skin is the largest 'organ' in the body and as such is commonly the source of symptoms in patients with Sjögren's Syndrome. The symptoms may not be as severe as those affecting the eyes or mouth but they are troublesome in approximately 50% of patients.

Dry Skin

Dry Skin (or Xerosis) is the commonest symptom but perhaps the most difficult to specifically help. It presents as rough, dry, slightly scaly skin which can feel itchy (or pruritis). But be careful not to scratch as sometimes this can stimulate pigmentation. This problem presents at a younger age in those with Ro or La antibodies than in those without these antibodies. Like many of the problems in Sjögren's, symptomatic therapy is the mainstay of treatment. Fortunately there are many moisturisers available which vary in their degree of greasiness. It is really a matter of 'trial and error' to find the right one for the individual. Sometimes the addition of emollient bath additives (such as Oilatum) to bath water can help, but be careful as it makes the bath very slippery! Avoidance of direct contact with washing up liquids by using rubber gloves may help. Over-use of soap and water, can dry out the skin. Perfumed soaps can sometimes irritate dry skin, therefore generally one should use 'simple' soaps or gels. Sometimes dry skin can occur in other conditions such as Diabetes, therefore if it is a new symptom do consult your doctor.

Angular Cheilitis

This is when you develop sore fissured skin at the corner of the mouth. It can occur due to dryness of the skin/lip alone. But it is also seen in cases of malnutrition, iron deficiency and celiac disease. However it can indicate infection; in particular candidal infections are common at this location. Herpes virus infections can also be localised to this spot. Appropriate local antibiotic treatment will help.

Photosensitive rashes

This is a type of rash precipitated by exposure to sun light. If you are prone to this sort of rash then even 'winter sun' can be enough to precipitate a further attack. The skin of the face, upper chest and arms are the most commonly affected. It may appear as a blotchy red rash of irregular shape. Sometimes the rash covers a small area but it can be extensive depending on the severity of the sun exposure. It particularly occurs in people with Ro antibodies. Prevention is the most sensible advice thus if on holiday, avoidance of the 'midday sun', hats, long sleeved shirts etc can be of help. You need protection against UVA and UVB. Many sun blockers are on the market, inevitably only the stronger ones with an SPF 30 or 60 will be of the most benefit. But they must be used in accordance with the maker's instructions. Taking a photograph of the rash on your phone can be very helpful to show your doctor for accurate identification.



Annular Erythema

This is a more serious photosensitive type rash which as the name suggests presents as recurrent annular (circular) lesions, which can be raised. The size can vary from 0.5 cm to several cms. They typically occur on sun exposed areas. It occurs almost invariably in those people with Ro antibodies. Rashes of this sort are not 'exclusive' to one connective tissue disease but can occur in other conditions such as Lupus. Therefore do not be surprised if these disorders are discussed or investigated for.

Raynaud's Syndrome

This problem occurs in many patients with connective tissue disease. It is a reversible reduction of blood flow to the fingers precipitated by a fall in ambient temperature. This results in cold blue fingers, which may become white and then red as they warm up. Keeping your core temperature stable can help by wearing thermal underwear, enough layers and gloves can help. If this is not enough then vasodilators such as slow release nifedipine can be of benefit.

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Purpuric Vasculitis

This is a common problem for patients with Sjögrens who have Ro or La antibody and hypergammaglobulinaemia (this is a raised protein level in the blood due to the over activity of your B lymphocytes producing excessive amounts of immunoglobulin). It results in small pin point or slightly larger palpable red spots on your legs that do not fade with pressure. They tend to come up as a 'crop', last for a few days and then fade only to reoccur every few months. They may come up after periods of prolonged standing. Sometimes they can be controlled by wearing support stockings (pop socks are not sufficient). If medical therapy is needed then hydroxychloroquine might help. Only rarely is more immunosuppression needed for this form of vasculitis. If you have hypergammaglobulinaemia then you are quite likely to be 'Rheumatoid Factor' positive, this does not mean that you have rheumatoid arthritis. It is what is called a 'false positive' result and occurs as a consequence of the high

immunoglobulin level in your blood. For the same reason your measures of 'inflammation' such as the 'ESR' or plasma viscosity can be artificially elevated, but reassuringly another measure of inflammation (not affected by a high immunoglobulin level) the 'CRP' should be normal.

Vasculitis

Rarely more severe involvement of the blood vessels can occur in which case the extremities are again most commonly involved. This can result in black areas appearing particularly on the fingers or around the ankles or toes. They tend to be painful. Vasculitis though can involve other parts of the body such as the nerves or kidney. Therefore this type of skin condition might indicate a more serious problem which would certainly need immunosuppressive therapy and should be reviewed by your Rheumatologist.