Editorial

# Welcoming an African asset: African Journal of Rheumatology

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It is with great pleasure that I allow myself to welcome the *African Journal of Rheumatology (AJR)* to our growing community of rheumatology journals. The AJR joins a highly competitive collection of more than 20 international journals in existence with some dating back more than 75 years and exclusively devoted to disseminate basic and clinical science developments of the specialty. On this era of global medicine and internet availability the AJR is a welcome addition as a representative of more than 50 African nations. A number of African national societies of rheumatology already have their own journal, but it is hoped the AJR will be representative of the African continent as a whole.

After reviewing the June 2014 issue of the journal I came across a variety of original clinical research and case report studies of great interest to clinical rheumatologists anywhere in the world, although some studies may be more representative of the rheumatic pathology seen in certain geographic areas of the African continent. Case in point, the two research articles on HIV infection and associated clinical manifestations. The first article describes the prevalence of HIV infection among a population of patients with avascular necrosis of the femoral head in Ouagadougou, Burkina Faso[1]. Findings showed that HIV infection accounts for 4.25% of avascular necrosis in a total of 141 patients seen at two medical centers in Burkina Faso, with alcohol consumption and steroids being the most common risk factors on this population. These findings are similar to what has been described in Western populations, but strongly indicates that patients exhibiting avascular necrosis on this highly endemic HIV infection area of the world should be screened for underlying HIV infection[2].

The second study that caught my attention originated in Nairobi, Kenya, another highly endemic area of HIV infection and reporting a high prevalence of fibromyalgia, 17.9%, among the HIV population and associated risk factors, WHO clinical stage 3 and a mean CD4 cell count of 276.2, comparable to what has been reported in Western countries[3-5].

Barasa *et al*[6] study on anti-phospholipid antibodies in patients with venous thrombosis at Kenyatta National Hospital, Nairobi, Kenya, is also of great interest. The study evaluated 60 patients, most of whom were females (86.7%), and their findings demonstrated that anti-phospholipid antibodies (Lupus anticoagulant and anti-β2glycoprotein I IgG antibodies) are present only in a minority of patients with venous thrombosis. In contrast, anti-cardiolipin IgG antibodies were present in the majority of patients, but their clinical significance was not entirely ascertained. As the authors acknowledged a number of issues hampered interpretation of the data. However, the study is one of a handful ever performed in the African continent, and points the way for the performance of more studies of this nature on similar, and more importantly in other populations of patients with anti-phospholilpid antibody syndrome exhibiting a myriad of clinical manifestations such as pregnancy loss, thrombocytopenia, thromboembolic disorders, autoimmune disorders. In addition, it would have been of great interest and importance that the authors of the study would have performed repeated anti-phospholipid determination several months after the initial episode of venous thrombosis. Another aspect that requires further investigation is the study of anti-phospholipid antibodies of IgM and IgA isotypes. The latter would have been of great interest, considering that our group and others have reported the IgA isotype to be the immunoglobulin isotype most commonly prevalent in anti-phospholipid antibody positivity in African American patients with systemic lupus erythematosus (SLE)[7,8].

A fascinating case report of a young 22-year old female exhibiting a systemic illness with renal involvement complicated with diffuse alveolar hemorrhage (DAH) in which a final diagnosis of SLE was made, promptly treated with a successful outcome also merits some comments[9]. DAH is an unusual complication of lupus that is accompanied by a high fatality rate if not recognized early and properly treated, and the authors should be commended for recognizing this complication and more importantly initiating rapid and aggressive therapy despite not counting with proper and adequate ancillary procedures and facilities. This case also brings forward the issue of how common or uncommon is lupus among black Africans. This topic

is superbly summarized and discussed by Professor Adelowo in his editorial in the same issue of the AJR[10].

Africa is the second-largest and most populous continent in the world and with over 1 billion people and more than 50 fully recognized countries surely deserves to have its own rheumatology journal. It should become a rich source of information about rheumatic disorders in the continent and it is a timely addition to our worldwide rheumatology community. It is my hope that the AJR parallels the rapid grows already in progress by the continent as a whole and becomes competitive on its own right. The editors and editorial board should be commended for their efforts in initiating this worthwhile academic enterprise.

## References


1. Ouedraogo DD, Ouedraogo T, Kabore F *et al*. Prevalence of HIV infection among the patients with an avascular necrosis of the femoral head in Ouagadougou, Burkina Faso. *Afr J Rheumato l.* 2013; **1**: 57-60.
2. Chevalier X, Larget-Piet B, Hernigou P, Gherardi R. Avascular necrosis of the femoral head in HIV infected patients. *J Bone Joint Surg.* 1993; **75**: 160.
3. Malombe NM, Oyoo GO, Maritim MC, Kwasa J. Prevalence of fibromyalgia in ambulatory HIV positive patients with musculoskeletal pain at Comprehensive Care Clinic, Kenyatta National Hospital. *Afr J Rheumatol.* 2013; **1**: 70-75.
4. Buskila D, Gladman D, Langevitz P. Fibromyalgia in HIV infection. *J Rheumatol*. 1990; **17**: 1202-1206.
5. Kaddu-Mukasa M, Ssekasanvu E, Ddumba E. Rheumatic manifestations among HIV positive adults attending the Infectious Disease Clinic at Mulago Hospital. *Afr Health Sci.* 2011; **11**: 24-29.
6. Barasa KA, Mwanda OW, Kitonyi GK, Gontier CS. Antiphospholipid antibodies in patients with venous thrombosis at Kenyatta National Hospital. *Afr J Rheumatol*. 2013; **1**: 52-56.
7. Molina JF, Gutierrez-Urena S, Molina J. *et al*. Variability of anticardiolipin antibody isotype distribution in 3 geographic populations of patients with systemic lupus erythematosus. *J Rheumatol*. 1997; **24**: 291-296.
8. Cucurull E, Gharavi AE, Diri E, Mendez E, Kapoor D, Espinoza LR. IgA anticardiolipin and anti-beta2-glycoprotein I are the most prevalent isotypes in African American patients with systemic lupus erythematosus. *Am J Med Sci.* 1999; **318**: 55-60.
9. Okwara CC, Ozoh G. Diffuse alveolar hemorrhage in a young woman with systemic lupus erythematosus: Case report and literature review. *Afr J Rheumatol.* 2013; **1**: 76-80.
10. Adelowo F. Systemic lupus erythematosus: not a rare disease among black Africans. *Afr J Rheumatol*. 2013; **1**: 46-47.