**Table**
Influence of Characteristics of Patients With Community-acquired Pneumonia on C-Reactive Protein (CRP) Values

| | Yes | | No | | P |
|---|---|---|---|---|---|
| | No. of Patients | CPR Levels,[a] mg/L | No. of Patients | CRP Levels,[a] mg/L | |
| Age >65 y | 87 | 240.4 (120.2) | 74 | 336.0 (181.6) | <.001 |
| Men | 112 | 285.1 (164.4) | 49 | 282.5 (145.5) | .924 |
| Comorbidities[b] | 84 | 283.0 (159.8) | 77 | 285.7 (157.9) | .917 |
| Symptoms >1 day | 134 | 291.4 (166.2) | 27 | 248.9 (107.5) | .205 |
| Previous antibiotic treatment[b] | 34 | 283.4 (183.8) | 127 | 284.6 (151.7) | .969 |

[a] C-reactive protein values are expressed as means (SD).
[b] Heart failure, respiratory failure, liver failure, kidney insufficiency, or immunodeficiency.
[c] Duration >1 day.

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## Adalimumab in the Treatment of Parotid Sarcoidosis

### *Adalimumab en el tratamiento de la sarcoidosis parotídea*

*To the Editor:*

Adalimumab (brand name Humira®), is a biological blocker specific to the tumoural necrosis action factor which causes a fast decrease in the reactants of acute stage inflammation. Its accepted indications in the technical specifications to date are rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis.[1-3] We present a case of systemic sarcoidosis with outbreak of acute parotiditis which does not respond to regular treatment, but presents important clinical improvement with this drug.

A female aged 40 with no known medical allergies or harmful habits, with pathologic background of high blood pressure under hydrochlorothiazide treatment, with a pacemaker since 2000 for sinus node dysfunction and 3 miscarriages. In February 2001, she developed erythema nodosum in the lower extremities together with an outbreak of bilateral parotiditis which responded to treatment with 30mg of orally administered prednisone. In February 2002 she presented heart failure due to possible myocardial sarcoidosis and the echocardiogram displayed a 32% ejection fraction and moderate aortic insufficiency. She responded appropriately to diuretic treatment (furosemide, 40mg/12 h) and angiotensin-converting enzyme inhibitors (enalapril, 20mg/day).

In April 2008 she presented a new outbreak of bilateral parotiditis with fever, arthralgia and dyspnoea. She received treatment with prednisone at a dose of 30mg/day for 2 months, with no improvement in the parotiditis. Given the lack of response, in June 2008, treatment was started with infliximab at a dose of 300mg/day (a monthly dose), reaching a maximum dose of 400mg, with no clinical response. Given the poor results obtained to that point from treatments, we considered the option of trying adalimumab (Humira®). In September 2008, adalimumab was commenced at a dosage of 40mg once a fortnight for 4 months, with which the patient presented a good clinical response with disappearance of the clinical signs of parotiditis.

Despite the scarce experience in the use of this drug for sarcoidosis that does not respond to conventional treatment, adalimumab could be considered a therapeutic alternative for this type of patients.

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