Ασθενής με Συστηματικό Ερυθηματώδη Λύκο και Εξάνθημα

Γεώργιος Δεμιρτζόγλου

Ειδικευόμενος ρευματολογίας,

Μονάδα ρευματολογίας και κλινικής ανοσολογίας, ΠΓΝ Αττικόν

ΔΕΝ ΥΠΑΡΧΕΙ ΣΥΓΚΡΟΥΣΗ ΣΥΜΦΕΡΟΝΤΩΝ

ΠΕΡΙΕΧΟΜΕΝΑ ΠΑΡΟΥΣΙΑΣΗΣ

- Παρουσίαση κλινικής περίπτωσης
- Λίγα λόγια για το εξάνθημα
  - Τι είναι
  - Διαφορική διάγνωση
  - Σχετίζεται με το νόσημα ;
  - Θεραπεία

Παρουσίαση κλινικής περίπτωσης

ΣΕΛ

- Άνδρας, 42
- Ελεύθερο α/α , πρόσφατο σύνδρομο λοιμώδους μονοπυρήνωσης
- Εμμονή κόπωσης, αρθραλγιών, δεκατικής πυρετικής κίνησης και εξάνθημα
- Εργαστηριακό φλεγμονώδες σύνδρομο-αναιμία
- Εργαστηριακό φλεγμονώδες σύνδρομο
- - ANA (1/640 πυρηνίων) - ENA (SSA/Ro60+) - C3,C4 ↓
- - Anti-dsDna: ELISA (89 UI/L / φτ < 30 U) – IFA (+)
- ACA, b2GPI IgG X2 Elisa

HCQ 400mg

Prednisone 10mg

Salospir 80mg

Παρουσίαση κλινικής περίπτωσης

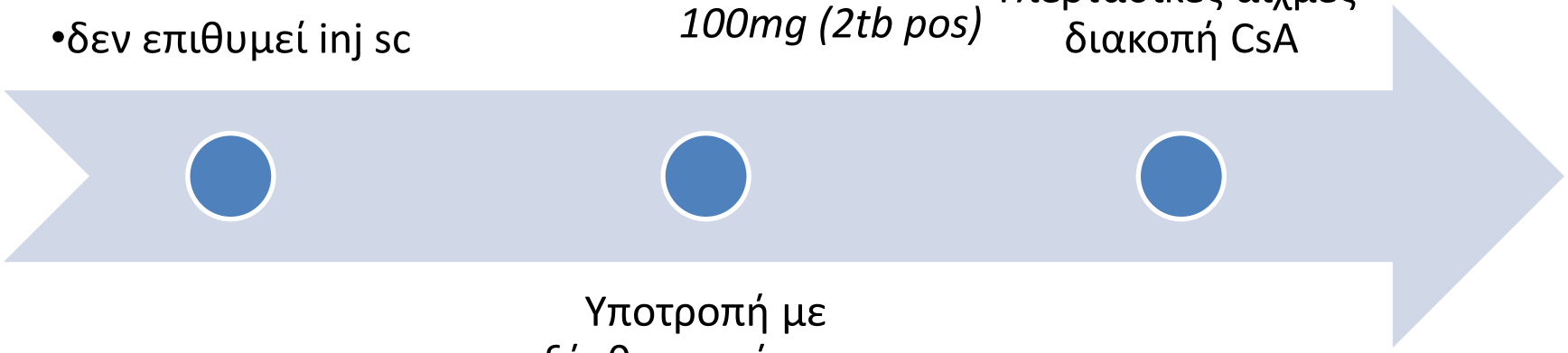
*Έναρξη **MTX** 10mg + Φολικό οξύ 5mg /εβδ*

•Τιτλοποίηση δόσης ως 20mg (4+4 tb pos)

•δεν επιθυμεί inj sc

Προσθήκη CsA 50mg (1tb) Τιτλοποίηση δόσης ως 100mg (2tb pos)

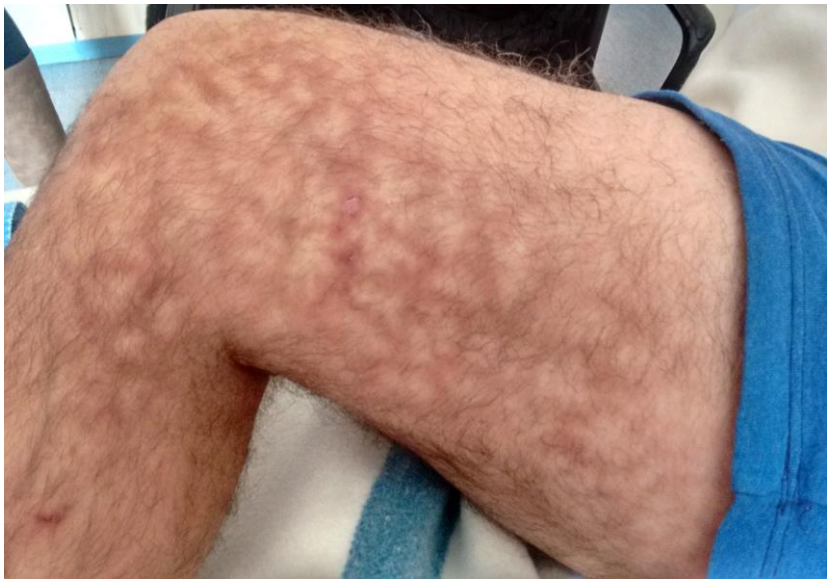
Υπερτασικές αιχμές-διακοπή CsA

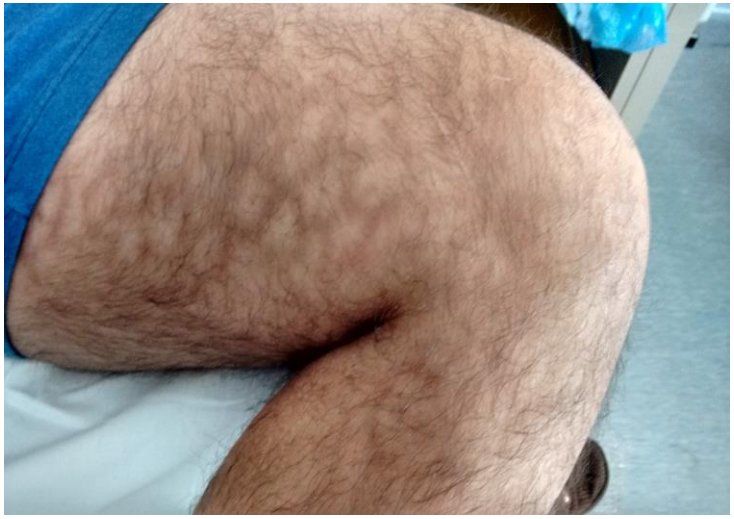


Υποτροπή με εξάνθημα, κόπωση, αρθραλγίες, δέκατα κσι λεμφαδενοπάθεια

Παρουσίαση κλινικής περίπτωσης

- Εμπύρετο
- Αρθρίτιδα
- Ρινορραγία
- Εξάνθημα (κνησμός +καύσος)



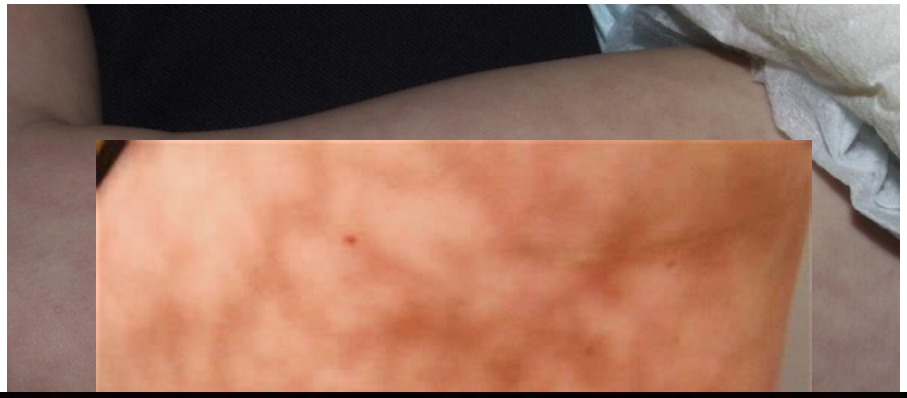


Προβληματισμοί

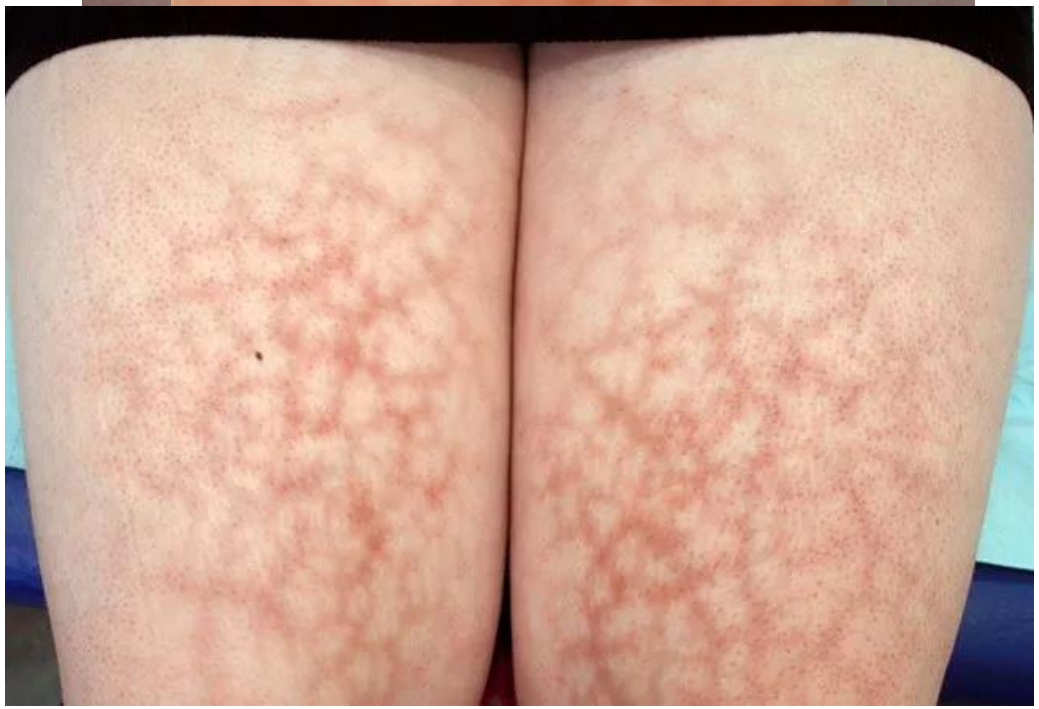
- Εξάνθημα σχετίζεται με τον ΣΕΛ, με τα αντιφωσφολιπιδικα αντισώματα ή δεν σχετίζεται με το νόσημα ;
- Εχει σχέση με την ενεργότητα και της υποτροπές;
- Θεραπεία ;

Εξάνθημα

- Livedo reticularis



- Livedo racemosa



- Erythema ab igne

Erythema ab igne

Erythema Ab Igne: A Clinical

Christina L Harview [1], Amanda Krenitsky [1]

Affiliations + expand

PMID: 37289686 DOI: 10.12788/cutis.0771

Abstract

Erythema ab igne (EAI) is a skin condition caused by chro
progresses over weeks to months of repeated or prolong
infrared radiation that is not hot enough to cause a burn
history and physical examination, but a biopsy can revea
pigment incontinence. Erythema ab igne initially was des
over wood-fire stoves but has been shown over the deca
describe various etiologies of EAI, including new heat-pr
psychiatric illnesses, and even iatrogenic causes. Howeve
heat for treatment of chronic pain, which may be a diagr
Although there are no current US Food and Drug Admin
EAI hyperpigmentation, the prognosis is excellent becau
in spontaneous resolution over time. Finally, chronic EAI
squamous cell carcinoma, poorly differentiated carcinom
even Merkel cell carcinoma.

Diagnosis	Population affected	Clinical morphology	Distribution	Blanchable	Associations	Treatment
Erythema ab igne	Most frequently middle-aged or older women; recent reports of young adults	Localized reticulated erythema that correlates with a vascular pattern; becomes increasingly hyperpigmented with time	Skin surface exposed to heating source	Early – yes; late – no	Due to chronic heat exposure; development of squamous cell carcinoma or Merkel cell carcinoma has been reported	Removal of heat source or decreasing the exposure duration; can try 5-fluorouracil[1]
Livedo reticularis	Young to middle-aged women	Mottled, net-like pattern of hyperpigmentation that is uniform, symmetric, and reversible	Primarily on the extremities	Yes	Can be idiopathic; due to an underlying disease (APS); physiologic	Treat underlying cause
Livedo racemosa	Young to middle-aged women	Mottled, net-like pattern of hyperpigmentation that is permanent	Primarily the proximal limbs and trunk	Partially	Can be associated with Sneddon syndrome, SLE,	Treat underlying cause

Take home messages

- Δεν αποδίδονται πάντα όλα τα εξανθήματα στον ΣΕΛ→ κριτική αξιολόγηση με βάση το ιστορικό του ασθενούς και την έκθεση σε περιβαλλοντικούς παράγοντες
- Η διαφορική διάγνωση του ερυθήματος από θερμότητα αφορά κυρίως livedo reticularis και livedo racemosa
- Στα αρχικά στάδια δεν χρήζει ειδικής θεραπείας →βραδεία αυτοίαση
- Η χρόνια μορφή δεν είναι τόσο αθώα

Ασθενής με φλεγμονώδη συμμετρική πολυαρθρίτιδα και αυξημένες τιμές ουρικού οξέος

Γεώργιος Δεμιρτζόγλου

Ειδικευόμενος ρευματολογίας,

Μονάδα ρευματολογίας και κλινικής ανοσολογίας, ΠΓΝ Αττικόν

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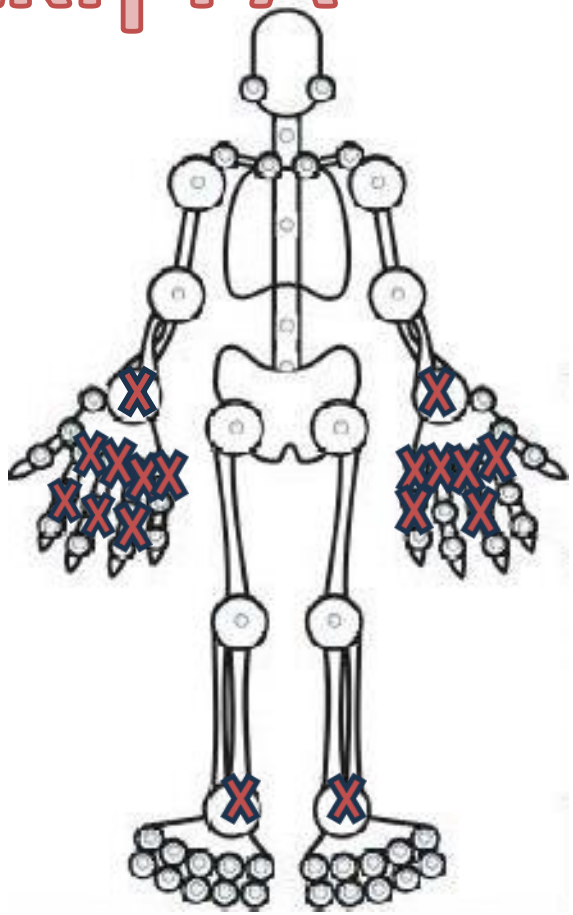
ΠΕΡΙΕΧΟΜΕΝΑ ΠΑΡΟΥΣΙΑΣΗΣ

- Παρουσίαση κλινικής περίπτωσης
- Ρευματοειδής αρθρίτιδα (ΡΑ)
  - Θεραπεία
- Ουρική αρθρίτιδα
  - Θεραπεία
- Συνύπαρξη ΡΑ- ουρικής
  - Συχνότητα
  - Επιδημιολογία
  - Θεραπεία

Παρουσίαση κλινικής περίπτωσης

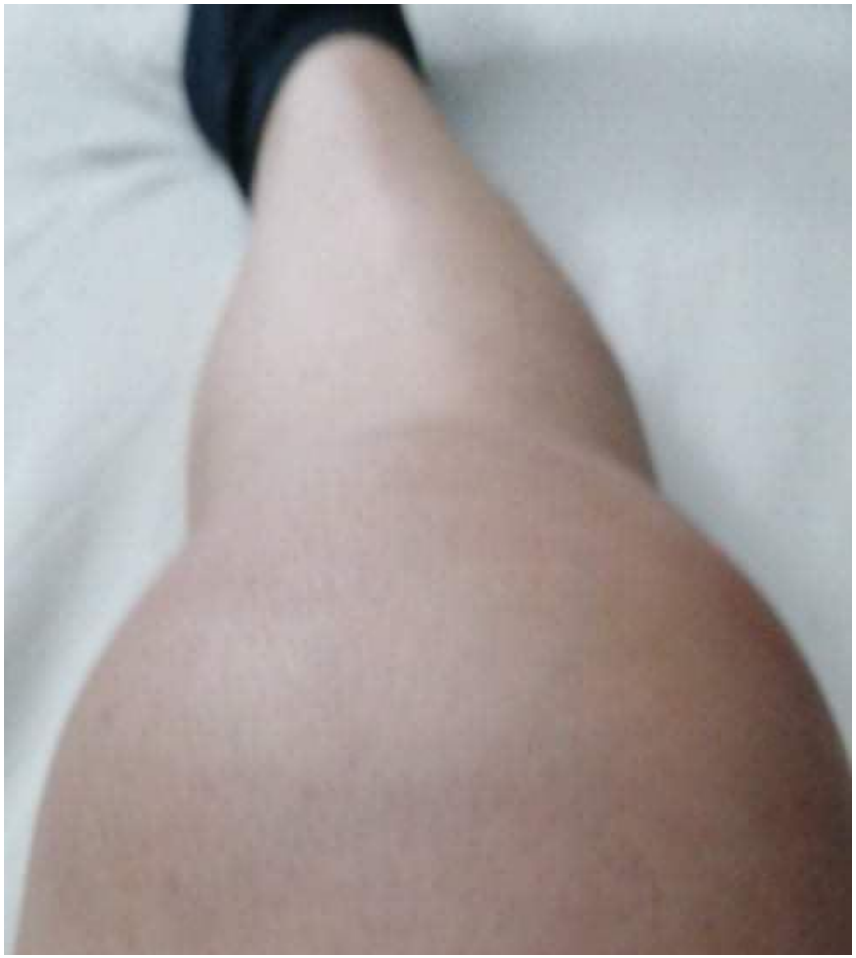
Οροαρνητική ΡΑ

- Άνδρας, 51
- Ελεύθερο α/α , κατάχρηση αλκοόλ
- Συμμετρική πολυαρθρίτιδα
- Πρωινή δυσκαμψία >30’
- Εργαστηριακό φλεγμονώδες σύνδρομο
- RF(-), antiCCP(-)



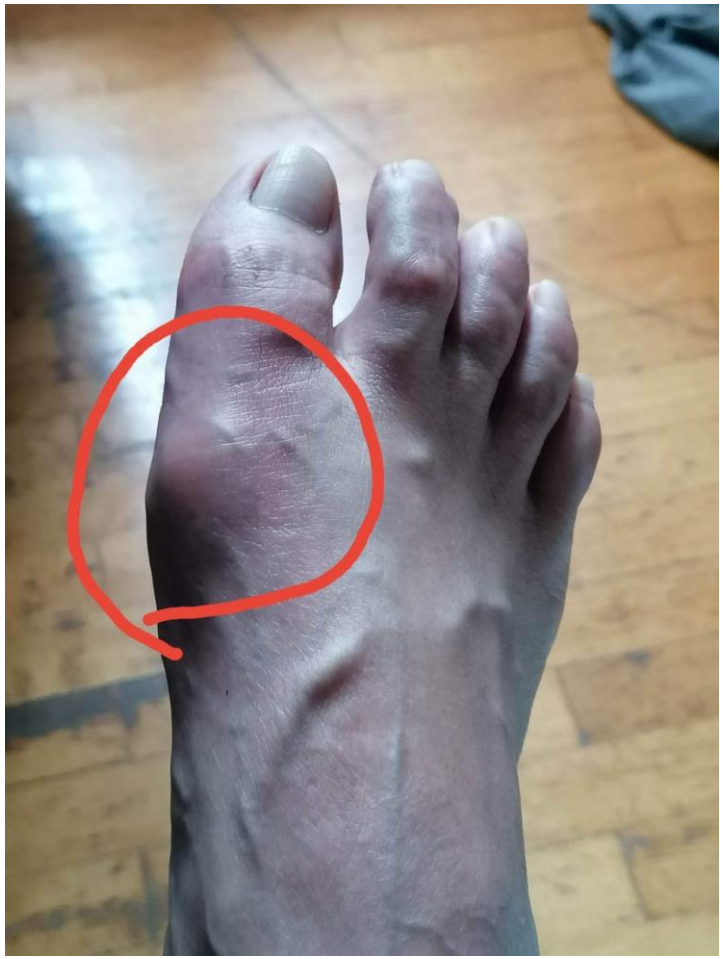
Παρουσίαση κλινικής περίπτωσης

- Έναρξη μεθοτρεξάτης
- Αρθρίτιδα γονάτων → έναρξη ανταλιμουμάμπης
- Πλημμελής παρακολούθηση – συμμόρφωση επισκέψεις κυρίως στα ΤΕΠ
- Παρακέντηση άρθρωσης → χωρίς κρυστάλλους



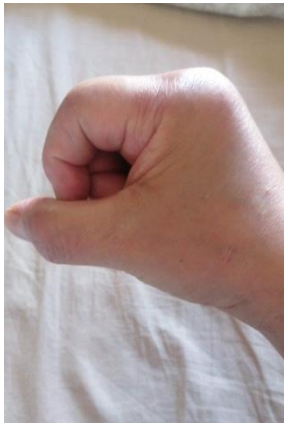
Παρουσίαση κλινικής περίπτωσης

- 1ο επεισόδιο ουρικής αρθρίτιδας
- ΜΣΑΦ+ κορτικοστεροειδή → άριστη ανταπόκριση πλήρης ύφεση σε 48h
- Υποτροπή ουρικής αρθρίτιδας με υπερουριχαιμία → έναρξη αλλοπουρινόλης

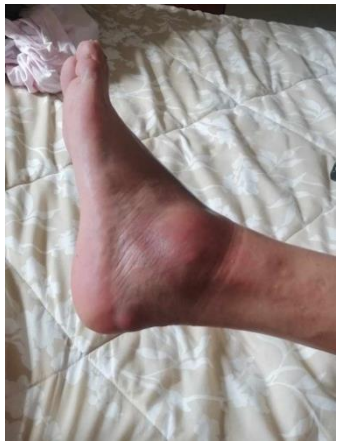


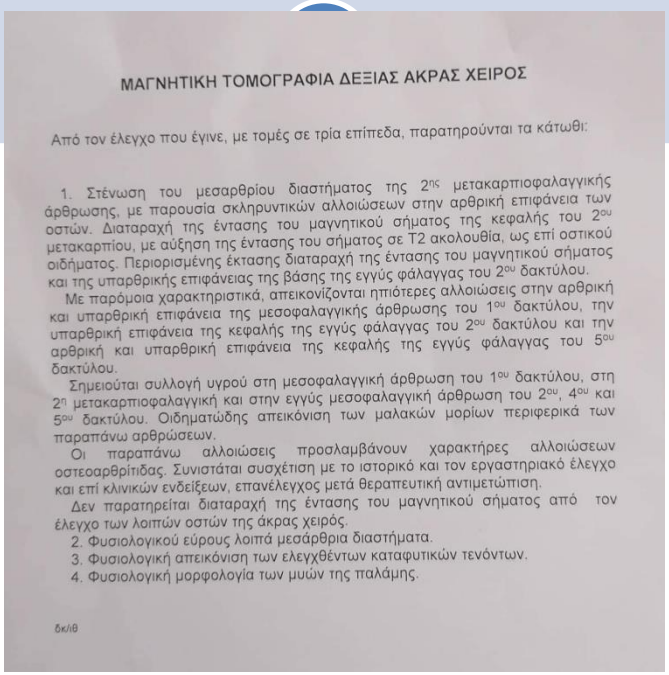
Παρουσίαση κλινικής περίπτωσης

Upatacitinib
2/2022-
1/2023



Infliximab sc
4/24-





ΜΑΓΝΗΤΙΚΗ ΤΟΜΟΓΡΑΦΙΑ ΔΕΞΙΑΣ ΑΚΡΑΣ ΧΕΙΡΟΣ

Από τον έλεγχο που έγινε, με τομές σε τρία επίπεδα, παρατηρούνται τα κάτωθι:

1. Στένωση του μεσαρθρίου διαστήματος της 2ης μετακαρπιοφαλαγγικής άρθρωσης, με παρουσία σκληρυντικών αλλοιώσεων στην αρθρική επιφάνεια των οστών. Διαταραχή της έντασης του μαγνητικού σήματος της κεφαλής του 2ου μετακαρπίου, με αύξηση της έντασης του σήματος σε Τ2 ακολουθία, ως επί οστικού οιδήματος. Περιορισμένης έκτασης διαταραχή της έντασης του μαγνητικού σήματος και της υπαρθρικής επιφάνειας της βάσης της εγγύς φάλαγγας του 2ου δακτύλου.

Με παρόμοια χαρακτηριστικά, απεικονίζονται ηπιότερες αλλοιώσεις στην αρθρική και υπαρθρική επιφάνεια της μεσοφαλαγγικής άρθρωσης του 1ου δακτύλου, την υπαρθρική επιφάνεια της κεφαλής της εγγύς φάλαγγας του 2ου δακτύλου και την αρθρική και υπαρθρική επιφάνεια της κεφαλής της εγγύς φάλαγγας του 5ου δακτύλου.

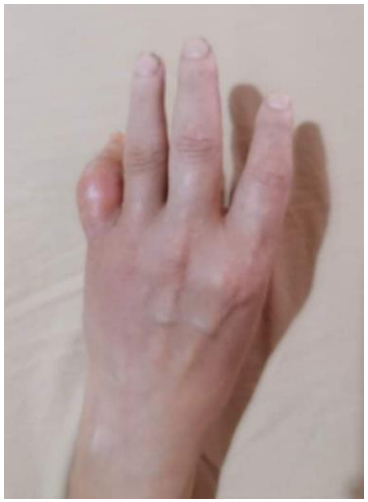
Σημειούται συλλογή υγρού στη μεσοφαλαγγική άρθρωση του 1ου δακτύλου, στη 2η μετακαρπιοφαλαγγική και στην εγγύς μεσοφαλαγγική άρθρωση του 2ου, 4ου και 5ου δακτύλου. Οιδηματώδης απεικόνιση των μαλακών μορίων περιφερικά των παραπάνω αρθρώσεων.

Οι παραπάνω αλλοιώσεις προσλαμβάνουν χαρακτήρες αλλοιώσεων οστεοαρθρίτιδας. Συνιστάται συσχέτιση με το ιστορικό και τον εργαστηριακό έλεγχο και επί κλινικών ενδείξεων, επανέλεγχος μετά θεραπευτική αντιμετώπιση.

Δεν παρατηρείται διαταραχή της έντασης του μαγνητικού σήματος από τον έλεγχο των λοιπών οστών της άκρας χειρός.

2. Φυσιολογικού εύρους λοιπά μεσάρθρια διαστήματα.
3. Φυσιολογική απεικόνιση των ελεγχθέντων καταφυτικών τενόντων.
4. Φυσιολογική μορφολογία των μυών της παλάμης.

δκ/ιθ



Παρουσίαση κλινικής περίπτωσης

Μέλαινες κενώσεις

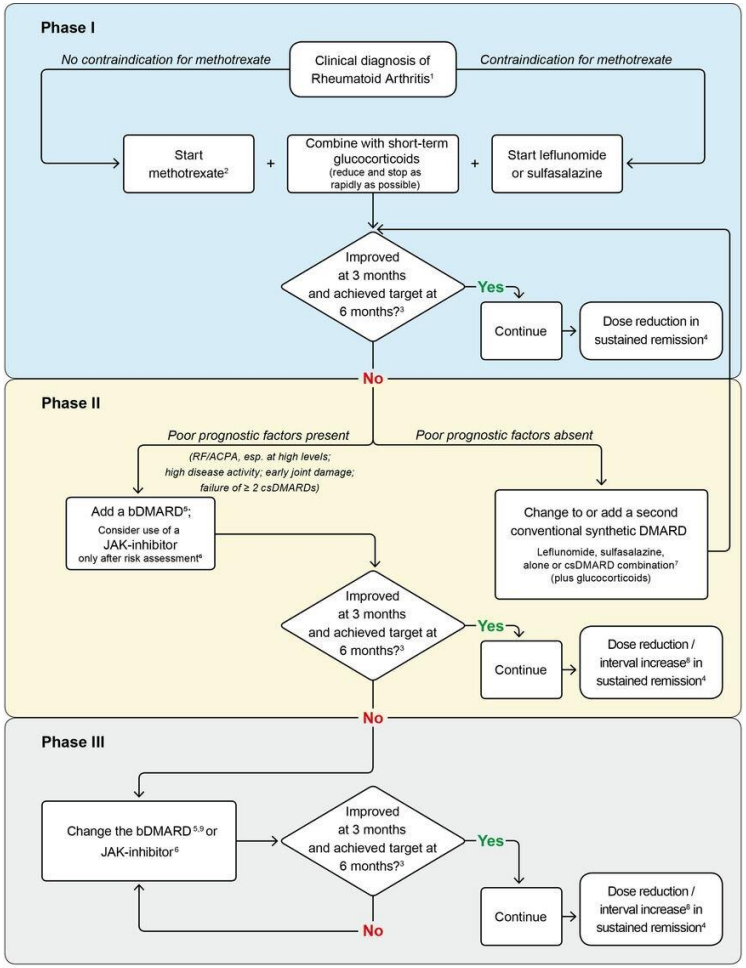
Πολυαρθρίτιδα κατά τη νοσηλεία

Παρακέντηση γονατος → κρύσταλλοι ουρικού

Προβληματισμοί

- Είναι σωστή η αρχική διάγνωση;
- Υποτροπές! ΡΑ ή ουρική;
- Πολλαπλές υποτροπές! Είναι μόνο η συμμόρφωση;
- Θεραπεία ;

Θεραπεία PA/ουρικής



1. 2010 ACR-EULAR classification criteria can support early diagnosis.
2. "Methotrexate should be part of the first treatment strategy". While combination therapy of csDMARDs is not preferred by the Task Force, starting with methotrexate does not exclude its use in combination with other csDMARDs although more adverse events without added benefit are to be expected, especially if MTX is combined with glucocorticoids.
3. The treatment target is clinical remission according to ACR-EULAR definitions or, if remission is unlikely to be achievable, at least low disease activity; the target should be reached after 6 months, but therapy should be adapted or changed if insufficient improvement (less than 50% of disease activity) is seen after 3 months.
4. Sustained remission: ≥ 6 months ACR/EULAR index based or Boolean remission.
5. Consider contraindications and risks. TNF-inhibitors (adalimumab, certolizumab, etanercept, golimumab, infliximab, including EMA/FDA approved bsDMARDs), abatacept, IL-6R inhibitors, or rituximab (under certain conditions); in patients who cannot use csDMARDs as comedication IL6-inhibitors and tsDMARDs have some advantages.
6. The following risk factors for cardiovascular events and malignancies must be considered when intending to prescribe a JAK-inhibitor: Age over 65 years, history of current or past smoking, other cardiovascular risk factors (such as diabetes, obesity, hypertension), other risk factors for malignancy (current or previous history of malignancy other than successfully treated NMSC), risk factors for thromboembolic events (history of MI or heart failure, cancer, inherited blood clotting disorders or a history of blood clots, as well as patients taking combined hormonal contraceptives or hormone replacement therapy, undergoing major surgery or immobile)
7. The most frequently used combination comprises methotrexate, sulfasalazine and hydroxychloroquine.
8. Dose reduction or interval increase can be safely done with all bDMARDs and tsDMARDs with little risk of flares; stopping is associated with high flare rates; most but not all patients can recapture their good state upon re-institution of the same bDMARD/tsDMARD, but before all this glucocorticoids must have been discontinued.
9. From a different or the same class.

Recommendation	PICO question	Certainty of evidence
For patients experiencing a gout flare, we strongly recommend using oral colchicine, NSAIDs, or glucocorticoids (oral, intraarticular, or intramuscular) as appropriate first-line therapy for gout flares over IL-1 inhibitors or ACTH (the choice of colchicine, NSAIDs, or glucocorticoids should be made based on patient factors and preferences). When colchicine is the chosen agent, we strongly recommend low-dose colchicine over high-dose colchicine given its similar efficacy and fewer adverse effects.	32	High†
For patients experiencing a gout flare for whom other antiinflammatory therapies are poorly tolerated or contraindicated, we conditionally recommend using IL-1 inhibition over no therapy (beyond supportive/ analgesic treatment).	33	Moderate
For patients who may receive NPO, we strongly recommend glucocorticoids (intramuscular, intravenous, or intraarticular) over IL-1 inhibitors or ACTH.	32	High†
For patients experiencing a gout flare, we conditionally recommend using topical ice as an adjuvant treatment over no adjuvant treatment.	31	Low

Strongly recommend | Conditionally recommend | Strongly recommend against | Conditionally recommend against

* PICO = population, intervention, comparator, outcomes; NSAIDs = nonsteroidal antiinflammatory drugs; IL-1 = interleukin-1; ACTH = adrenocorticotropic hormone; NPO = nothing by mouth (nulla per os).

† High quality of evidence from network meta-analyses supporting canakinumab, which has superior mean pain score reduction and mean day-2 joint tenderness reduction. However, the Voting Panel raised concern that the comparator was weak (triamcinolone 40 mg) and that cost issues significantly favor other agents.

Είναι σωστή η διάγνωσή μας ;

Mandatory: (All should be present):

1. Chronic inflammatory polyarthritis (Documented joint swelling of 5 or more joints on examination)
2. Raised ESR and/or raised CRP
3. Negative RF and negative ACPA.

Supportive: (1–3 depending upon clinical features):

1. Absence of SPA features including psoriasis
2. Synovitis confirmed by ultrasonography OR magnetic resonance imaging.
3. Absence of clinical features of connective tissue diseases and negative AN
4. Absence of HCV, HBSAg, HIV, TB, and leprosy (in endemic regions).

- Υψηλό ουρικό (10mg/dl)
- Τυπική κλινική εικόνα
- Ανταπόκριση σε ΜΣΑΦ-κορτικοστεροειδή σε 48h
- Πλήρης υποχώρηση της ‹ρίσης εντός ξβδομάδας

Υποτροπές! PA ή ουρική;

Comorbidity of gout and rheumatoid arthritis in a large population database

Original Article | Published: 11 November 2016
Volume 36, pages 657–660, (2017) Cite this article

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Rona Merdler-Rabinowicz, Shmuel Tiosano, Doron Comaneshter, Arnon D. Cohen & Howard Amital

Abstract

Comorbidity of gout and rheumatoid arthritis in a large population database

study was designed as a population-based cross-sectional study, utilizing the medical database of Clalit Health Services, the largest healthcare provider organization in Israel. Data of adult patients who were previously diagnosed with rheumatoid arthritis was retrieved. For each patient, five age- and sex-matched control patients were randomly selected. Different parameters including BMI, socioeconomic status, and existence of gout as well as smoking and hypertension were examined for both groups. The study included 11,540 patients with rheumatoid arthritis and 56,763 controls. The proportion of gout in the study group was high compared to controls (1.61 vs. 0.92%, $P < 0.001$). In a multivariate analysis, rheumatoid arthritis was associated with gout (OR = 1.72, 95% CI 1.45–2.05, $P = 0.00$). The proportion of gout in rheumatoid arthritis patients is not lower than in the general population.

Arthritis Care & Research
American College of Rheumatology

Original Article | Full Access

Coexistent Hyperuricemia and Gout in Rheumatoid Arthritis: Associations With Comorbidities, Disease Activity, and Mortality

Andrew Chiou, Bryant R. England, Harlan Sayles, Geoffrey M. Thiele, Michael J. Duryee, Joshua F. Baker, Namrata Singh, Grant W. Cannon, Gail S. Kerr, Andreas Reimold, Angelo Gaffo, Ted R. Mikuls

First published: 10 May 2019 | https://doi.org/10.1002/acr.23926 | Citations: 22

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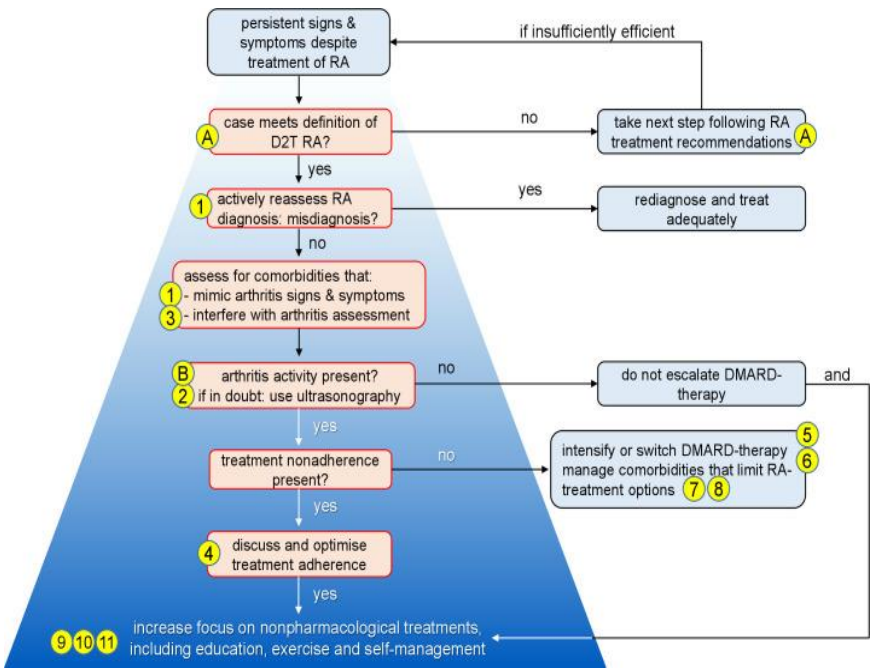
[1] Andrew Chiou, BS, Harlan Sayles, MS: University of Nebraska Medical Center, Omaha; [2] Bryant R. England, MD, Geoffrey M. Thiele, PhD, Michael J. Duryee, MS, Ted R. Mikuls, MD, MSPH: University of Nebraska Medical Center and VA Nebraska–Western Iowa Health Care System, Omaha, Nebraska; [3] Joshua F. Baker, MD, MSCE: Corporal Michael J. Crescenz VAMC and University of Pennsylvania, Philadelphia; [4] Namrata Singh, MBBS: Iowa City VAMC and University of Iowa, Iowa City; [5] Grant W. Cannon, MD: Salt Lake City VAMC and University of Utah, Salt Lake City; [6] Gail S. Kerr, MD: Washington, DC VAMC, Georgetown University, and Howard University, Washington, DC; [7] Andreas Reimold, MD: Dallas VAMC and University of Texas Southwestern, Dallas; [8] Angelo Gaffo, MD, MSPH: Birmingham VAMC and University of Alabama at Birmingham.

No potential conflicts of interest relevant to this article were reported.

Πολλαπλές υποτροπές! Είναι μόνο η συμμόρφωση;



An Overview on Causes of Nonadherence in the Treatment of Rheumatoid Arthritis: Its Effect on Mortality and Ways to Improve Adherence

Monitoring Editor: Alexander Muacevic and John R Adler

Tutul Chowdhury,[1] Jui Dutta,[2] Pharlin Noel,[3] Ratul Islam,[4] Gael Gonzalez-Peltier,[4] Samzorna Azad,[4] Malavika Shankar,[5] Aditya Keerthi Rayapureddy,[5] Padmaja Deb Roy,[2] Nicole Gousy,✉[4] and Khondokar N Hassan[6]

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Abstract

Go to: ▸

Rheumatoid arthritis is one of the most prevalent musculoskeletal disorders that, when insufficiently treated, results in detrimental sequelae including joint damage and reduced quality of life. Poor patient adherence to medication is a significant blockade to effective management. The purpose of this review is to highlight and discuss the factors responsible for defiance of antirheumatic medication and ways to overcome these barriers. Education level, health literacy, cohabitation status, multi-morbidities, complicated drug regimen, intermittent co-payments, prescribed regimen adverse effects, and cognitive impairment are a few among many common barrier factors leading to poorer outcomes in rheumatoid arthritis. While there is an abundance of inhibitory factors leading to worsening disease progression, they each can be easily dealt with an effective approach at the beginning or during the treatment course to ensure a better outcome.

Θεραπεία ;

Canakinumab for refractory RA: a case report

Nikolaos Marketos[1,2,3], Ilias Bournazos[2,3], Dimitrios Ioakimidis[2,3]

Authors Information

1. Department of Rheumatology, University Hospital of Linköping, Linköping, Sweden

2. Private Practice Rheumatologist, Athens, Greece

3. Rheumatology Outpatient Department, Henry Dunant Hospital Centre, Athens, Greece

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Abstract

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Abstract

Rheumatoid arthritis is a common autoimmune disease leading often to joint destruction and reduced quality of life. We report a case of a young woman with rheumatoid arthritis with fever and rapid, destructive joint involvement verified with magnetic resonance imaging. She had failed therapy with methotrexate and leflunomide, anti-TNF, IL-6 inhibitor, B cell depletion and IL-1RA. Her laboratory results remained insignificant despite the aggressiveness of her disease. In this case, the patient only partly responded to anakinra but developed side effects, and therefore was switched to Canakinumab that led to sustained remission.
There are no clear biomarkers or other clues in order to separate early in the beginning of the disease course if a polyarticular inflammatory spectrum can be IL-1β driven. The young age of the patient at onset of disease, its aggressive course, inflammatory fever without significant laboratory inflammatory markers but with polyarthritis affecting small joints, may raise the suspicion of an IL=1β-driven disease and alert the treating rheumatologist to the use of IL-1β inhibitors early in the disease course.

Interleukin-1β inhibitors for the management of acute gout flares: a systematic literature review

Naomi Schlesinger[1*], Michael H. Pillinger[2], Lee S. Simon[3] and Peter E. Lipsky[4]

Abstract

Objectives The objective of this systematic review was to assess the effects of interleukin-1β (IL-1β) inhibitors on gout flares.

Methods Studies published between 2011 and 2022 that evaluated the effects of IL-1β inhibitors in adult patients experiencing gout flares were eligible for inclusion. Outcomes including pain, frequency and intensity of gout flares, inflammation, and safety were assessed. Five electronic databases (Pubmed/Medline, Embase, Biosis/Ovid, Web of Science and Cochrane Library) were searched. Two independent reviewers performed study screening, data extraction and risk of bias assessments (Cochrane Risk of Bias Tool 2 for randomised controlled trials [RCTs] and Downs and Black for non-RCTs). Data are reported as a narrative synthesis.

Results Fourteen studies (10 RCTs) met the inclusion criteria, with canakinumab, anakinra, and rilonacept being the three included IL-1β inhibitors. A total of 4367 patients with a history of gout were included from the 14 studies ($N=3446$, RCTs; $N=159$, retrospective studies [with a history of gout]; $N=762$, post hoc analysis [with a history of gout]). In the RCTs, canakinumab and rilonacept were reported to have a better response compared to an active comparator for resolving pain, while anakinra appeared to be not inferior to an active comparator for resolving pain. Furthermore, canakinumab and rilonacept reduced the frequency of gout flares compared to the comparators. All three medications were mostly well-tolerated compared to their comparators.

Conclusion IL-1β inhibitors may be a beneficial and safe medication for patients experiencing gout flares for whom current standard therapies are unsuitable.

Review protocol registration PROSPERO ID: CRD42021267670.

Keywords Gout flare, Interleukin-1β, Randomised controlled trials, Canakinumab, Rilonacept, Anakinra

Take home messages

- Η συνύπαρξη της πολυαρθρικής ουρικής αρθρίτιδας με την ρευματοειδή αρθρίτιδα ίσως είναι πιο συχνή τελικά
- Σε οροαρνητική PA → επανεξέταση της διάγνωσης
- Η συμμόρφωση στη θεραπεία και η σωστή παρακολούθηση παίζουν καθοριστικό ρόλο για την ύφεση και στα 2 νοσήματα
- Η off label θεραπεία με αναστολείς της IL-1β ίσως έχει θέση στη συνύπαρξη PA και ουρικής