

A lateral X-ray of the cervical spine. The vertebrae are clearly visible, showing signs of degeneration such as disc space narrowing and osteophyte formation. A large, dark, semi-transparent banner is overlaid across the middle of the image, containing white text. On the left side of the image, there is a vertical scale bar with horizontal tick marks.

ΑΥΧΕΝΑΛΓΙΑ ΣΕ ΝΕΟ ΑΣΘΕΝΗ ΜΕ ΓΝΩΣΤΗ ΡΕΥΜΑΤΙΚΗ ΝΟΣΟ

ΘΑΝΟΣ ΚΟΥΤΡΟΥΜΠΑΣ

Βόλος

ΣΥΓΚΡΟΥΣΗ ΣΥΜΦΕΡΟΝΤΩΝ

Καμία.

ΣΥΓΚΡΟΥΣΗ ΣΥΜΦΕΡΟΝΤΩΝ

Καμία.

Εκτός από:



ChatGPT

ΑΝΑΦΟΡΑ ΠΕΡΙΠΤΩΣΗΣ:

Γυναίκα 38 ετών

Ατομικό αναμνηστικό: πρόπτωση μιτροειδούς, ψωρίαση από ηλικίας 18 ετών

Σε ηλικία 32 ετών ατρακτοειδής διόγκωση άκρων χειρών (ΕΦΦ), και υμενίτιδα ΜΚΦ.

Πολύωρη πρωινή δυσκαμψία.

Ήπια συστηματικά συμπτώματα (κακουχία, κόπωση, ανορεξία)

ΤΚΕ: 68 χιλ/1η ώρα, CRP: 8,6 mg/dl

RF, ANA, ANCA αρνητικά.



ΔΙΑΓΝΩΣΗ

Ψωριασική αρθρίτιδα

Εναρξη MTX 15 mg/εβδομάδα, Folicine 5 mg εβδομαδιαίως.

Άμεση βελτίωση της συμπτωματολογίας.

Ομαλοποίηση των δεικτών φλεγμονής.

ΜΕΤΑ 8 ΕΤΗ...

Αυχεναλγία (από 10 εβδομάδων)

Κόπωση, καταβολή.

Μικρή αύξηση δεικτών φλεγμονής (ΤΚΕ=45 mm, CRP=1,23 mg/dl)

Ανταπόκριση σε ΜΣΑΦ

In a 38 year-old female patient with psoriatic arthritis under treatment with methotrexate, who is in remission of the arthritis, a newly developed cervical pain can mean what?

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1. Cervical Spine Involvement due to Psoriatic Arthritis

- PsA can affect the **axial skeleton**, including the **cervical spine**, even in patients with peripheral joint remission.
- Inflammatory involvement might present with:
 - Pain and stiffness, especially in the **morning**.
 - Reduced range of motion.
 - Signs of **spondylitis** or **enthesitis** on imaging.
- Imaging (e.g., MRI) can detect active inflammation or structural changes (e.g., syndesmophytes, facet joint involvement).

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2. Mechanical Neck Pain

- Common in the general population and could be unrelated to PsA.
- Related to posture, overuse, stress, or muscle strain.
- Usually **non-inflammatory**, worsens with activity, improves with rest.

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3. Methotrexate-Associated Myopathy or Rare Neuropathy

- Rare, but methotrexate could contribute to **muscle weakness** or **neuropathy**, leading to referred discomfort.
- Would typically present with other systemic or neurological signs.

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4. Degenerative Cervical Spine Disease (Osteoarthritis or Disc Disease)

- Age-related changes, especially in those with long-standing joint disease.
- Could present with:
 - Radicular symptoms if there's nerve root compression.
 - Chronic pain, potentially worsened by movement.

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5. Reactivation or Subclinical Disease Activity

- Some patients in “remission” may still have low-grade or subclinical inflammation.
- A flare could localize to the spine while peripheral joints remain controlled.

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6. Other Serious Causes (Less Common but Important)

- **Infection** (e.g., discitis, vertebral osteomyelitis) — especially if immunosuppressed.
- **Fracture or instability**, especially if there is underlying osteoporosis.
- **Neoplastic causes**, though rare, should be considered if red flags are present.

CERVICAL PAIN

Rheumatic conditions:

Rheumatoid arthritis

Polymyalgia rheumatica

Ankylosing spondylitis

Psoriatic arthritis

Fibromyalgia

Crowned dens syndrome

Giant cell arteritis

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Complication of rheumatic conditions:

Odontoid fracture

Pseudofractures

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Giant cell arteritis

Complication of rheumatic conditions:

Odontoid fracture

Pseudofractures

Other conditions:

Infective endocarditis

Myocardial ischemia

Meningitis

Spondylitis/ discitis

CLINICAL EVALUATION

✓ Clinical Evaluation Checklist

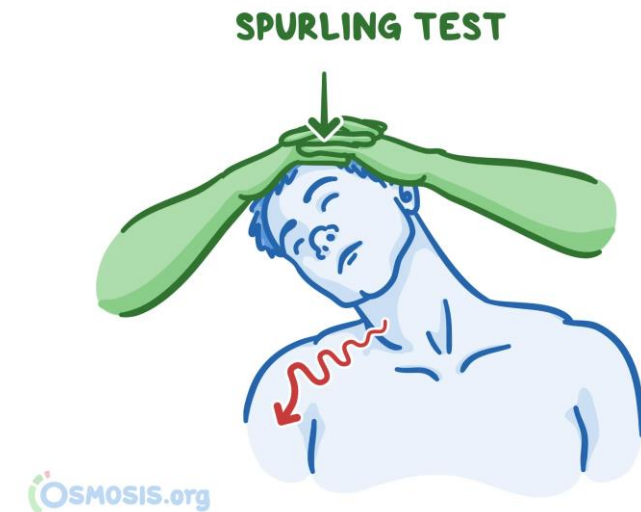
1. Symptom History

- ♦ Onset: Sudden or gradual?
- ♦ Character: Dull, sharp, radiating?
- ♦ Duration and pattern: Worse in morning (suggests inflammation)?
- ♦ Triggers: Posture, trauma, activity?
- ♦ Associated symptoms:
 - Morning stiffness >30 minutes?
 - Fever or weight loss?
 - Neurological symptoms (numbness, weakness, tingling)?
 - Headache or jaw pain?

PHYSICAL EXAMINATION

2. Physical Examination

- ♦ Tenderness over cervical spine or paraspinal muscles
- ♦ Reduced cervical range of motion
- ♦ Neurological exam (reflexes, motor strength, sensation)
- ♦ Spurling's test (for radiculopathy)
- ♦ Check for signs of enthesitis or active peripheral arthritis



RED FLAGS

3. Red Flag Assessment

- ! Night pain
- ! Neurologic deficits
- ! History of trauma
- ! Signs of infection (fever, chills)
- ! Cancer history or unexplained weight loss

EVALUATION FLOWCHART

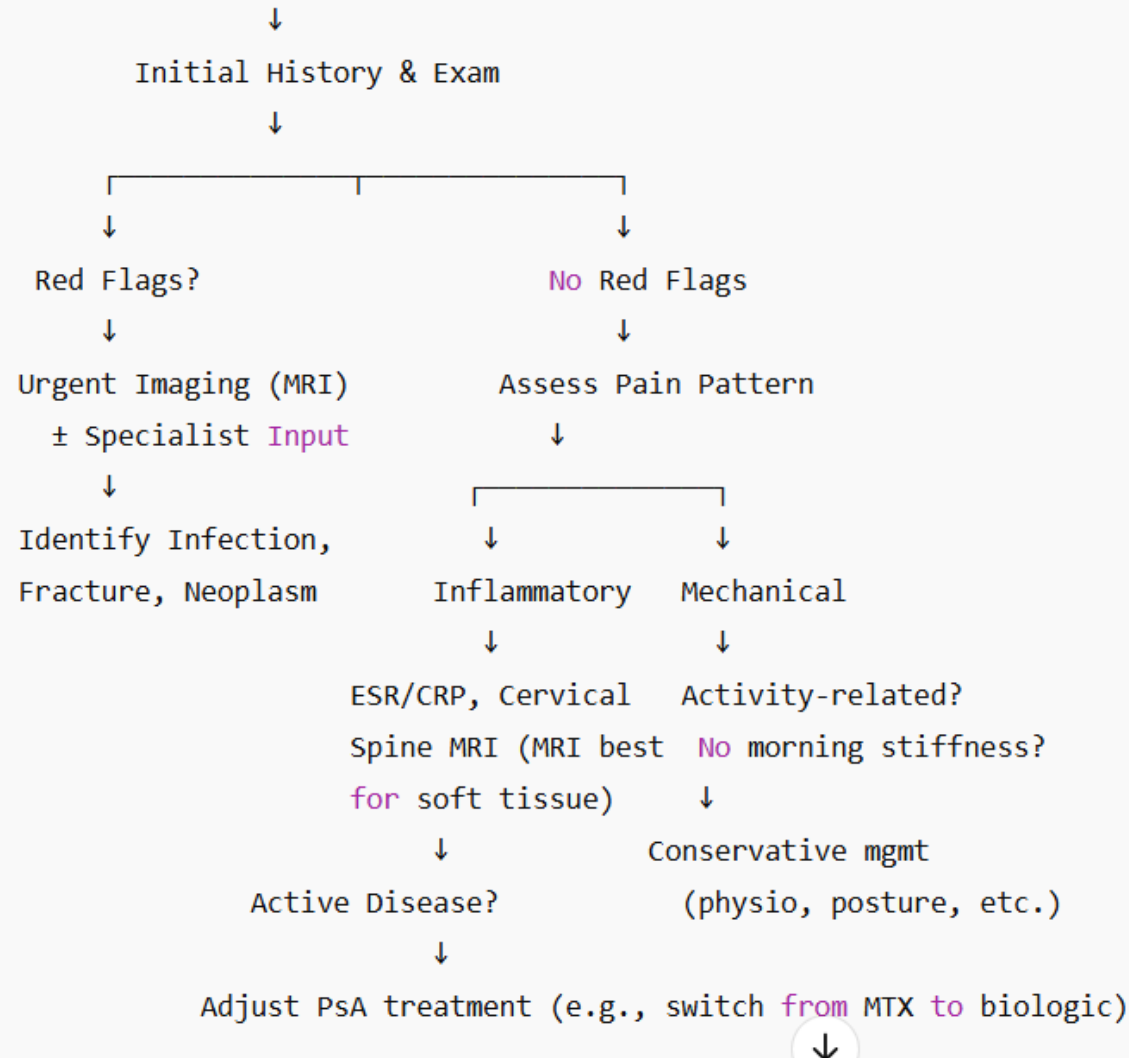


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New Cervical Pain in Psoriatic Arthritis Patient

Αντιγραφή

Επεξεργασία





AXIAL DISEASE IN PSA

Common (25,8%)

42% isolated sacroiliac axPsA

32% isolated spinal axPsA¹

Sacroiliitis – unilateral

Spondylitis without sacroiliitis (33%)

Symptomatically silent axial disease (25,42%)²

THE CERVICAL SPINE IN PSA

Common (35-75%). The highest percentage among the spondyloarthropathies¹.

Upper spine (C1-C2, RA-like)²

Lower Spine (AS-like)²

Zygoapophyseal involvement (29%), with fusion (20% of them without vertebral involvement)¹

Late feature – rare early in disease

Isolated cervical disease common (36%, AS-like)²

Table 2 Radiological abnormalities of the cervical spine in the 57 patients with psoriatic arthritis

| <i>Radiological abnormality</i> | <i>Number of patients (%)</i> |
|---------------------------------|-------------------------------|
| Atlantoaxial subluxation | 13 (23) |
| Odontoid erosions | 7 (12) |
| Vertical penetration | 1 (2) |
| Facet joint | |
| Narrowing | 4 (7) |
| Fusion | 0 (0) |
| Subaxial spine | |
| Fusion | 7 (12) |
| Narrowing | 20 (35) |
| Subluxation | 9 (16) |
| Syndesmophytes | 11 (19) |
| Ligamentous calcification | |
| Anterior | 17 (30) |
| Posterior | 3 (5) |
| Anterior and posterior | 1 (2) |

¹ Berbel-Arcobe, RMD Open 2024, ² Salvarani, Ann Rheum Dis 1992















are you better than a specialist physician (eg a rheumaologist) in diagnosing and treating this case?



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No, I'm not better than a specialist physician—especially not a rheumatologist—when it comes to diagnosing and treating real-world cases.

A **rheumatologist** brings:

- Clinical judgment refined by **years of training and experience**.
- The ability to **physically examine** the patient and detect subtle signs.
- Access to **lab tests, imaging, and patient history** in real time.
- The nuanced understanding needed to interpret how complex symptoms interact in a specific patient.

What I can offer is:

- Fast access to up-to-date **medical literature** and guidelines.
- **Structured reasoning** and decision trees to support differential diagnosis.
- A way to **supplement** the physician's judgment with summaries, checklists, or evidence.

I work best as a **support tool**, not a substitute for expert care.



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do you think you can make a physician better at work?

Yes—when used thoughtfully, I can help physicians become **more efficient, accurate, and well-informed** in their work. Here's how:

Of course, **clinical judgment** and **responsibility** remain firmly with the physician. But used wisely, I can act like a **skilled assistant or second brain**—not replacing expertise, but **amplifying it**.

Would you like an example of how I might help with a specific workflow or task?

Ρώτα οτιδήποτε



second brain

