NOVEDADES EN LA PRÁCTICA CLÍNICA. LO ÚLTIMO EN REUMATOLOGÍA

XXXII Congreso Nacional de la SEMI
XIV Congreso de la Sociedad Canaria de Medicina Interna
26 – 28 Octubre 2011
Las Palmas de Gran Canaria

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Conflicto de intereses

Ninguno

ARTRITIS REUMATOIDE

Sociedad Española de Reumatología

Criterios de clasificación de AR 2010

Presencia de erosiones tipicas de AR ?

AR

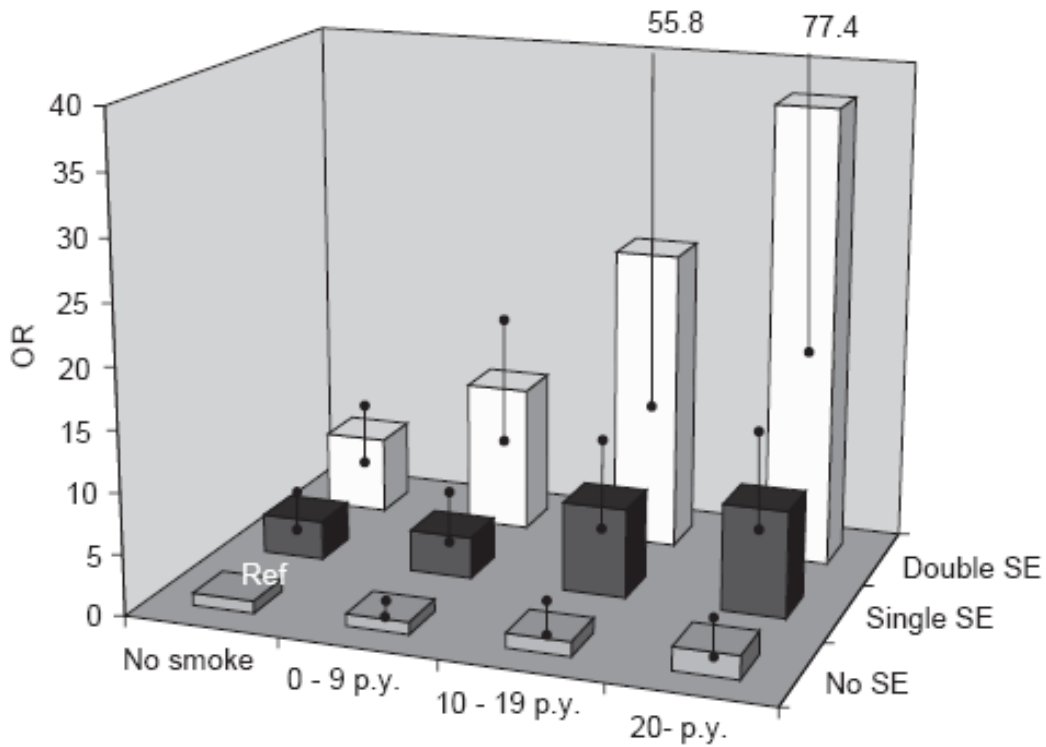
Table 3. The 2010 American College of Rheumatology/European League Against Rheumatism classification criteria for rheumatoid arthritis

	Score
Target population (Who should be tested?): Patients who	
1) have at least 1 joint with definite clinical synovitis (swelling)*	
2) with the synovitis not better explained by another disease†	
Classification criteria for RA (score-based algorithm: add score of categories A–D; a score of ≥6/10 is needed for classification of a patient as having definite RA)‡	
A. Joint involvement§	
1 large joint¶	0
2–10 large joints	1
1–3 small joints (with or without involvement of large joints)#	2
4–10 small joints (with or without involvement of large joints)	3
>10 joints (at least 1 small joint)**	5
B. Serology (at least 1 test result is needed for classification)††	
Negative RF *and* negative ACPA	0
Low-positive RF *or* low-positive ACPA	2
High-positive RF *or* high-positive ACPA	3
C. Acute-phase reactants (at least 1 test result is needed for classification)‡‡	
Normal CRP *and* normal ESR	0
Abnormal CRP *or* abnormal ESR	1
D. Duration of symptoms§§	
<6 weeks	0
≥6 weeks	1

Aletaha D et al Ann Rheum Dis 2010;69:1580-88
Arthritis Rheum 2010;62:2569-81

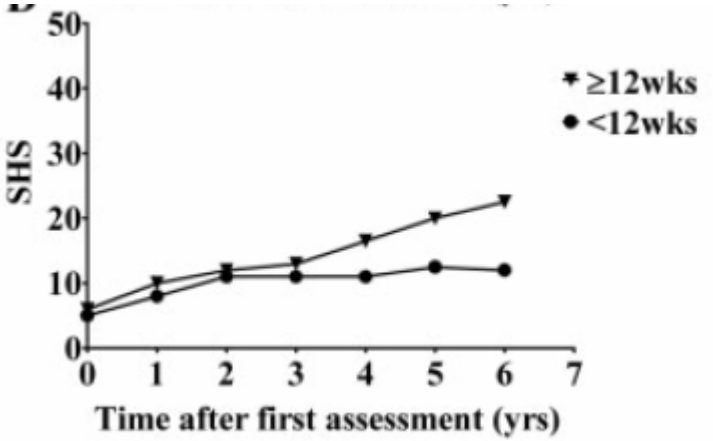
Factores modificadores de desencadenamiento

- Tabaco, sílice, polución



Källberg H. et al Ann Rheum Dis 2011;70;508-511

¿QUÉ ES RETRASO DIAGNÓSTICO EN AR?



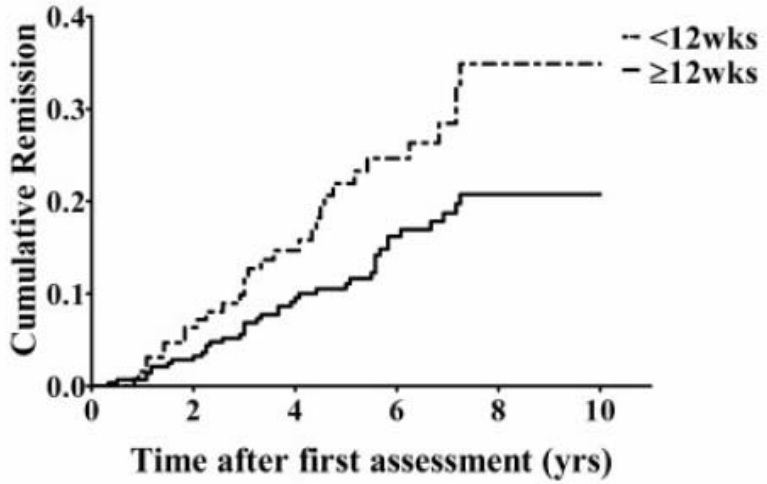


Figure 2. Probability of achieving sustained disease-modifying antirheumatic drug (DMARD)–free remission in rheumatoid arthritis (RA) patients according to the different categories of delay in assessment by a rheumatologist. Remission was used as an outcome measure for the amount of total delay. Remission was defined as the persistent absence of synovitis for at least 1 year after the cessation of DMARD therapy and the identification of disease remission by the patient's rheumatologist (14). Total delay was calculated as the sum of the patient delay (time from symptom onset until being seen by the general practitioner [GP]) and the GP delay (time from assessment by the GP until being seen by the rheumatologist) (see Patients and Methods for details).

van der Linden MPM et al Arthritis Rheum 2010;62:3537-3546

AR. Criterios de remisión ACR/ EULAR

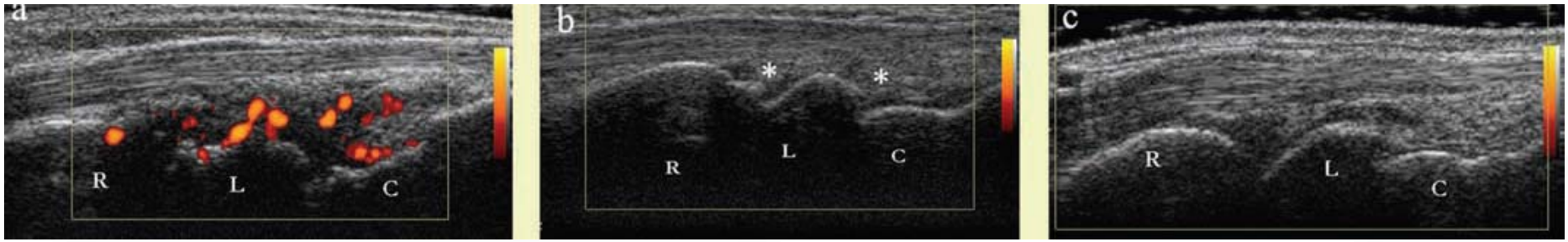
Boolean-based definition:
At any time point, patient must satisfy all of the following:
- Tender joint count ≤1†
- Swollen joint count ≤1†
- C-reactive protein ≤1 mg/dl
- Patient global assessment ≤1 (on a 0–10 scale)‡

Index-based definition:
At any time point, patient must have a
- Simplified Disease Activity Index score of ≤3.3§

→ Suma simple de
NAT 28
NAD28
VGP
VGM
PCR mg/dl

Felson DT et al Ann Rheum Dis 2011;70:403, Arthritis Rheum 2011; 63:573-586

Clinical and ultrasonographic remission determines different chances of relapse in early and long standing rheumatoid arthritis



Dorsal longitudinal ultrasound images of three wrists. (A) Presence of synovial hypertrophy (SH) (score=2) with power Doppler (PD) signal (score=3). (B) Presence of SH (asterisks) (score=2) without PD signal. (C) Normal wrist without SH or PD signal. R, radius bone; L, lunate bone; C, capitate bone.

REMISIÓN CLÍNICA	REMISIÓN ECOGRÁFICA	
	ERA	LSRA
DAS 28 < 1,6	43,7%	17,4%
ACR	66,7%	47,1%

Brote en 1 año	PD (-) 20%	PD (+) 47,1%

Giusy Peluso, Alessandro Michelutti, Silvia Bosello, Elisa Gremese, Barbara Tolusso, Gianfranco Ferraccioli

*Ann Rheum Dis 2011;**70:172–175***

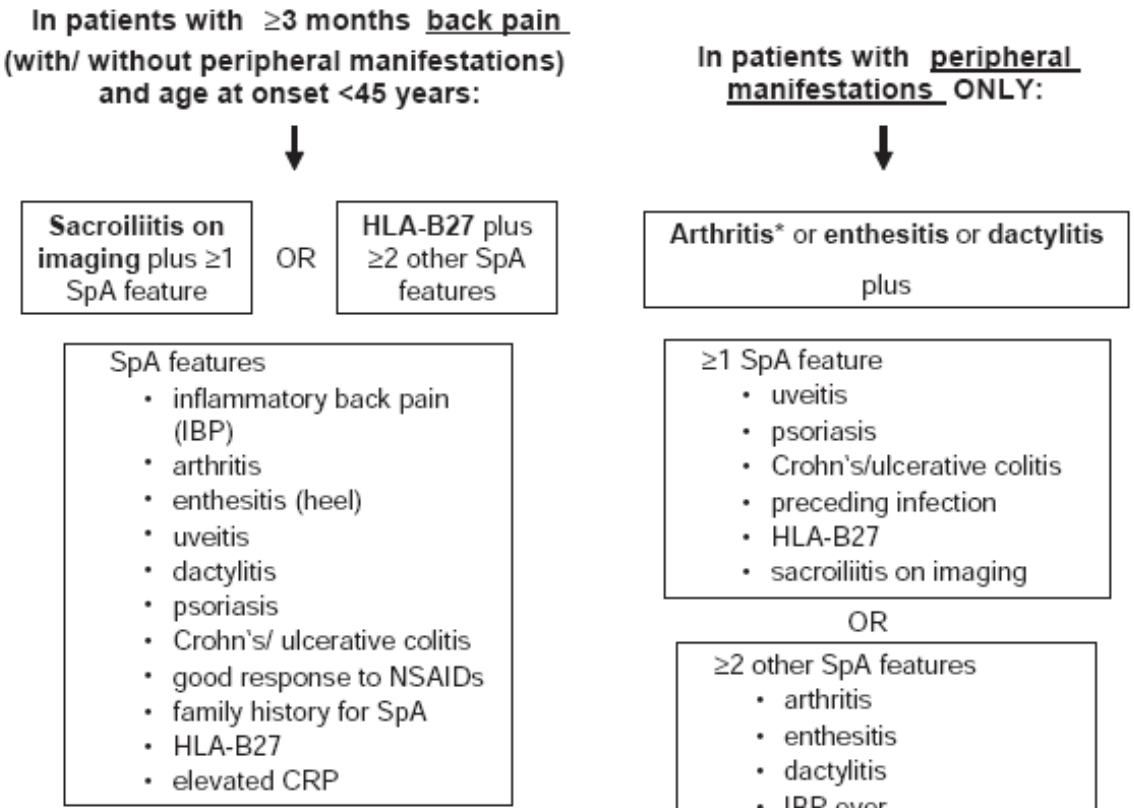
Sociedad Española de Reumatología

ESPONDILOARTRITIS

Sociedad Española de Reumatología

The Assessment of SpondyloArthritis international Society classification criteria for peripheral spondyloarthritis and for spondyloarthritis in general

M Rudwaleit, D van der Heijde, R Landewé, N Akkoc, J Brandt, C T Chou, M Dougados, F Huang, J Gu, Y Kirazli, F Van den Bosch, I Olivieri, E Roussou, S Scarpato, I J Sørensen, R Valle-Oñate, U Weber, J Wei, J Sieper



Ann Rheum Dis 2011;**70**:25–31.

Diagnostic accuracy of enthesis ultrasound in the diagnosis of early spondyloarthritis

Eugenio de Miguel,[1] Santiago Muñoz-Fernández,[2] Concepción Castillo,[1] Tatiana Cobo-Ibáñez,[2] Emilio Martín-Mola[1]

Ann Rheum Dis 2011;**70**:434–439.

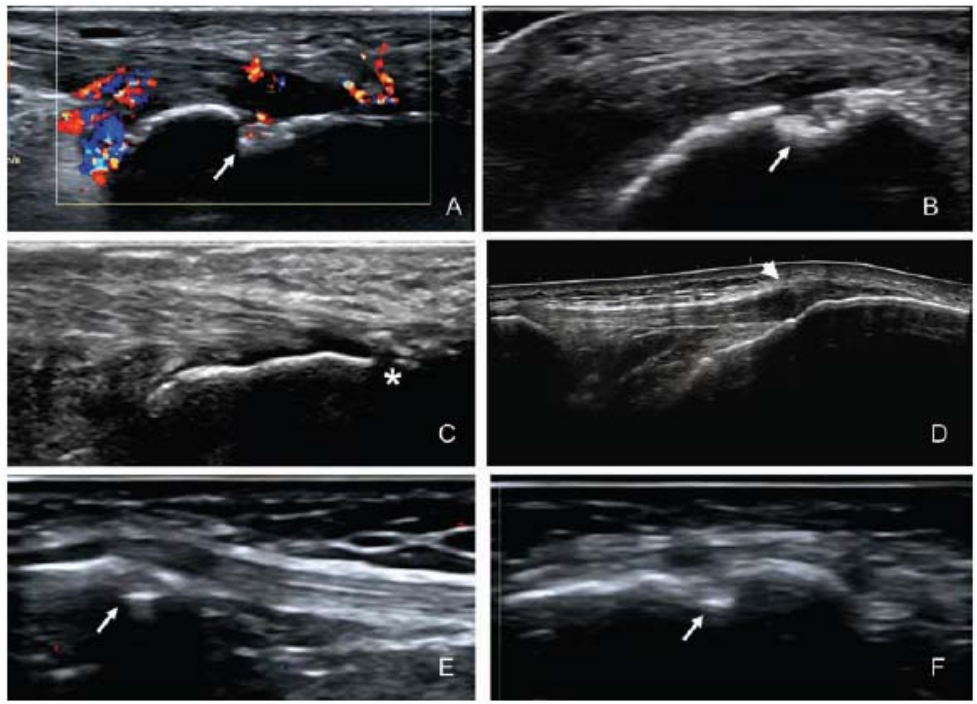


Figure 1 Ultrasonographic appearance of entheseal insertions. (A) Achilles entheses, longitudinal view, Doppler in bursa and tendon entheses, and erosion with Doppler signal (arrow). (B) Erosion, transverse view (arrow), same patient in image A. (C) Achilles tendon entheses, calcification grade II, longitudinal view (*). (D) Distal patellar entheses, longitudinal view, panoramic, abnormally hypoechoic (loss of normal fibrillar architecture) and thickened tendon at its bone attachment (arrow head). (E) and (F) Proximal patellar entheses insertion with an erosion (arrow), (E) longitudinal view and (F) short axis.

Effectiveness of switching between TNF inhibitors in ankylosing spondylitis: data from the NOR-DMARD register

E Lie,[1] D van der Heijde,[1,2] T Uhlig,[1] K Mikkelsen,[3] E Rødevand,[4] W Koldingsnes,[5] C Kaufmann,[6] T K Kvien[1]

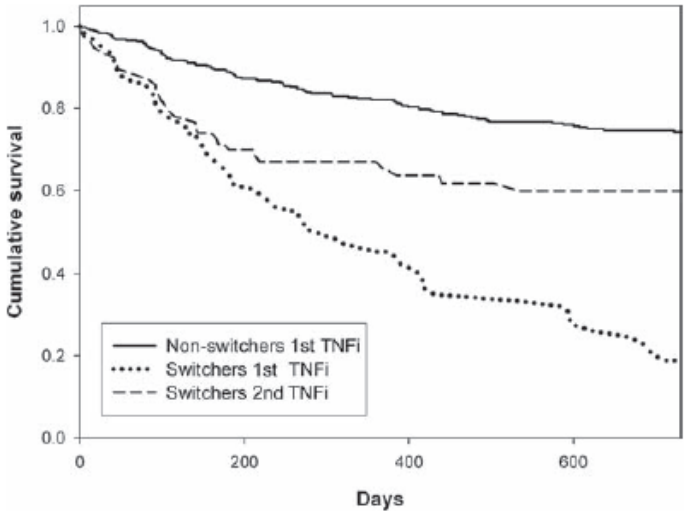


Figure 2 Crude 2-year retention to tumour necrosis factor inhibitor (TNFi) therapy (Kaplan–Meier analysis; log rank test p=0.001 for non-switchers vs switchers' second TNFi; log rank test p<0.001 for non-switchers vs switchers' first TNFi). Numbers of patients in the study were 437/77/77 at baseline, 411/64/67 at 3 months, 375/47/51 at 6 months, 294/32/40 at 12 months and 189/13/22 at 24 months for non-switchers, switchers' first TNFi and switchers' second TNFi, respectively.

Ann Rheum Dis 2011;70:157–163.

GOTA

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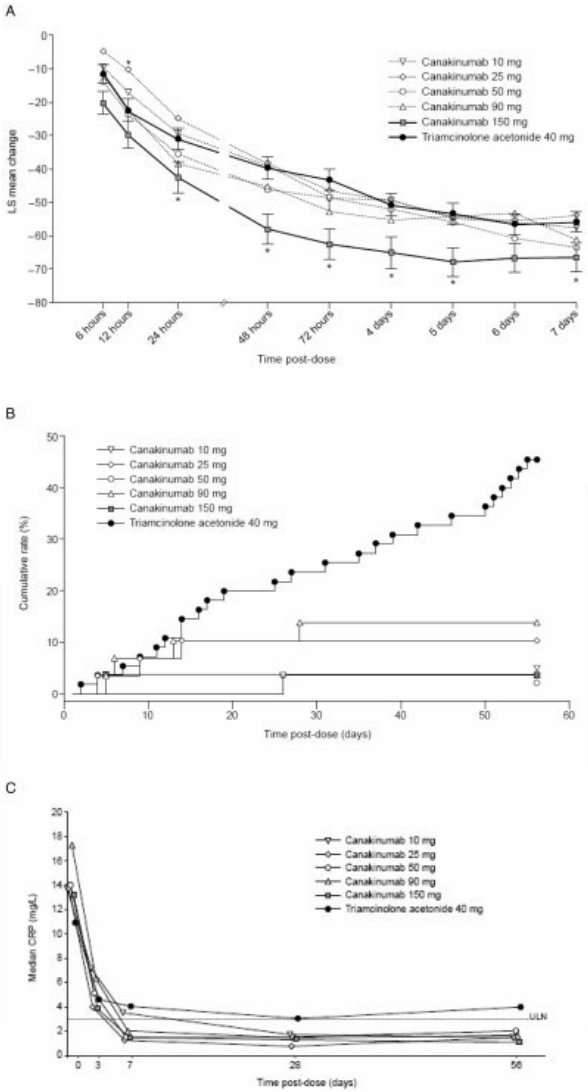
Canakinumab for the Treatment of Acute Flares in Difficult-to-Treat Gouty Arthritis. Results of a Multicenter, Phase II, Dose-Ranging Study

Alexander So, Marc De Meulemeester, Andrey Pikhlak, A. Eftal Yu¨cel, Dominik Richard, Valda Murphy, Udayasankar Arulmani, Peter Sallstig, and Naomi Schlesinger

ARTHRITIS & RHEUMATISM 62, 10, October 2010



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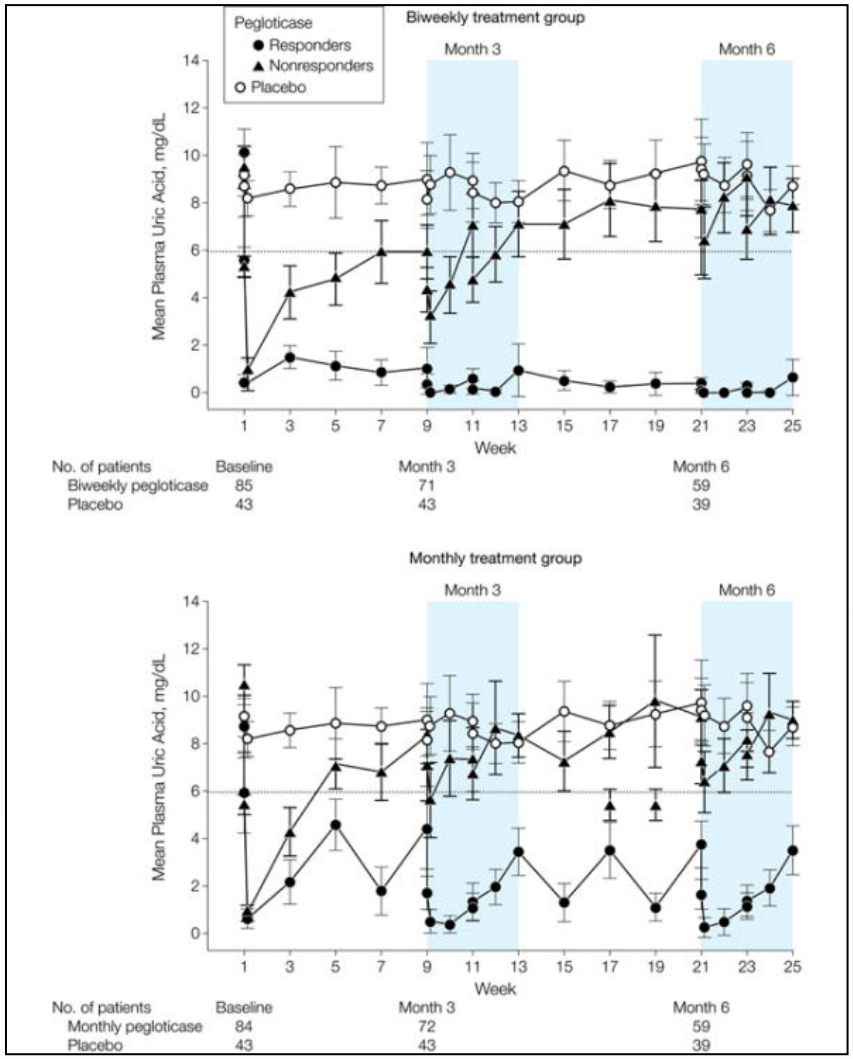
Efficacy and tolerability of pegloticase for the treatment of chronic gout in patients refractory to conventional treatment: two randomized controlled trials.

Sundy JS; Baraf HS; Yood RA; Edwards NL; Gutierrez-Urena SR; Treadwell EL; Vazquez-Mellado J; White WB; Lipsky PE; Horowitz Z; Huang W; Maroli AN; Waltrip RW 2nd; Hamburger SA; Becker MA

JAMA. 306(7):711-20, 2011 Aug 17.



Plasma Uric Acid Levels During Treatment Period for Patients Receiving Biweekly or Monthly Pegloticase Treatment. Responders are patients in each treatment group sustaining plasma uric acid (UA) levels of less than 6.0 mg/dL for 80% of the time in months 3 and 6 of the trial; nonresponders are patients in each group not sustaining UA levels less than 6.0 mg/dL throughout the trial. All patients treated with placebo were nonresponders. Plasma UA levels were determined at baseline; at 2 and 24 hours after the first infusion (which occurred at week 1); before each biweekly infusion; and at 2 hours, 1 day, and 7 days after the week-9 and week-21 infusions. Achievement or failure to achieve responder status was determined for each patient from a plot made from the multiple UA determinations during months 3 and 6. Dotted line indicates treatment response threshold; error bars indicate 95% confidence intervals.

OSTEOPOROSIS

Annals of Internal Medicine

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov
USPSTF

SCREENING FOR OSTEOPOROSIS
CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

Population	**Women aged ≥65 years without previous known fractures or secondary causes of osteoporosis**	**Women aged <65 years whose 10-year fracture risk is equal to or greater than that of a 65-year-old white woman without additional risk factors**	**Men without previous known fractures or secondary causes of osteoporosis**
Recommendation	**Screen**		**No recommendation**
	Grade: B		**Grade: I (insufficient evidence)**

Risk Assessment	As many as 1 in 2 postmenopausal women and 1 in 5 older men are at risk for an osteoporosis-related fracture. Osteoporosis is common in all racial groups but is most common in white persons. Rates of osteoporosis increase with age. Elderly people are particularly susceptible to fractures. According to the FRAX fracture risk assessment tool, available at www.shef.ac.uk/FRAX/, the 10-year fracture risk in a 65-year-old white woman without additional risk factors is 9.3%.
Screening Tests	Current diagnostic and treatment criteria rely on dual-energy x-ray absorptiometry of the hip and lumbar spine.
Timing of Screening	Evidence is lacking about optimal intervals for repeated screening.
Interventions	In addition to adequate calcium and vitamin D intake and weight-bearing exercise, multiple U.S. Food and Drug Administration–approved therapies reduce fracture risk in women with low bone mineral density and no previous fractures, including bisphosphonates, parathyroid hormone, raloxifene, and estrogen. The choice of treatment should take into account the patient's clinical situation and the tradeoff between benefits and harms. Clinicians should provide education about how to minimize drug side effects.
Suggestions for Practice Regarding the I Statement for Men	Clinicians should consider: • Potential preventable burden: increasing because of the aging of the U.S. population • Potential harms: likely to be small, mostly opportunity costs • Current practice: routine screening of men is not widespread • Costs: additional scanners are required to screen sizeable populations.

Bisphosphonate Use and the Risk of Subtrochanteric or Femoral Shaft Fractures in Older Women

Laura Y. Park-Wyllie, PharmD, MSc

JAMA, February 23, 2011—Vol 305, No. 8

Table 2. Risk of Subtrochanteric or Femoral Shaft Fractures Among Women Taking Bisphosphonate Therapy

	Duration of Bisphosphonate Therapy			
	Transient, <100 days	Short-term Use, 100 days to 3 years	Intermediate Use, 3 to 5 Years	Long-Term Use, ≥5 Years
No. (%) of patients				
Case (n = 716)	42 (5.9)	349 (48.7)	204 (28.5)	121 (16.9)
Control (n = 3580)	218 (6.1)	1832 (51.2)	1070 (29.9)	460 (12.9)
Odds Ratio (95% CI)				
Crude	1.0 [Reference]	1.00 (0.70-1.43)	1.08 (0.73-1.59)	1.74 (1.11-2.73)
Adjusted[a]	1.0 [Reference]	0.90 (0.48-1.68)	1.59 (0.80-3.15)	2.74 (1.25-6.02)

Abbreviation: CI, confidence interval.
[a] The full list of covariates for the adjusted model are given in eAppendix 2 (available at http://www.jama.com).

Table 3. Risk of Femoral Neck or Intertrochanteric Hip Fractures Among Women Taking Bisphosphonate Therapy

	Duration of Bisphosphonate Therapy			
	Transient, <100 days	Short-term Use, 100 days to 3 years	Intermediate Use, 3 to 5 Years	Long-Term Use, ≥5 Years
No. (%) of patients				
Case (n = 9723)	817 (8.4)	5587 (57.5)	2438 (25.1)	881 (9.1)
Control (n = 48 564)	3434 (7.1)	27 086 (55.8)	13 148 (27.1)	4896 (10.1)
Odds Ratio (95% CI)				
Crude	1.0 [Reference]	0.87 (0.80-0.94)	0.72 (0.65-0.79)	0.65 (0.58-0.74)
Adjusted[a]	1.0 [Reference]	0.93 (0.81-1.07)	0.86 (0.73-1.00)	0.76 (0.63-0.93)

Abbreviation: CI, confidence interval.
[a] The full list of covariates for the adjusted model are given in eAppendix 2 (available at http://www.jama.com).

ARTROSIS

Meta-analysis of genome-wide association studies confirms a susceptibility locus for knee osteoarthritis on chromosome 7q22

Evangelos Evangelou

One genome-wide significant locus was identified on chromosome **7q22** for knee OA (rs4730250, $p=9.2\times10^{-9}$), thereby confirming its role as a susceptibility locus for OA.

The associated signal is located within a large (500 kb) linkage disequilibrium block that contains six genes.

Gene expression analyses of the (six) genes in primary cells derived from different Joint tissues confirmed expression of all the genes in the joint environment.

Ann Rheum Dis 2011;70:349–355.

ENFERMEDADES AUTOINMUNES SISTÉMICAS

Sociedad Española de Reumatología

Factors involved in the progress of preclinical atherosclerosis associated with systemic lupus erythematosus: a 2-year longitudinal study

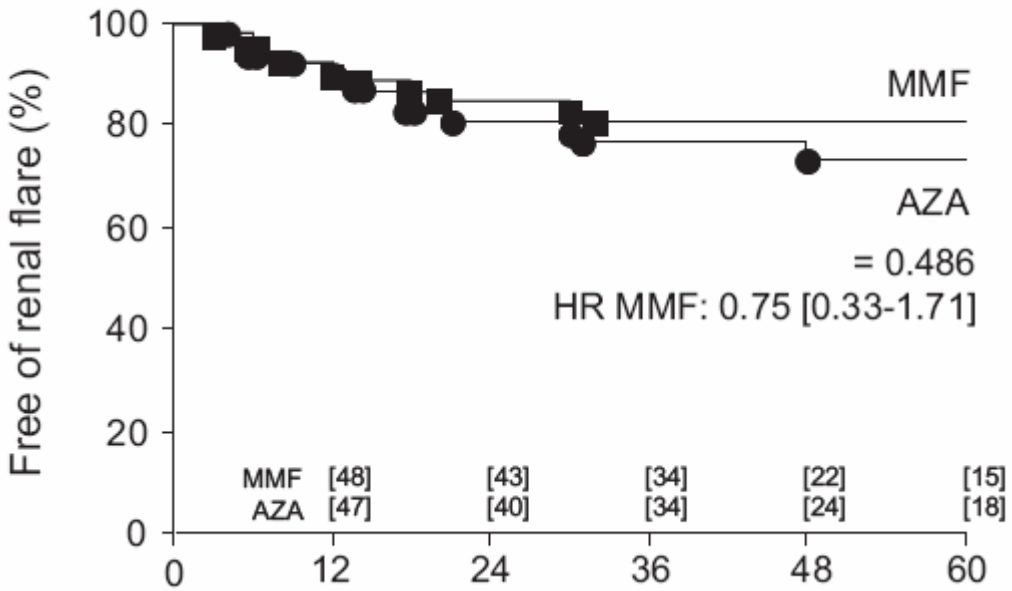
I Rua-Figueroa

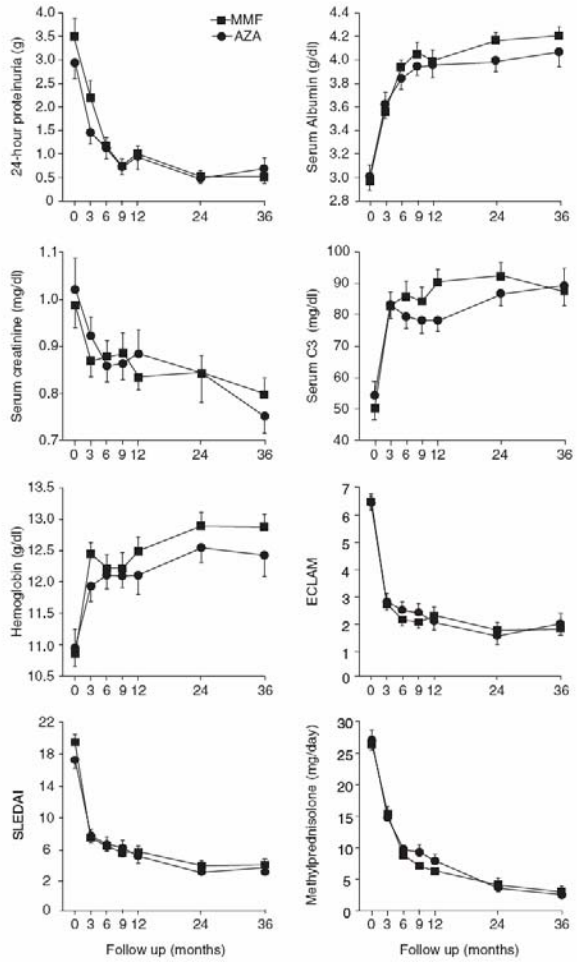
An increase of 0.078 mm in carotid intima-media thickness was detected over 2 years, from a mean baseline measurement (bIMT) of 0.37 mm to a mean bIMT of 0.44 mm ($p<0.001$).

When adjusted for the bIMT, multiple linear regression identified bIMT, age at diagnosis, homocysteine, C3 and C5a as risk factors for carotid intima-media thickness progression.

Ann Rheum Dis 2010;69:1136–1139.

Azathioprine versus mycophenolate mofetil for long-term immunosuppression in lupus nephritis: results from the MAINTAIN Nephritis Trial





Houssiau FA et al Ann Rheum Dis 2010;**69**:2

Increased Risk for Heart Valve Disease Associated With Antiphospholipid Antibodies in Patients With Systemic Lupus Erythematosus

Meta-Analysis of Echocardiographic Studies

Overall, the presence of aPL in SLE patients is significantly associated with an increased risk for HVD including Libman-Sacks endocarditis. The risk conferred by IgG anticardiolipin antibodies is as strong as by lupus Anticoagulant.

S. Zuily, MD;

Circulation. 2011;124:215-224

Preliminary criteria for the very early diagnosis of systemic sclerosis: results of a Delphi Consensus Study from EULAR Scleroderma Trials and Research Group

J Avouac,[1] J Fransen,[2] UA Walker,[3] V Riccieri,[4] V Smith,[5] C Muller,[6] I Miniati,[7] IH Tarner,[8] S Bellando Randone,[6] M Cutolo,[9] Y Allanore,[1] O Distler,[10] G Valentini,[11] L Czirjak,[12] U Müller-Ladner,[8] DE Furst,[13] A Tyndall,[3] M Matucci-Cerinic,[7] EUSTAR Group

Table 2 Final list of criteria determined and ratified by the EUSTAR assembly

	Criteria selected by experts
Criteria considered as having a high clinical relevance for the very early diagnosis of SSc	Raynaud's phenomenon Puffy swollen digits turning into sclerodactily Abnormal capillaroscopy with scleroderma pattern Positive anticentromere antibodies Positive anti-topoisomerase-1 antibodies
Criteria considered as leading to an early referral	Raynaud's phenomenon Puffy fingers Positive antinuclear antibodies

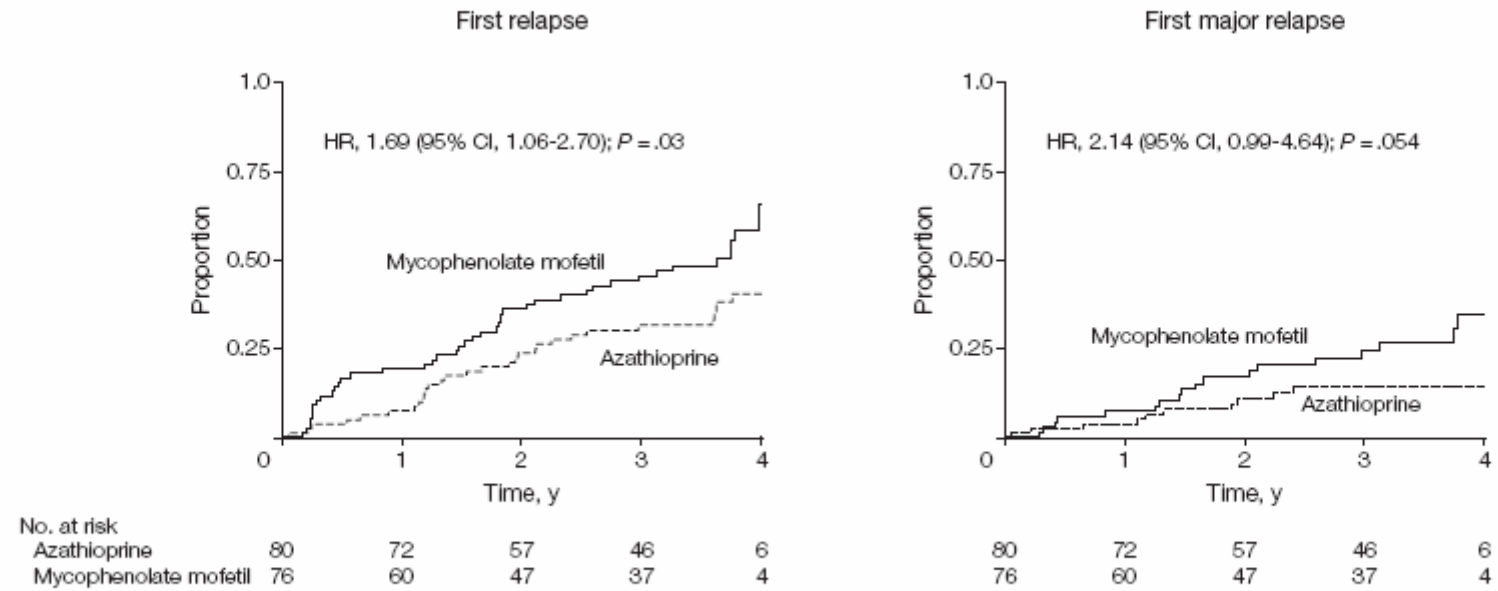
EUSTAR, European League Against Rheumatism Scleroderma Trial and Research; SSC, systemic sclerosis.

Ann Rheum Dis 2011;70:476–481.

Mycophenolate Mofetil vs Azathioprine for Remission Maintenance in Antineutrophil Cytoplasmic Antibody–Associated Vasculitis

A Randomized Controlled Trial

Figure 2. Time to First Relapse and First Major Relapse



Patients were censored at first relapse or death. CI indicates confidence interval; HR, hazard ratio.

Thomas F. Hiemstra, JAMA 2010; 304:**2381-2388**

The Five-Factor Score revisited: assessment of prognoses of systemic necrotizing vasculitides based on the French Vasculitis Study Group (FVSG) cohort.

Guillevin L; Pagnoux C; Seror R; Mahr A; Mouthon L; Le Toumelin P; French Vasculitis Study Group FVSG
Medicine. 90(1):19-27, 2011 Jan.

	PAN		MPA		CSS		WG		Global 2009 FFS	
Parameter	HR (95% CI)	p	HR (95% CI)	p	HR (95% CI)	p	HR (95% CI)	p	HR (95% CI)	p
Age	1.04 (1.02–1.06)	<0.001	1.05 (1.02–1.08)	0.001	1.04 (1.01–1.07)	0.01	1.03 (1.01–1.06)	0.001	1.1 (1.02–1.15)	0.001
Renal insufficiency*	1.4 (0.7–2.9)	0.09	2.6 (1–6)	0.055	1.1 (0.7–9)	0.09	3.6 (1.8–7)	0.001	1.8 (1.3–2.6)	0.001
Gastrointestinal signs	3 (1.9–5.6)	0.003	1.1 (0.4–2.7)	0.82	0.6 (0.5–2)	0.49	0.9 (0.8–3)	0.88	1.7 (1.3–2.4)	0.01
Cardiac insufficiency	1.8 (0.98–3)	0.06	1.1 (0.5–2)	0.51	2.8 (1.2–5.9)	0.02	2 (1–4)	0.06	1.6 (1.1–2.2)	0.005
ENT manifestations	1.3 (0.4–4)	0.58	0.46 (0.2–1.6)	0.28	0.3 (0.15–0.9)	0.03	0.4 (0.2 –0.8)	0.01	0.64 (0.44–0.9)	0.01
Neurologic signs	1.5 (0.7–3)	0.29	1.8 (0.7–4)	0.2	0.7 (0.2–1.8)	0.4	1 (0.6–2)	0.8	0.9 (0.8–1.9)	0.2

Abbreviations: HR = hazard ratio, CI = confidence interval.
*Defined as stabilized peak creatinine ≥150 μmol/L.

High-dose cyclophosphamide without stem cell rescue in 207 patients with aplastic anemia and other autoimmune diseases.

DeZern AE; Petri M; Drachman DB; Kerr D; Hammond ER; Kowalski J; Tsai HL; Loeb DM; Anhalt G; Wigley F; Jones RJ; Brodsky RA

Medicine. 90(2):89-98, 2011 Mar.

Autoimmune hemolytic anemia event-free survival.