LE SERATE DELL'ORDINE:

Appropriatezza in REUMATOLOGIA

Dottore ho male alle spalle: e se fosse Polimialgia Reumatica?

Cosa fare in attesa della visita specialistica

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DOTTORE HO MALE ALLA SPALLA/SPALLE

E se fosse Polimialgia Reumatica?

Epidemiologia

- Malattia relativamente comune: circa un caso ogni 130 soggetti di età superiore a 50 anni
- L'incidenza aumentata con l'età con un picco tra i 70-80 anni
L'incidenza è maggiore nel sesso femminile
- Esiste un chiaro gradiente legato alla latitudine, con le maggiori incidenze nei paesi nordici
- I tassi di mortalità non differiscono da quelli della popolazione generale
- L'incidenza della PMR appare essere relativamente stabile negli ultimi anni.

Eziologia e patogenesi

- L’esatta causa non si conosce. In alcuni casi si associa all’ arterite a cellule giganti di Horton.

- Mancano segni comuni ad altre malattie autoimmuni, quali l’ipocomplementemia e l’aumento delle immunoglobuline.

- La preferenza per la razza bianca ha fatto ipotizzare l’esistenza di una predisposizione genetica: gli studi sul sistema HLA hanno dimostrato una lieve preponderanza di DR4 e CW3.

Clinica

- La malattia predilige il sesso femminile oltre i 55-60 anni;
- Tra i sintomi generali è frequente anoressia, astenia e perdita di peso con febbricola;
- Dolore muscolare e rigidità spesso ad insorgenza improvvisa; principalmente interessati i cingoli scapolare e pelvico; inizialmente può essere asimmetrica;
- All'insorgenza, movimenti delle spalle limitati nel 90%;
- Sinovite transitoria non deformante nel 20%.

Diagnosi differenziale:

- Artrite reumatoide senile sieronegativa;
- Neoplasie occulte
- Mialgie in corso di infezioni virali;
- Polimiosite;
- Fibromialgia;
- Periartrite bilaterale delle spalle;
- Artrosi;
- Sindromi depressive;
- Endocrinopatie: es. ipotiroidismo, miopatia tireotossica, ecc…
- Morbo di Parkinson.

Esami di laboratorio e strumentali

- La VES è aumentata così come la PCR, le mucoproteine, la ferritina, il fibrinogeno e gli altri markers sierologici di flogosi.

- Si ha un'anemia normocromica.

- Enzimi muscolari: negativi;

- I quadri radiologico, bioptico ed elettromiografico non forniscono elementi di rilievo.

Table 1. Classification Criteria for Giant-Cell Arteritis and Polymyalgia Rheumatica.*

ACR classification criteria for giant-cell arteritis, 1990[47]
At least three criteria must be met:
Age at disease onset ≥50 yr
New headache, either new onset or new type of localized pain in the head
Abnormal temporal artery, with tenderness to palpation or decreased pulsation
Elevated ESR, >50 mm/hr during first hr of testing (Westergren method)
Biopsy evidence of vasculitis with predominance of mononuclear-cell infiltration or granulomatous inflammation, usually with multinucleated giant cells
Provisional ACR–EULAR classification criteria for polymyalgia rheumatica, 2012[28]
Mandatory criteria:
Age ≥50 yr
[illegible]
Abnormal C-reactive protein level, ESR, or both
Additional criteria†
Morning stiffness lasting >45 min (2 points)
Hip pain or reduced range of motion (1 point)
Negative rheumatoid factor or antibodies to cyclic citrullinated peptides (2 points)
Absence of peripheral synovitis (1 point)
Ultrasonographic findings
At least one shoulder with subdeltoid bursitis, biceps tenosynovitis, or glenohumeral synovitis, or at least one hip with synovitis or trochanteric bursitis (1 point)
Subdeltoid bursitis, biceps tenosynovitis, or glenohumeral synovitis in both shoulders (1 point)

* ACR denotes American College of Rheumatology, ESR erythrocyte sedimentation rate, and EULAR European League against Rheumatism.

† According to the provisional ACR–EULAR classification criteria for polymyalgia rheumatica, diagnosis requires that in addition to the mandatory criteria, there must be a score of 4 or more points for additional criteria without ultrasonographic findings (diagnostic sensitivity and specificity, 68% and 78%, respectively) and a score of more than 5 points with ultrasonographic findings (diagnostic sensitivity and specificity, 66% and 81% respectively).

more aggressive, longer-term immunosuppression improves outcomes.

The coexistence of several vasculogenic immune abnormalities has complicated the development of new, glucocorticoid-sparing therapies. Current therapy offers prompt suppression of some inflammatory pathways, but resistant pathways sustain chronic vascular remodeling.

GUIDELINES

The American College of Rheumatology (ACR) and the Chapel Hill Consensus Conference have developed criteria to distinguish giant-cell arteritis from other vasculitides (Table 1).[47] The specificity of these criteria for diagnostic purposes in a general population is undetermined. The EULAR and ACR have suggested provisional classification criteria for polymyalgia rheumatica,[28] but even a score of 5 or more (Table 1)[28] has a sensitivity of only 66% and a specificity of only 81% for the purpose of distinguishing polymyalgia rheumatica from nonpolymyalgic rheumatic conditions. The [illegible] of giant-cell arteritis[31] and polymyalgia rheumatica,[48] and the EULAR has published guidelines for the management of large-vessel vasculitis.[32] The recommendations in this article are generally consistent with the available guidelines.

CONCLUSIONS AND RECOMMENDATIONS

The patient in the vignette has biopsy-confirmed giant-cell arteritis, which has responded well to high-dose glucocorticoid therapy and subsequent tapering. As is common in such patients, the patient now presents with symptoms of polymyalgia rheumatica, without evidence of recurrent ischemic manifestations. In this case, the dose of prednisone should be temporarily increased to 10 mg per day to suppress myalgias. Once there are clinical indications of improvement, an attempt should be made to taper the dose again while monitoring the clinical response and levels of inflammatory markers. Additional disease recurrences would raise the possibility of large-vessel involvement, which should be assessed with MRA or CTA. Careful follow-up is required to monitor the patient for any adverse effects of treatment with glucocorticoids.

No potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

REFERENCES

1. Weyand CM, Goronzy JJ. Medium- and large-vessel vasculitis. N Engl J Med 2003;349:160-9.
2. Weyand CM, Liao YJ, Goronzy JJ. The immunopathology of giant cell arteritis: diagnostic and therapeutic implications. J Neuroophthalmol 2012;32:259-65.
3. Aiello PD, Trautmann JC, McPhee TJ, Kunselman AR, Hunder GG. Visual prognosis in giant cell arteritis. Ophthalmology 1993;100:550-5.
4. Miller DV, Isotalo PA, Weyand CM, Edwards WD, Aubry MC, Tazelaar HD. Surgical pathology of noninfectious ascending aortitis: a study of 45 cases with emphasis on an isolated variant. Am J Surg Pathol 2006;30:1150-8.
5. Kermani TA, Warrington KJ. Polymyalgia rheumatica. Lancet 2013;381:63-72. [Erratum, Lancet 2013;381:28.]
6. Salvarani C, Pipitone N, Versari A, Hunder GG. Clinical features of polymyalgia rheumatica and giant cell arteritis. Nat Rev Rheumatol 2012;8:509-21.
7. Kreiner F, Langberg H, Galbo H. Increased muscle interstitial levels of inflammatory cytokines in polymyalgia

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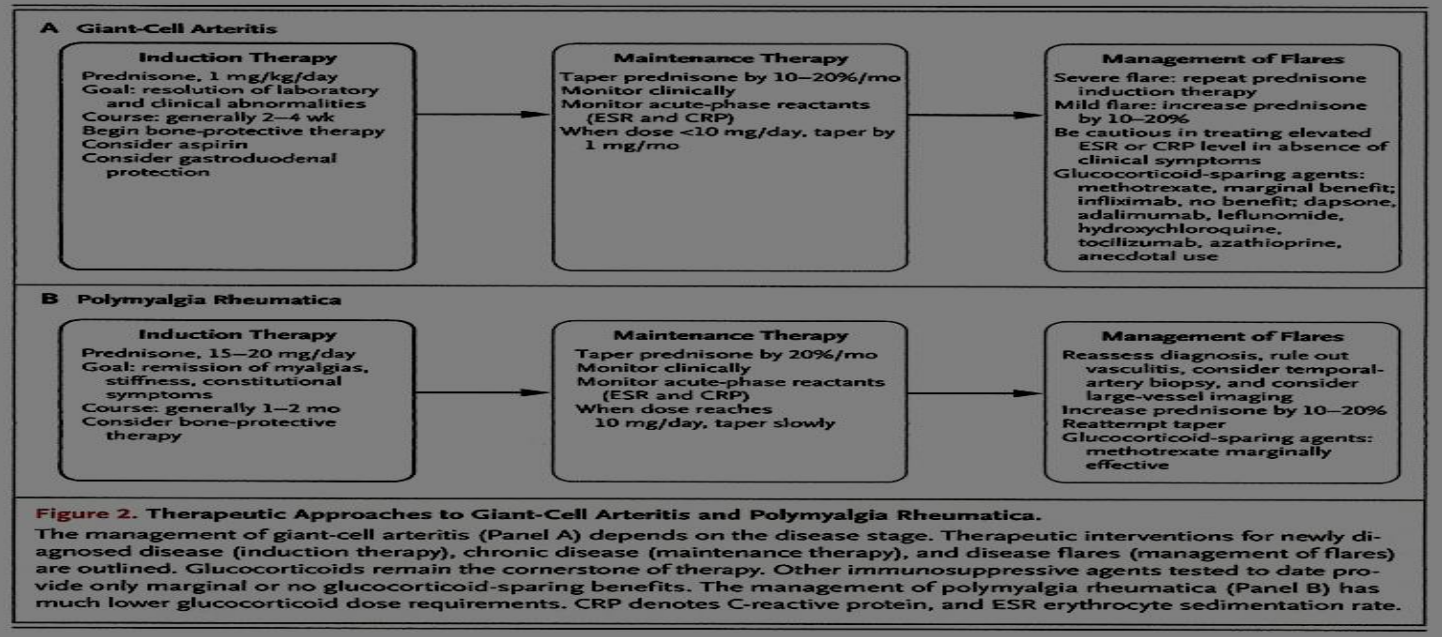

Figure 2. Therapeutic Approaches to Giant-Cell Arteritis and Polymyalgia Rheumatica.
The management of giant-cell arteritis (Panel A) depends on the disease stage. Therapeutic interventions for newly diagnosed disease (induction therapy), chronic disease (maintenance therapy), and disease flares (management of flares) are outlined. Glucocorticoids remain the cornerstone of therapy. Other immunosuppressive agents tested to date provide only marginal or no glucocorticoid-sparing benefits. The management of polymyalgia rheumatica (Panel B) has much lower glucocorticoid dose requirements. CRP denotes C-reactive protein, and ESR erythrocyte sedimentation rate.

These recommendations match those developed by the British Society for Rheumatology (BSR).[31] Guidelines from the European League against Rheumatism (EULAR) suggest a faster initial tapering to a dose of 10 to 15 mg per day within 3 months after treatment initiation.[32] Inflammatory markers are monitored monthly during the first year of treatment, bimonthly during the subsequent year, and at intervals of 3 to 6 months during long-term follow-up.

When glucocorticoids are tapered, disease flares may occur frequently (an average of one to two episodes per person-year) and are often manifested as new-onset or recurrent polymyalgia rheumatica.[22,33] Relapses are rarely manifested as ischemic complications and often respond to slight increases in the dose of glucocorticoids. Elevated levels of laboratory markers alone, without concomitant clinical signs, should not automatically trigger substantial intensification of immunosuppression. Some patients do not fare well when glucocorticoids are discontinued, which may indicate continuous, smoldering disease activity.

The doses of glucocorticoids used to treat polymyalgia rheumatica are much lower than those used for the treatment of giant-cell arteritis.[5] In the majority of patients, a dose of 15 to 20 mg of prednisone per day is sufficient to control myalgias. Clinical findings should be used to guide a slow tapering of glucocorticoids (Fig. 2B). The BSR recommendations suggest the administration of 10 to 15 mg of prednisolone daily over a period of about 10 weeks, followed by a slow taper.[31] Recurrent myalgias are common and require dose adjustment. Repetitive flares should prompt diagnostic reassessment, including evaluation for full-blown giant-cell arteritis and for nonvasculitic conditions.

The use of glucocorticoids calls for careful monitoring for adverse effects, especially with the prolonged use of supraphysiologic doses. During a 10-year follow-up of a population-based cohort of patients with giant-cell arteritis,

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Dottore ho male alle spalle

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POLIMIALGIA REUMATICA

- Malattia infiammatoria di origine sconosciuta
- caratterizzata da dolore e rigidità mattutina, localizzati al cingolo scapolare e pelvico
- colpisce persone con più di 50 anni
- generalmente risponde rapidamente allo steroide la prognosi è favorevole

Diagnosi:

- Età avanzata;
- Esordio brusco;
- Dolore e rigidità ai cingoli scapolare e pelvico;
- Notevole aumento degli indici di flogosi;
- Brillante risposta agli steroidi.

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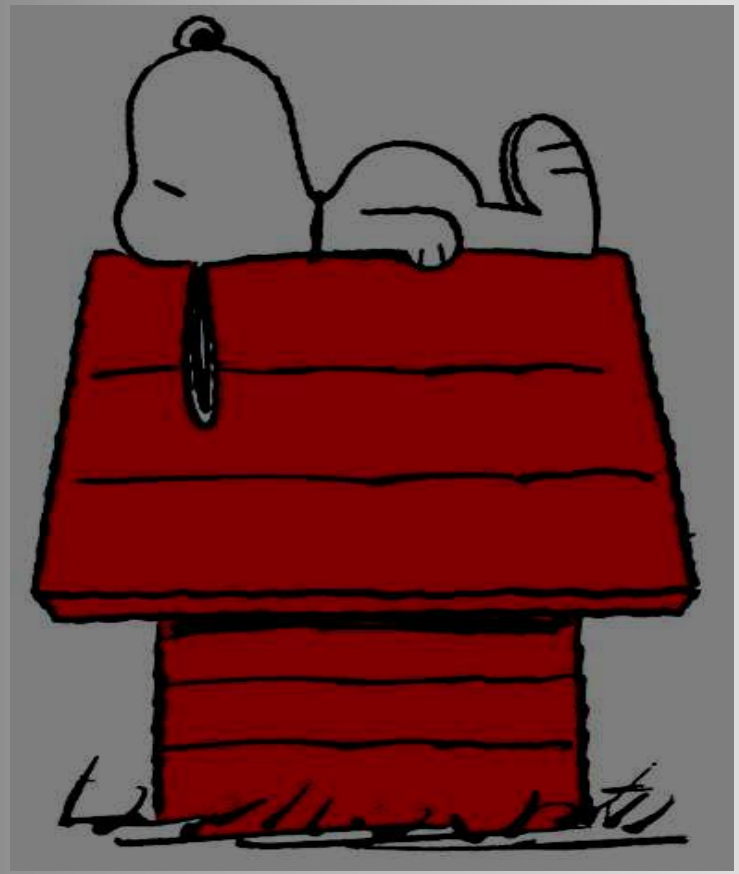

Gli steroidi sono il farmaco di scelta nella terapia della Polimialgia Reumatica

Nella maggior parte dei pazienti è sufficiente una dose iniziale di 10-20 mg di prednisone o suoi equivalenti.

La dose va somministrata per almeno quattro settimane e può in seguito essere ridotta progressivamente ogni 2-4 settimane del 10% rispetto alla dose iniziale.

GRAZIE PER L’ATTENZONE