

Οστεοαρθρίτιδα-Κρίση ουρικής αρθρίτιδας

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Οστεοαρθρίτιδα

Osteoarthritis (OA) is the most common form of arthritis. Some people call it degenerative joint disease or “wear and tear” arthritis. It occurs most frequently in the hands, hips, and knees.

What are the signs and symptoms of OA?

Pain or aching

Stiffness

Decreased range of motion (or flexibility)

Swelling

What causes OA?

OA is caused by damage or breakdown of joint cartilage between bones.

What are the risk factors for OA?

Joint injury or overuse—Injury or overuse, such as knee bending and repetitive stress on a joint, can damage a joint and increase the risk of OA in that joint.

Age—The risk of developing OA increases with age.

Gender—Women are more likely to develop OA than men, especially after age 50.

What are the risk factors for OA?

Obesity—Extra weight puts more stress on joints, particularly weight-bearing joints like the hips and knees. This stress increases the risk of OA in that joint. Obesity may also have metabolic effects that increase the risk of OA.

Genetics—People who have family members with OA are more likely to develop OA. People who have hand OA are more likely to develop knee OA.

Race— Some Asian populations have lower risk for OA.

How is OA diagnosed?

A doctor diagnoses OA through a review of symptoms, physical examination, X-rays, and lab tests.

A rheumatologist, a doctor who specializes in arthritis and other related conditions, can help if there are any questions about the diagnosis.

How is OA treated?

There is no cure for OA, so doctors usually treat OA symptoms with a combination of therapies, which may include the following:

Increasing physical activity

Physical therapy with muscle strengthening exercises

Weight loss

Medications, including over-the-counter pain relievers and prescription drugs

Supportive devices such as crutches or canes

Surgery (if other treatment options have not been effective)

Κρίση ουρικής αρθρίτιδας

Gout is characterized by painful joint inflammation, most commonly in the first metatarsophalangeal joint, resulting from precipitation of monosodium urate crystals in a joint space.



ILLUSTRATION BY JONATHAN DIMES

Table 1. Risk Factors for Gout

<i>Risk factor</i>	<i>Notes</i>	<i>Relative risk (95% confidence interval)</i>
Diuretic use*	—	3.37 (2.75 to 4.12)
Alcohol intake	≥ 50 g per day vs. none	2.53 (1.73 to 3.70)
Beer	≥ 2 drinks per day vs. none	2.51 (1.77 to 3.55)
Spirits	≥ 2 drinks per day vs. none	1.60 (1.19 to 2.16)
Wine	≥ 2 drinks per day vs. none	1.05 (0.64 to 1.72)
Hypertension	—	2.31 (1.96 to 2.72)
Body mass index	≥ 30 kg per m ² at 21 years of age	2.14 (1.37 to 3.32)
Sweetened beverage consumption	≥ 2 drinks per day vs. none	1.85 (1.08 to 3.16)
Fructose intake	Highest vs. lowest quintile	1.81 (1.31, 2.50)
Seafood consumption	Highest vs. lowest quintile	1.51 (1.17, 1.95)
Meat consumption	Highest vs. lowest quintile	1.41 (1.07, 1.86)
Dairy product consumption	Highest vs. lowest quintile	0.56 (0.42, 0.74)
Vitamin C intake	≥ 1,500 mg vs. < 250 mg per day	0.55 (0.38, 0.80)
Coffee consumption	≥ 6 cups per day vs. none	0.41 (0.19, 0.88)

*—Adjusted for age.

Adapted with permission from Roddy E, Doherty M. *Epidemiology of gout*. *Arthritis Res Ther*. 2010;12(6):223, with additional information from reference 12.

Table 2. American College of Rheumatology Diagnostic Criteria for Gout

Presence of characteristic urate crystals in the joint fluid
or

Presence of a tophus proven to contain urate crystals by chemical means or polarized light microscopy
or

Presence of six or more of the following clinical, laboratory, or radiologic findings:

Asymmetric swelling within a joint on radiography

Attack of monoarticular arthritis

Culture of joint fluid negative for microorganisms during attack of joint inflammation

Development of maximal inflammation within one day

Hyperuricemia

Joint redness

More than one attack of acute arthritis

Pain or redness in the first metatarsophalangeal joint

Subcortical cyst without erosions on radiography

Suspected tophus

Unilateral attack involving first metatarsophalangeal joint

Unilateral attack involving tarsal joint

Adapted with permission from Wallace SL, Robinson H, Masi AT, Decker JL, McCarty DJ, Yu TF. Preliminary criteria for the classification of the acute arthritis of primary gout. Arthritis Rheum. 1977;20(3):896.



Figure 1. Hard nodules on distal digit.



Figure 2. Tender red papules on digit.

Θεραπεία ουρικής αρθρίτιδας

Table 3. Medications for Treatment of Acute Gout

<i>Medication</i>	<i>Example regimen</i>	<i>Notes</i>
NSAIDs	Indomethacin (Indocin), 50 mg three times per day	First-line therapy; all NSAIDs are equally effective; adverse effects include gastric bleeding and kidney injury
Colchicine (Colcrys)	1.2 mg initially, then 0.6 mg one hour later, then 0.6 to 1.2 mg per day	No analgesic properties; gastrointestinal adverse effects are common; avoid use in patients with renal and hepatic insufficiency; contraindicated in patients receiving clarithromycin (Biaxin)
Corticosteroids	Oral, intramuscular, or intra-articular routes, variable dosing (e.g., prednisone, 40 mg for four days, then 20 mg for four days, then 10 mg for four days)	Preferred therapy for patients in whom NSAIDs and colchicine are contraindicated; when discontinuing oral corticosteroids, taper to avoid rebound flares

NSAIDs = nonsteroidal anti-inflammatory drugs.

Information from reference 21.

Πρόληψη ουρικής αρθρίτιδας

Table 4. Medications for Prevention of Chronic Gout

<i>Medication</i>	<i>Dosage</i>	<i>Notes</i>
Colchicine (Colcrys)	0.6 to 1.2 mg per day	May cause reversible axonal neuromyopathy; may increase risk of rhabdomyolysis when used with statins or clarithromycin (Biaxin)
Pegloticase (Krystexxa)	8 mg intravenously every two weeks	Indicated for refractory gout; expensive (more than \$5,000 per dose ²⁸)
Probenecid	250 mg two times per day initially; titrate up to 2 g per day	High risk of nephrolithiasis; encourage hydration and urine alkalization with potassium citrate; multiple drug interactions
Xanthine oxidase inhibitors:		
Allopurinol (Zyloprim)	100 mg per day initially, except in patients with renal dysfunction; common effective dosage is 300 mg per day, but higher dosages may be needed	Genetic testing recommended before initiating treatment in patients at risk of severe hypersensitivity skin reaction (those of Han Chinese or Thai descent, regardless of kidney function, or Koreans with chronic kidney disease stage 3 or greater)
Febuxostat (Uloric)	40 mg once per day; may increase up to 80 mg per day if serum uric acid level > 6 mg per dL (357 μmol per L) after two weeks	Contraindicated in patients receiving azathioprine (Imuran) and mercaptopurine

Information from references 21 and 28.

Ευχαριστώ!