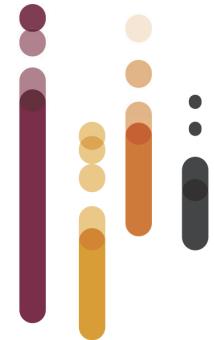


10 al 14 de  
noviembre  
2024

Ciudad San Diego  
(USA)



# ACRreview 23

#ACReview23



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Sociedad Española de  
Reumatología



# ACReview 23



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## Miscelánea

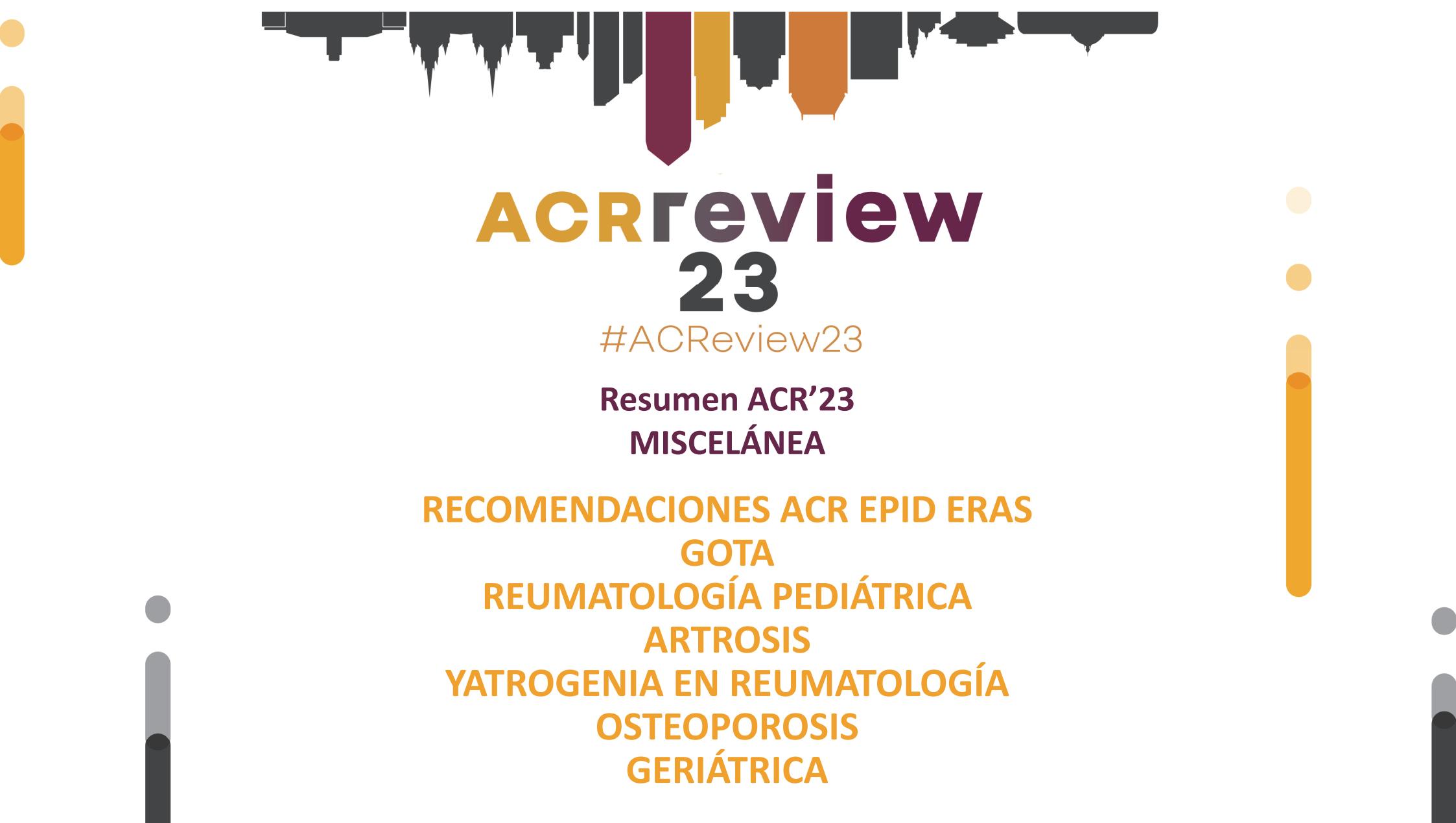
**Dr. Vicenç Torrente Segarra**

Servicio de Reumatología  
Hospital Comarcal de Vilafranca del Penedés. Barcelona



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# ACRreview 23

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Resumen ACR'23  
MISCELÁNEA

RECOMENDACIONES ACR EPID ERAS

GOTA

REUMATOLOGÍA PEDIÁTRICA

ARTROSIS

YATROGENIA EN REUMATOLOGÍA

OSTEOPOROSIS

GERIÁTRICA

# RECOMENDACIONES ACR EPID en ERAS



*Empowering rheumatology professionals to excel in their specialty*

2200 Lake Boulevard NE, Atlanta, GA 30319

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## **2023 American College of Rheumatology (ACR) Guideline for the Screening and Monitoring of Interstitial Lung Disease in People with Systemic Autoimmune Rheumatic Disease**

<https://rheumatology.org/interstitial-lung-disease-guideline#2023-ild-guideline>

**Who should be screened?**

RA, SSc, IIM, MCTD, and SjD all confer an increased risk of developing ILD compared to the general population.

However, risks of developing ILD and ILD progression vary between and within these diseases.

Disease	Risk Factors
Systemic sclerosis	<ul style="list-style-type: none"> <li>ScI-70, ANA with nucleolar pattern</li> <li>Diffuse subtype, male sex, African-American race</li> <li>Early disease (first 5-7 years after onset)</li> <li>Elevated acute phase reactants</li> </ul>
Rheumatoid arthritis	<ul style="list-style-type: none"> <li>High titer RF, high titer anti-CCP</li> <li>Smoking, older age at RA onset, high disease activity</li> <li>Male sex, higher BMI</li> </ul>
Idiopathic inflammatory myopathies	<ul style="list-style-type: none"> <li>Jo-1, PL7, PL12, EJ, OJ, KS, Ha, Zo, Ku, Pm/Scl, Ro52</li> <li>Anti-MDAS</li> <li>Mechanic's hands, arthritis/arthritis, ulcerating lesions</li> </ul>
Mixed connective tissue disease	<ul style="list-style-type: none"> <li>Dysphagia, Raynaud phenomenon,</li> <li>Other SSc clinical or laboratory features</li> </ul>
Sjögren's disease	<ul style="list-style-type: none"> <li>Anti-Ro52 antibody, ANA</li> <li>Raynaud phenomenon, older age, lymphopenia</li> </ul>

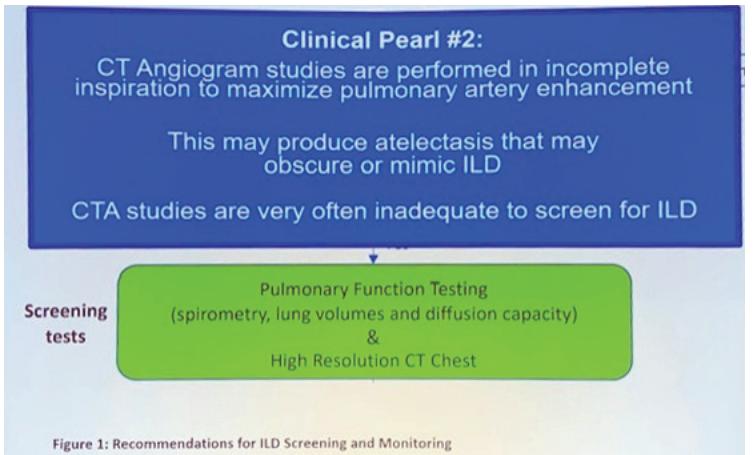
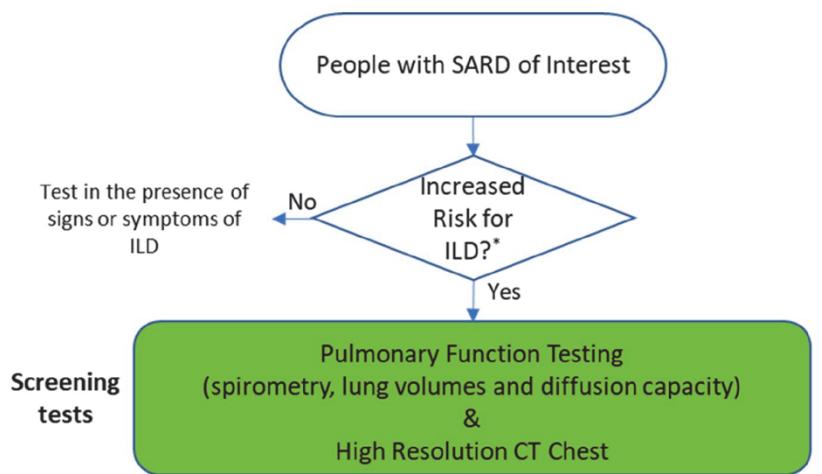
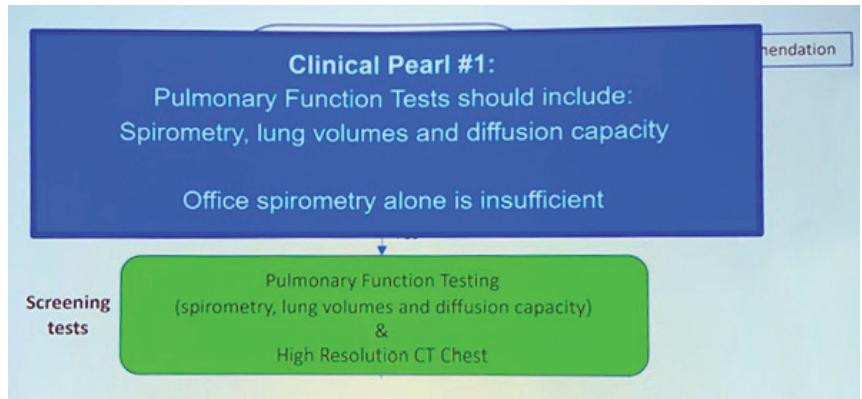
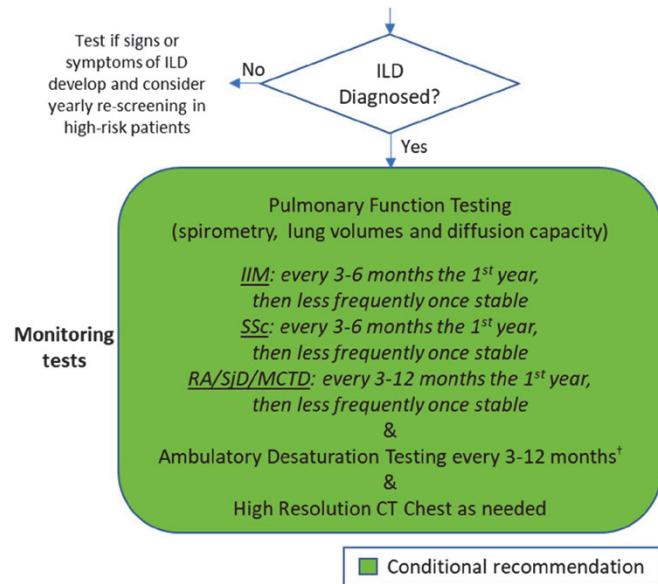


Figure 1: Recommendations for ILD Screening and Monitoring



**Clinical Pearl #3:**  
A 6MWT with continuous oximetry is insufficient.

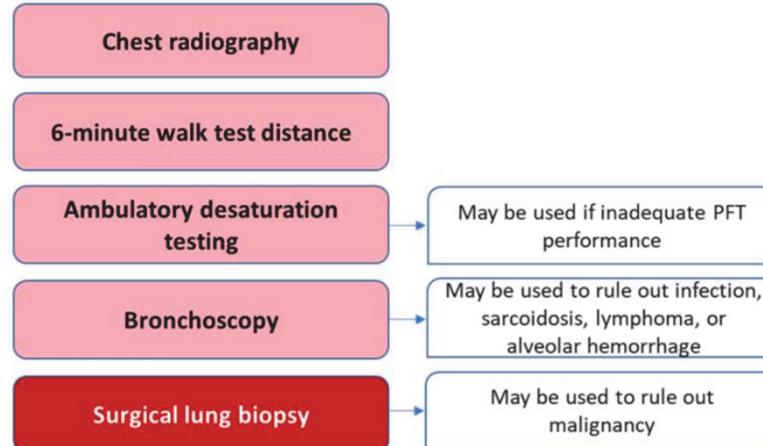
Ambulatory desaturation testing includes up titration of oxygen.

*BASUMACTD: every 3-12 months the 1<sup>st</sup> year, then less frequently once stable  
&  
Ambulatory Desaturation Testing every 3-12 months<sup>†</sup>  
&  
High Resolution CT Chest as needed*

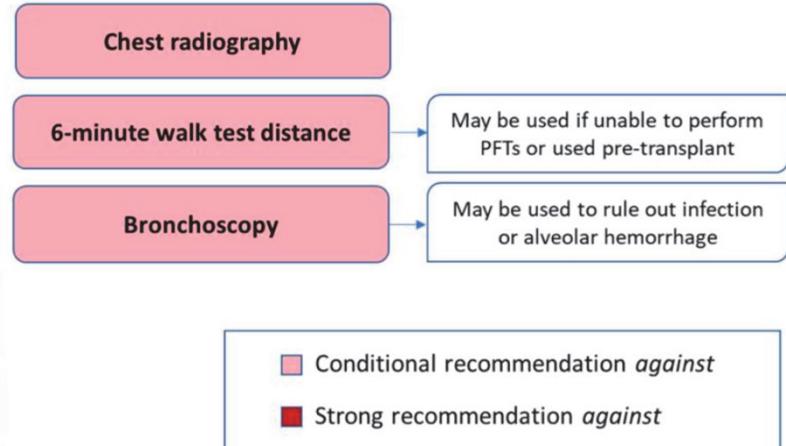
Conditional recommendation

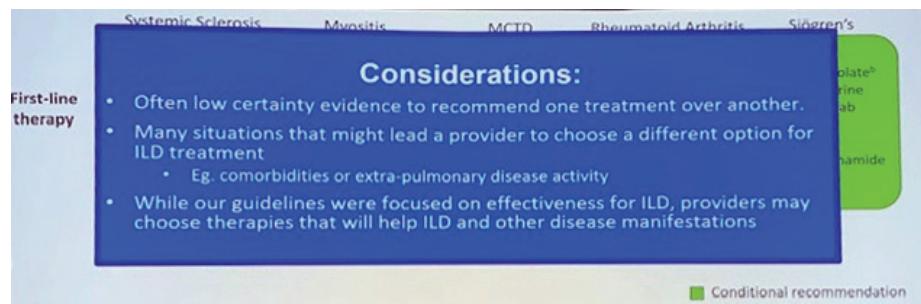
Figure 1 (continued): Recommendations for ILD Screening and Monitoring

#### Screening tests recommended *against*



#### Monitoring tests recommended *against*



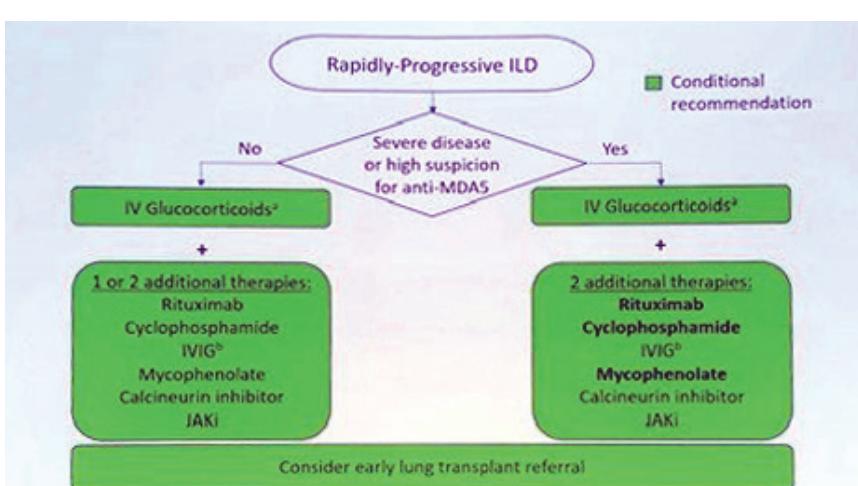


Systemic Sclerosis	Myositis	MCTD	Rheumatoid Arthritis	Sjögren's
Preferred First-line ILD therapy	Mycophenolate <sup>†</sup> Tocilizumab Rituximab	Mycophenolate <sup>†</sup> Azathioprine Rituximab CNI	Mycophenolate <sup>†</sup> Azathioprine Rituximab	Mycophenolate <sup>†</sup> Azathioprine Rituximab
Additional options + Glucocorticoids	Cyclophosphamide Nintedanib Azathioprine	JAK1 Cyclophosphamide	Tocilizumab Cyclophosphamide	Cyclophosphamide

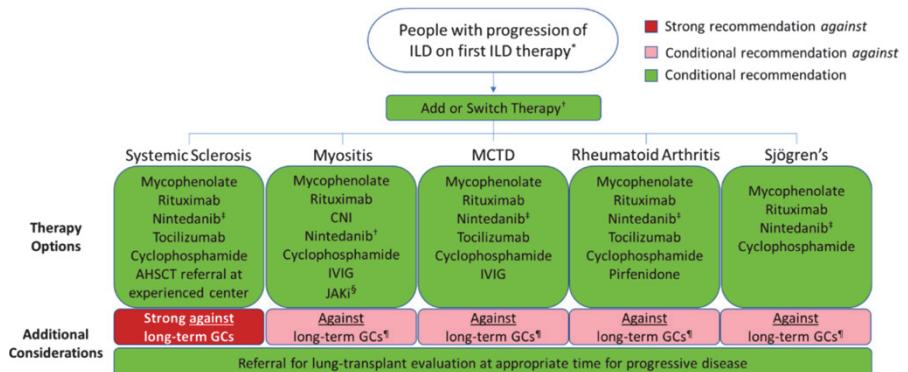
Legend: [Red box] Strong recommendation against [Green box] Conditional recommendation

**Figure 1: Initial treatment options for the treatment of interstitial lung disease associated with systemic autoimmune rheumatic diseases of interest.**  
 \* Decisions on GC dose and use of oral versus intravenous therapy depend on severity of disease. GCs should be used cautiously in patients with MCTD with a systemic sclerosis phenotype who may be at increased risk of renal crisis.

<sup>†</sup> Treatments are listed in order based on a hierarchy established by head-to-head votes, although the panel noted that decisions on which first-line therapy to use were dependent on specific situations and patient factors. In all diseases, mycophenolate was conditionally recommended over the other listed therapies. Therapies here are divided into "preferred" options and "additional options" based on the rank-order hierarchy.  
 MCTD = mixed connective tissue disease; GCs = glucocorticoids; CNI = calcineurin inhibitor; JAK1 = janus kinase inhibitor



<sup>‡</sup> In rare patients with systemic sclerosis with rapidly progressive ILD there was no consensus on whether or not to use glucocorticoids – if used patients should be monitored closely for evidence of renal crisis.



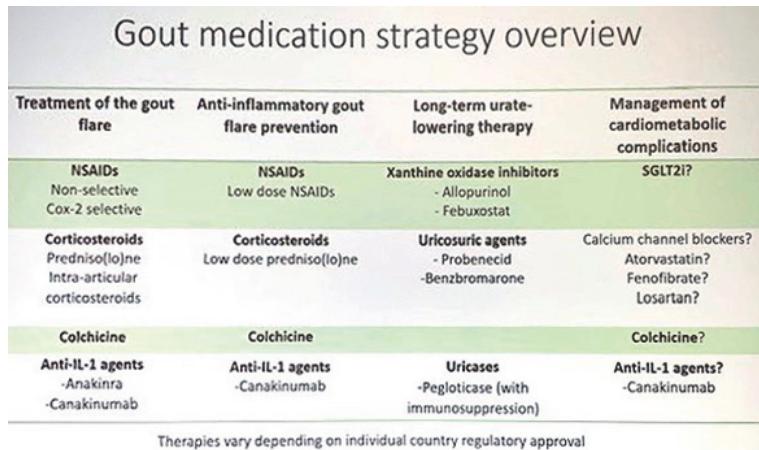


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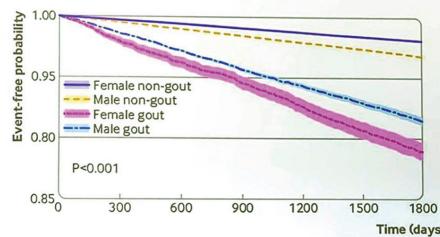
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GOTA

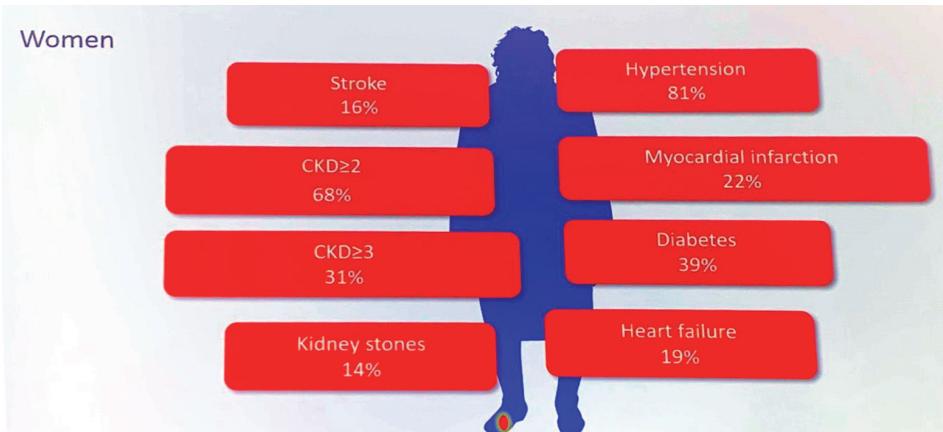
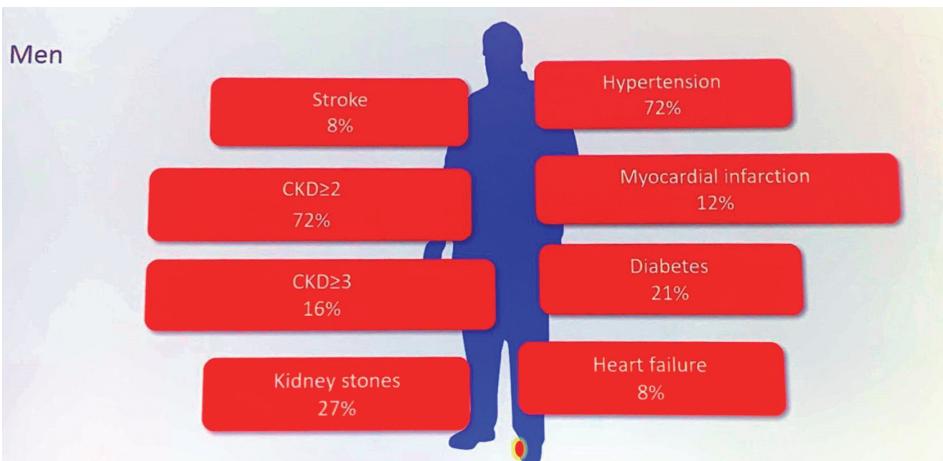
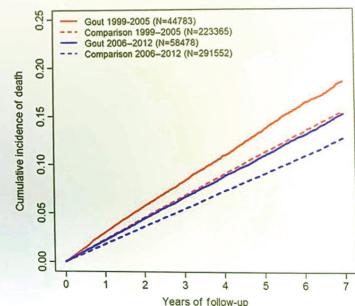
# Optimizing care in gout



## CVD risk and the premature mortality gap



ation between gout and cardiovascular disease in 1 million New Zealand adults  
o history of cardiovascular disease



- Optimizing care in gout
- Programa sistemático para evaluar riesgo CV
- Insistir en revisar FRCV tradicionales (dieta-zumo cerezas, antiHTA-losartan-, hipolipemiantes)
- Valorar el potencial beneficio CV con el uso de colchicina y SGLT2
- Reducir niveles urato → menor uso AINE y GC
- Mejorar manejo gota permite memorar otros aspectos de salud!!!

### Active management of comorbidities in gout

- Systematic programme of CVD and CKD risk reduction for people with gout
  - assess CVD risk and screen for CKD
  - intensive management of traditional risk factors
  - potential for treatment strategies with benefit both for comorbidities and gout, particularly colchicine and SGLT2 inhibitors
  - effective urate-lowering therapy to prevent gout flares and reduce exposure to NSAIDs and corticosteroids
- Effective gout management enables better control of other health issues!



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## REUMATOLOGÍA PEDIÁTRICA

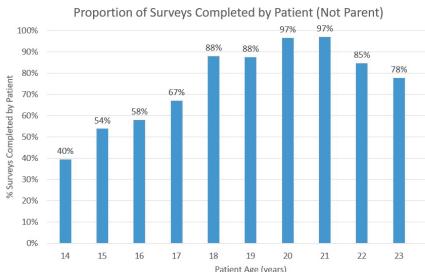
# Transición

ABSTRACT NUMBER: 2046

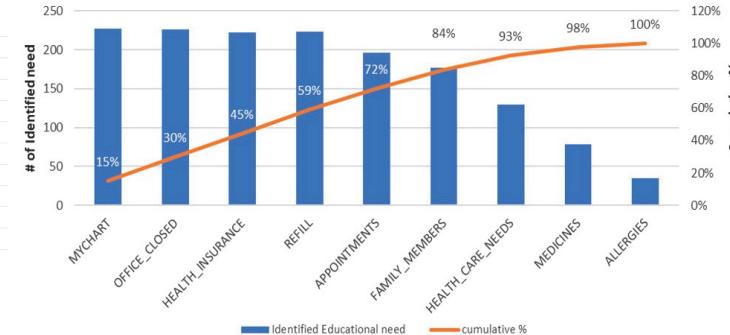
## Implementation of an Automated Transition Readiness Assessment in a Pediatric Rheumatology Clinic

Elizabeth Murray<sup>1</sup>, Melissa Argraves<sup>1</sup>, Alysha Taxter<sup>2</sup>, Kelly Wise<sup>3</sup>, Paul Jensen<sup>4</sup>, Alana Goldstein-

- 14-21a de edad
- TRAQ, equipo multidisciplinar
- 6 necesidades principales: recogida medicación, conseguir citas, situación familiares, qué hacer si consulta cerrada, cobertura.



## Transition Readiness Assessment Education Needs



ABSTRACT NUMBER: 0379

## Clinical Evolution of Patients Diagnosed of Juvenile Idiopathic Arthritis After the Transitional Care Consultation

Alba Maria Torrat Noves<sup>1</sup>, Rebeca Perpiñan Perez<sup>2</sup>, Jose Ivorra Cortes<sup>1</sup>, Elena Grau Garcia<sup>1</sup>, Daniel



<b>Table 1</b>	Oligoarthritis (n=20)	Enthesitis related arthritis (n=16)	RF negative polyarthritis (n=13)	Systemic arthritis (n=7)	Undifferentiated arthritis (n=6)	RF positive polyarthritis (n=4)	Psoriatic arthritis (n=4)
Diagnosis changes N (%)	2 (10)	-	1(7.7)	1(14.3)	4(66.6)	1(25)	-
New diagnosis	Spondyloarthr itis	-	Rheumatoid arthritis	Rheumatoid arthritis	Beçhet's disease	Sjögren's disease	-
	Rheumatoid arthritis				Behçet's disease		

- n=70; Mayoría remisión en edad juvenil, mantuvieron remisión en etapa adulta (seguimiento Trans 4 años)
- 50% H<sup>a</sup> previa de uveítis presentaron al menos un rebrote en etapa adulta
- 12.8% presentaron cambio diagnóstico (Tabla 1)



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## ARTROSIS

- A más ejercicio, mejoría dolor (6000 pasos, 60' al día) hay más evidencia desde 1998, 5 estudios
- Hablar con el paciente de ‘cuáles son sus expectativas’ en cuanto a ejercicio
- Debemos acompañarles a decidir qué les conviene más y avisar de otros grandes beneficios en salud
- No existe un ejercicio superior a otro en OA rodilla o cadera

<https://startwalkwitthease.org/>

<https://healthsciences.unimelb.edu.au/departments/physiotherapy/chesm/patient-resources/my-knee-exercise>

- **Health disparities in OA**
- Pacientes con KOA y HipOA con nivel SE bajo presentan peores resultados relacionados con salud en EEUU, Canada y Europa
- Vivir en barrios más pobres se ha asociado a un mayor tasa de puntuaciones de dolor por KOA y HOA e incluso mayuor dolor y funcionalidad tras PTR
- OA initiative 2006-2014, EEUU: Raza negra más dolor y depresión baseline y 96m Peor QOL, asociado a dolor y depresión
- Existe muy poca literatura en razas latinas-hispánicas, asiáticas



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## Yatrogenia y Reumatología

# Artralgia y Artritis

## Inhibidores Aromatasa

- Adjuvant: post-menopausal, HR+ breast cancer
- Prevalence
  - Arthralgia: 20-47%
  - **Arthritis: 5-15%**
- Proposed risk factors
  - **Pre-existing joint pain**
  - Obesity
  - Shorter time from LMP

- Onset: 1.5-6 mo after AI start
- **May mimic RA**
- Oligo- or Polyarticular
- Symmetrical
- Ankles/feet > Knees > Back > Hips > Hands/wrists (1-5%)
- **Seronegative**



## Retinoides

- Retinoid: natural compounds or synthetic derivatives of Vit A
- Used for: Acne vulgaris, Psoriasis
- Prevalence
  - Arthralgia: 18-30%
  - **Back pain: 80%**
    - Inflammatory back pain: 25%
  - Sacroiliitis: 3-5%
- Risk factors: med dose, duration

- Onset: 2-6 mo after retinoid start
- **DDx: SAPHOS, PsA with SI-ititis**
  - Sacroiliitis UL > BL
  - UL Achilles enthesopathy
  - No dactylitis, uveitis, IBD
  - HLA-B27+ in 15% of radiographic sacroiliitis



## Dipeptidil Peptidasa-4

- Dipeptidyl peptidase 4 inhibitors
- Oral hypoglycemic
- Prevalence
  - Arthralgia: 3-5%
  - Arthritis: 1%
- 2015: FDA black box warning:  
**severe, debilitating joint pain**

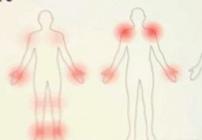
- Onset: 1 day – years after start
- Mimics rheumatoid arthritis
- Symmetrical
- Polyarticular
- “Severe” “disabling”
- **RF+ in 9%**



## Inhibidores Checkpoint

- Cancer immunotherapy (melanoma, lung, RCC, etc.)
- **Prevalence**
  - Arthralgia: 43%
  - Arthritis: ~8%
- ICI type (of ICI-arthritis cases)
  - PD(L)1i: 78%
  - Combination: 17%
- **Cancer at time of arthritis: 66-80% without progression**

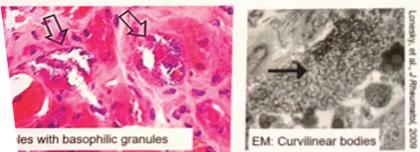
- Onset: 4 mo - 2yrs  
**Even after ICI cessation**
- Clinical phenotypes:
  - Symmetrical small or med joints
  - PMR-like (+/- hand inflammation)
  - Asymmetrical large joint
- Tendon involvement
- Early damage
- **RF/CCP pos: 9%**



# Miositis

## Antimaláricos

- Immunomodulators
- Prevalence
  - Myopathy: Rare
- Risk factors
  - **Higher doses**
  - CQ > HCQ



- **Onset: 6 mo. Median: 9.5 yrs**
- Proximal, GI (dysphagia!), Resp mm, Restrictive cardiomyopathy
- CK/Aldolase/LDH: normal to mildly high

### Biopsy

- Light microscopy: cytoplasmic vacuoles and granules (lysosomal dysfunction)
- Electron Microscopy: myeloid and **curvilinear bodies**

## Colchicina

- Immunomodulator: inhibits microtubule formation and neutrophil function
- **Prevalence: <1%**
- Risk factors:
  - **CYP3A4 inhibitors**
  - **macrolides, cyclosporin, -azoles**
  - P-glycoprotein inhibitors
  - Kidney disease
  - High drug doses

- Onset: Most 1-3 mo
- Proximal mm wknss: Lower > upper
- Neuropathy: Distal areflexia
- **CK: 10-20 x ULN**
- EMG: irritative myopathy
- Biopsy: autophagic vacuoles and lysosomal dysfunction



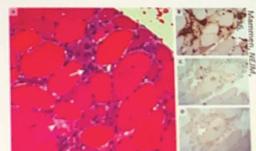
## Estatinas

### Epidemiology

- Lowers cholesterol (block HMG-CoA)
- Prevalence
  - Muscle pain or wknss: 9-27%
  - Myonecrosis/IMNM: 0.1-0.5%
- 60% discontinue med due to SAMS
- Risk factors
  - **Concurrent meds: CYP3A4 inhibitors**
  - High dose, intensity (atorvastatin)
  - Reduced function SNP of SLC01B1 gene
- **? Protective: Coenzyme Q10**

### Clinical presentation

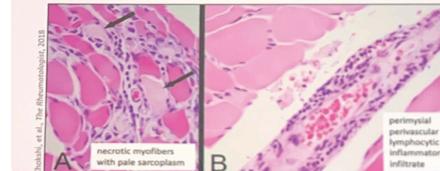
- Onset: Usually <6 mo, up to 2 years
- Proximal, symmetrical **muscle weakness and/or pain**
- Muscle enzymes:
  - SAMS: Normal, mild-mod elevation
  - IMNM: Mod-high: rhabdo, myonecrosis



## Inhibidores Checkpoint

### Epidemiology

- ICIs: cancer immunotherapy
- Comb >PD1/PDL1i > CTLA4i
- Prevalence: <1%
- **Case-fatality rate 24%**
- Risk factors: Combination ICI



### Clinical presentation

- Onset: Median 1 mo (1wk-6mo)
- Proximal, symmetric wknss **+ pain**
- Axial, GI (dysphagia), Resp mm
- Rare: ILD, Skin
- **"3M": Myositis, myocarditis, MG**
- Biopsy: myofiber necrosis, perivascular inflammation
- DDx: paraneoplastic, primary IIM, neuropathy, ICI-PMR

# Yatrogenia - Artralgia/Arthritis, Mialgia/Miositis

## RA mimickers

- Aromatase inhibitors
- DPP-4 inhibitors
- Immune checkpoint inhibitors

## Spondy mimics

- Retinoids
- Immune checkpoint inhibitors

## PMR-like

- Immune checkpoint inhibitors
- Statin SAMS
- Colchicine myopathy
- CQ/HCQ myotox

## IIM DDx

- Immune checkpoint inhibitors
- SAMS, Statin-IMNM
- Colchicine
- CQ/HCQ myotox

# Yatrogenia - LES/Vasculitis inducido por fármacos

## Not all drugs carry the same risk for drug-induced lupus

- High-risk: procainamide, hydralazine
- Intermediate risk: quinidine, isoniazid
- Low-risk: D-penicillamine, minocycline
- Very-low risk: statins, anti-TNF agents

- Skin
- Constitutional symptoms
- Arthritis, serositis
- Avoids major organs
- Anti-histone antibodies

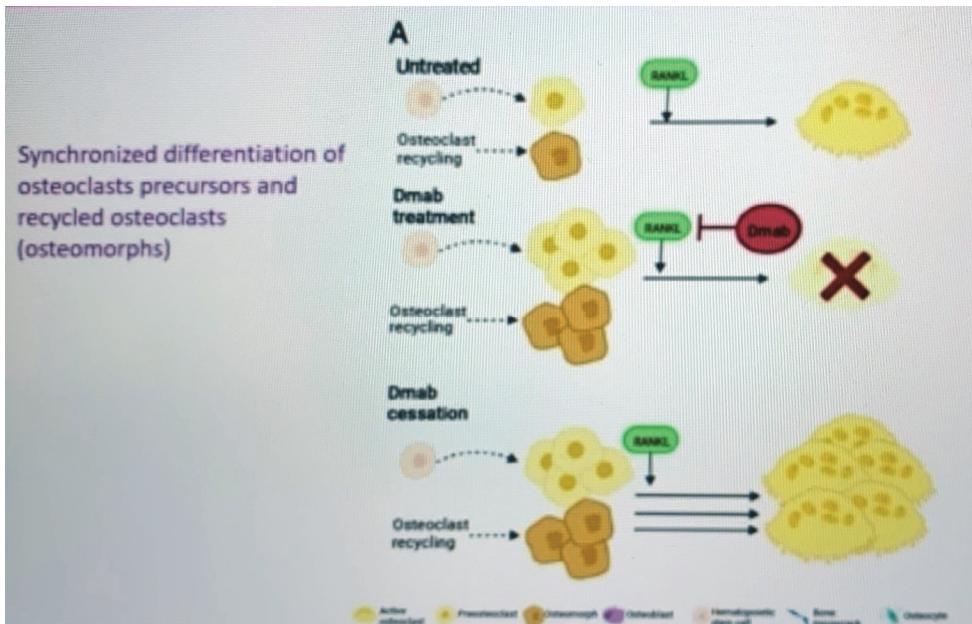
Clinical features	Systemic lupus erythematosus	Drug-induced lupus <sup>a</sup>
Age (years)	20–40	50
Female:Male	9:1	1:1
Onset symptoms	Gradual	Abrupt
Symptom severity	Mild to severe	Generally mild
Constitutional symptoms	83%	50%
Arthralgia and arthritis	90%	95%
Pleuropericarditis (procainamide)	50%	50%
Hepatomegaly	5–10%	15–20%
Cutaneous involvement	54–70% (malar, discoid rash, oral ulcers)	<5–25% (photosensitivity, purpura)
Renal disease	32–53%	5–10%
CNS disease	20–32%	<5%
Haematological abnormalities	Common	Unusual
SEROLOGICAL FEATURES		
ANA	>95%	>95%
Anti-histone	60–80%	90–95%
Anti-dsDNA	50–70%	<5%
Anti-Sm	20–30%	Rare
Hypocomplementemia	50–60%	<5%

- A medication history or **medication reconciliation** should be a part of every evaluation of potential vasculitis.
- Clues that a case might have a drug trigger:
  - **Multiple serologies**
    - MPO and PR3, ANCA and dsDNA, etc.
  - **Cytopenias** in a cutaneous vasculitis case
  - **Older patients**
- Identification of a potential drug trigger **might simplify treatment** (e.g., cessation of the drug and a course of glucocorticoids), but sometimes more intense immunosuppression is needed in severe cases.

## Osteoporosis

- ¿Qué vida hay después de Denosumab?
- DMB eficacia superior demostrada a BF OR y EV, beneficio continuado a largo plazo
- Descenso DMO importante tras discontinuación; riesgo de Fx (incluso múltiples) tras discontinuación (más que PCB)-no se recomienda VPlastia (riesgo de más Fx)
  - Se recomienda asociar a los 6m de la discontinuación BF OR o EV
  - Explicación: al inhibir RANK-L podrían quedar preOC que se acumulan con el tiempo, y que se activarían rápidamente cuando desaparece DMB
- Peores datos si uso DMB >2.5a
- Pensar ‘objetivo’ DMO, apoyarse en marcadores remodelado (CTX)

# Osteoporosis



## Duration of DMAb treatment and subsequent bone loss

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Study	DMAb (yrs)	ALN (yrs <sup>A</sup> )	ZOL (yrs <sup>A</sup> )	LS change (%) <sup>B</sup>	TH(FN) change (%) <sup>B</sup>
DAPS (trial) <sup>1</sup>	1	1		+0.6	-0.4
AfterDMAb (trial) <sup>2</sup>	2		1	+1.8	+1.2
Lehmann (obs) <sup>3</sup>	2.5		2.5	-3.8	-1.7
Everts-Graber (obs) <sup>4</sup>	2–5		2–2.5 <sup>C</sup>	-3.3	-2.2
ZOLARMAB (trial) <sup>5</sup>	4.6		1	-4.8	-2.6
Reid (obs) <sup>6</sup>	7		2	-10	-8

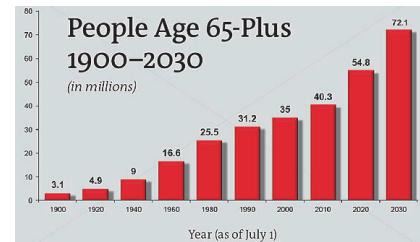
## Managing the patient after denosumab

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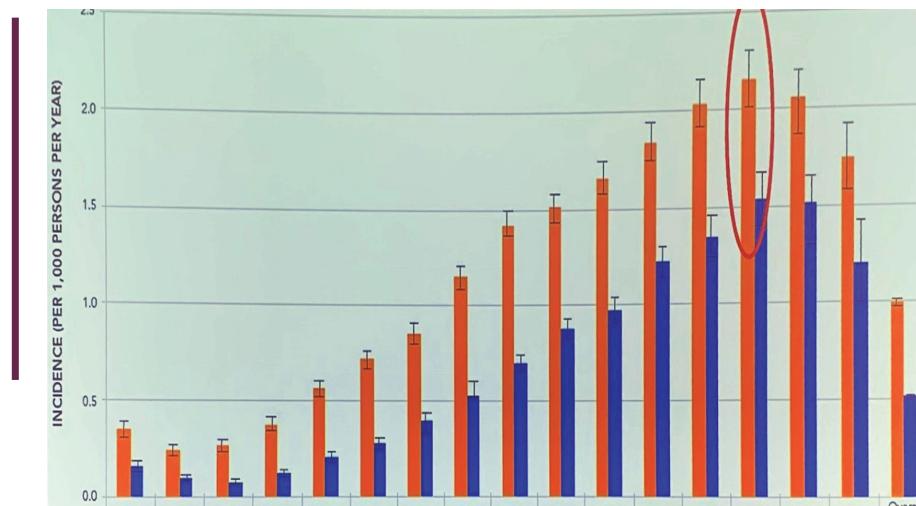
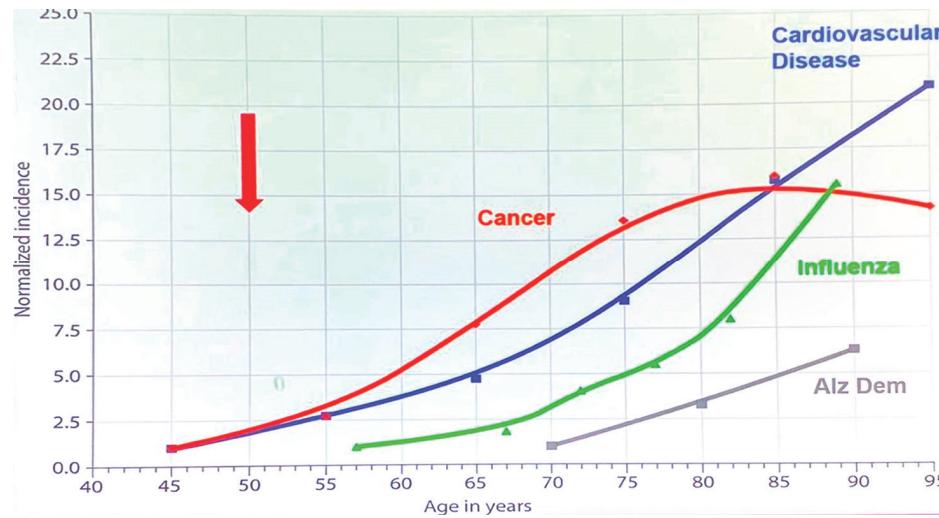
Expect bone loss in patients on long-term treatment and aim for higher BMD before considering stopping denosumab

- Short-term treatment with denosumab – up to 2.5 years
  - Alendronate for 1–2 years
  - Monitor response with CTX
  - Infusion of zoledronate 5 mg 6 months after last denosumab injection
- Long-term treatment with denosumab – more than 2.5 years
  - Infusion of zoledronate 5 mg 6 months after last denosumab injection
  - Monitor CTX after 3 and 6 and 12 months
    - If CTX is above premenopausal mean repeat infusion of zoledronate
  - If unable to monitor with CTX
    - Repeat infusion of zoledronate 5 mg after 6 months
- Maintenance BMD beyond the first year
  - No long-term protection
  - Expect age-related bone loss to resume
  - Consider bisphosphonates

# Reumatología Geriátrica Silver Tsunami

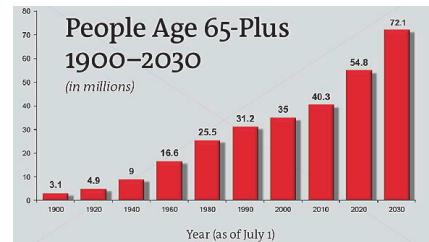


- Cómo envejece el sistema inmune (Dra Weyand)
- “No cumplir más de 50a!!!”
- Edad es un fc riesgo para la autoinmunidad

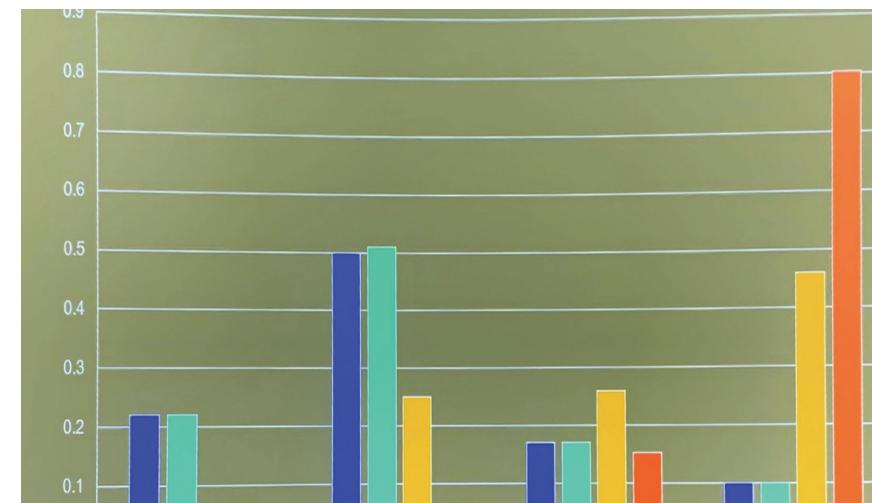
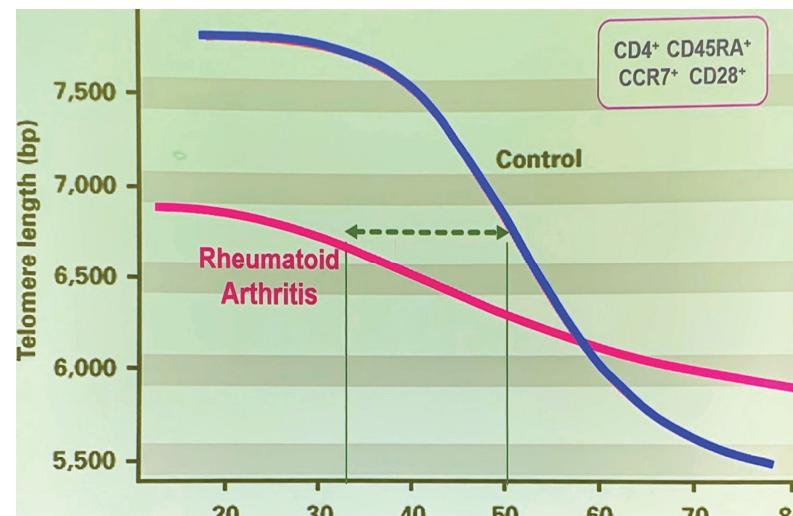


# Reumatología Geriátrica

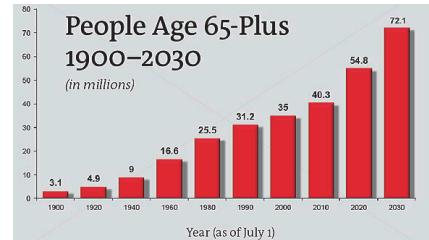
## Silver Tsunami



- Acortamiento de telómeros por los T cells-- puede estar en relación a producir menos ATP (p ej TCD4 cells; en modelos murinos a menor nivel de producción de ATP, peor es la gravedad de la artritis; con expresión genética de marcadores proinflamatorios), Mayor susceptibilidad a infecciones (episodios VZV 'pista').
- “T cells are PROINFLAMMATORY”, las T Cells ‘envejecen mal’. ‘INFLAMMAGING’



# Reumatología Geriátrica Silver Tsunami



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## T cell aging as a risk factor for autoimmunity

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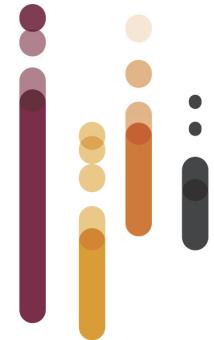
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