Οσφυαλγία σε νέο ασθενή με γνωστή ρευματική νόσο

Οσφυαλγία: μήπως είναι σύμπτωμα φλεγμονώδους έξαρσης αυτοάνοσου νοσήματος;

Θάνος Κουτρούμπας

Συγκρουση συμφερόντων

Καμία για την παρουσίαση αυτή

Για την παρουσίαση αυτή χρησιμοποιήθηκαν τα προγράμματα τεχνητής νοημοσύνης Google Gemini & ChatGPT. Καθώς οι μηχανές μπορεί να κάνουν λάθη, η ευθύνη για την παρουσίαση αυτή βαρύνει τον ομιλητή.

Η περίπτωση:

Άνδρας 58 ετών

ΑΣ

Διάγνωση στα 25

Υπό βιολογική θεραπεία

Πολυμυοσίτιδα

Διάγνωση στα 53

Υπό αζαθιοπρίνη και μεθυλπρεδνιζολόνη 2 mg ημερησίως

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Πόνος συνεχής- με τις κινήσεις. Νυχτερινό άλγος.
Πιθανά δέκατα (νιώθει ζεστός αλλά δεν έβαλε θερμόμετρο…)
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Beyond flare...

New onset of back pain in patient with a diagnosis of an inflammatory, autoimmune disease.

Flare, comorbidity, complication, or coincidence?

Flare: AS, Axial spondyloarthritis, Psoriatic spondylitis.

Comorbidity: Mechanical back pain, fibromyalgia.

Complication: Infection, referred pain (pancreas, aorta), (osteoporotic) fracture

Coincidence: malignancy.

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ΑΣ: το αρχέτυπο της προσβολής ΣΣ στην ρευματολογία

Φλεγμονώδης οσφυαλγία

Box 5 IBP according to ASAS experts' to be applied in patients with chronic back pain (>3 months)

- Age at onset <40 years
- Insidious onset
- Improvement with exercise
- No improvement with rest
- Pain at night (with improvement upon getting up)

The criteria are fulfilled if at least four out of five parameters are present.

Sieper J, van der Heijde D, Landewe R, Brandt J, Burgos-Vargas R, CollantesEstevez E, et al. New criteria for inflammatory back pain in patients with chronic back pain: a real patient exercise by experts from the Assessment of SpondyloArthritis International Society (ASAS). Ann Rheum Dis 2009;68:784–8.

Risk of inflammatory flare while on biologic treatment

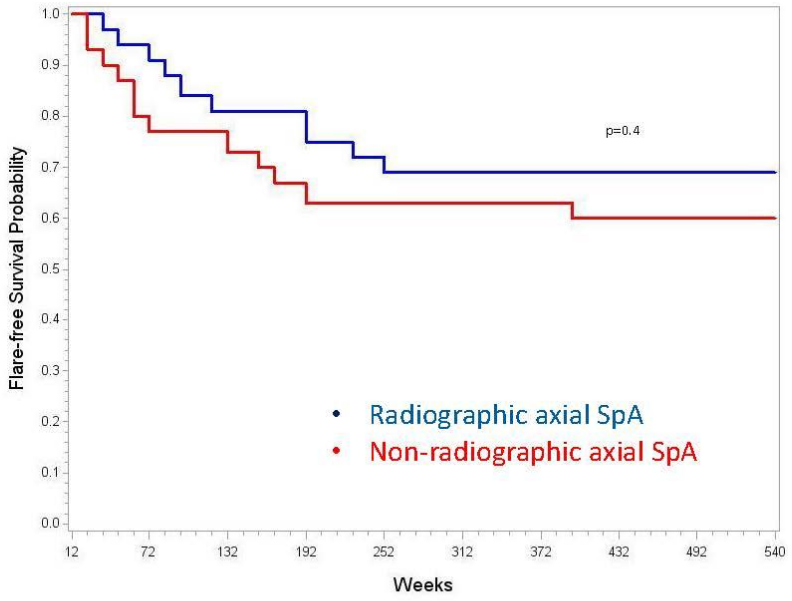
With continuing treatment: annual flare rate 10-30%

Dose reduction/spacing: 20-50% within 6-12 months

Drug discontinuation: 70-90% within 6-12 months

Risk of inflammatory flare while on biologic treatment (etanercept)

Figure. Kaplan-Meier curves indicating time to the first flare and flare free survival propability in patients with early axial spondyloarthritis on stable etanercept treatment



Proft, ACR Annual Meeting 2019

Biologics reduce flare risk but do not abolish it

Factors associated with higher flare risk

Disease-related
High baseline disease activity
Short duration of remission
MRI activity (bone marrow edema)

Patient-related
Smoking
Male sex (in some cohorts)
HLA-B27 positivity (inconsistent data)

Treatment-related
Drug discontinuation
Irregular dosing

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Mechanical back pain

The most usual form

Common in patients with autoimmune, inflammatory conditions

20-40~% (estimate) excluding AS/SpA

- Muscle sprain
- Ligament sprain
- Degenerative disk disease
- Herniated disk
- Facet joint syndrome
- Spinal stenosis
- Spondylolisthesis
- Vertebral fractures

Fibromyalgia: the great pretender

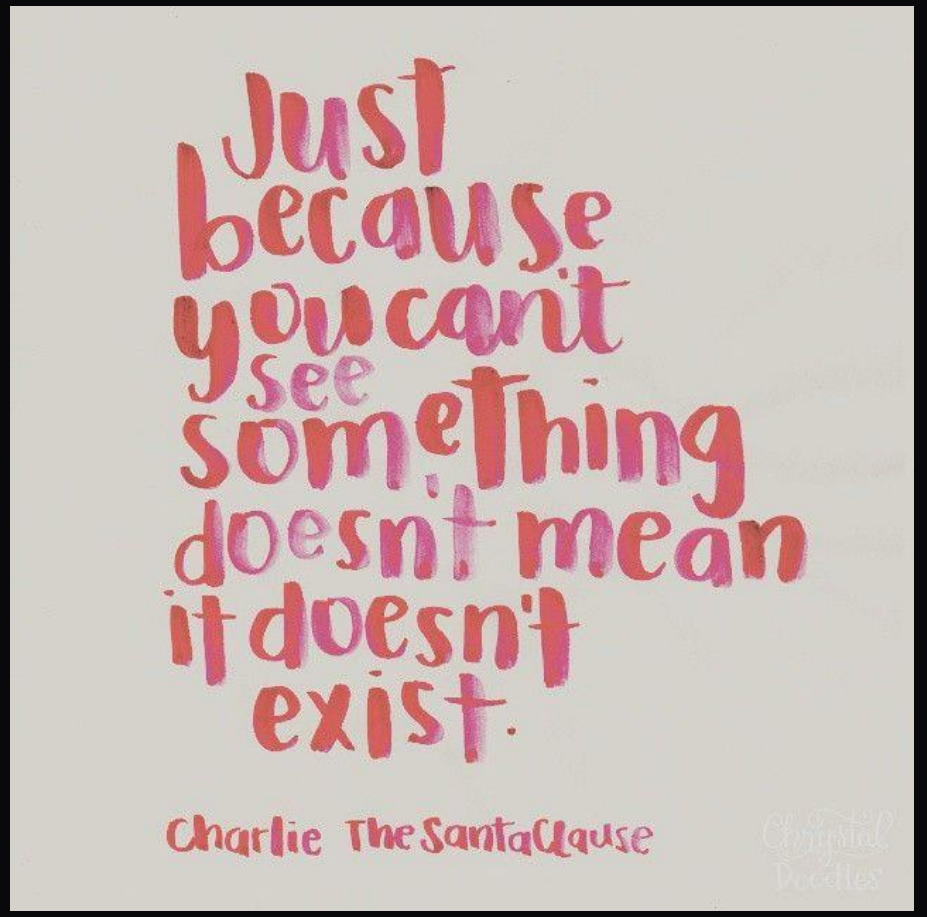
15-30% of patients with autoimmune, rheumatic dieseases have concomittant fibromyalgia

RA: 21%

SLE: 16-30%

AxSpA/AS: 13%

PsA:18%



Duffield, Rheumatology 2018

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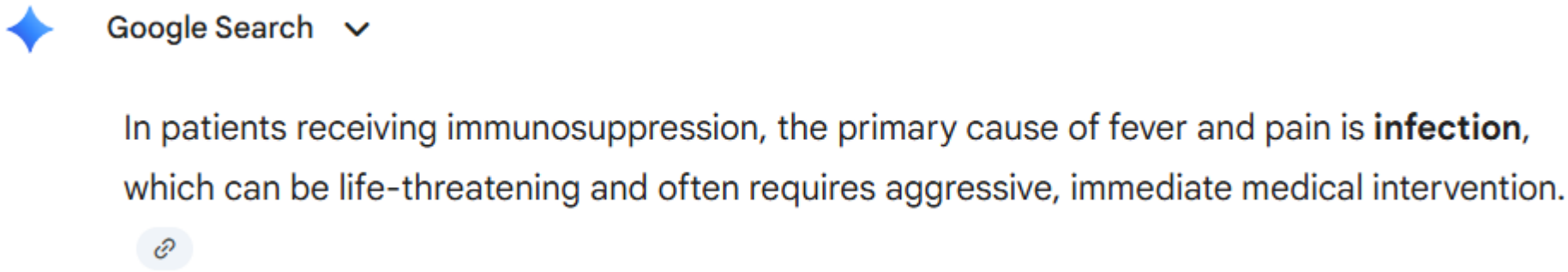
Immunicompromized patients with fever have infection, unless a proven cause is found



Spinal infections

Uncommon but severe

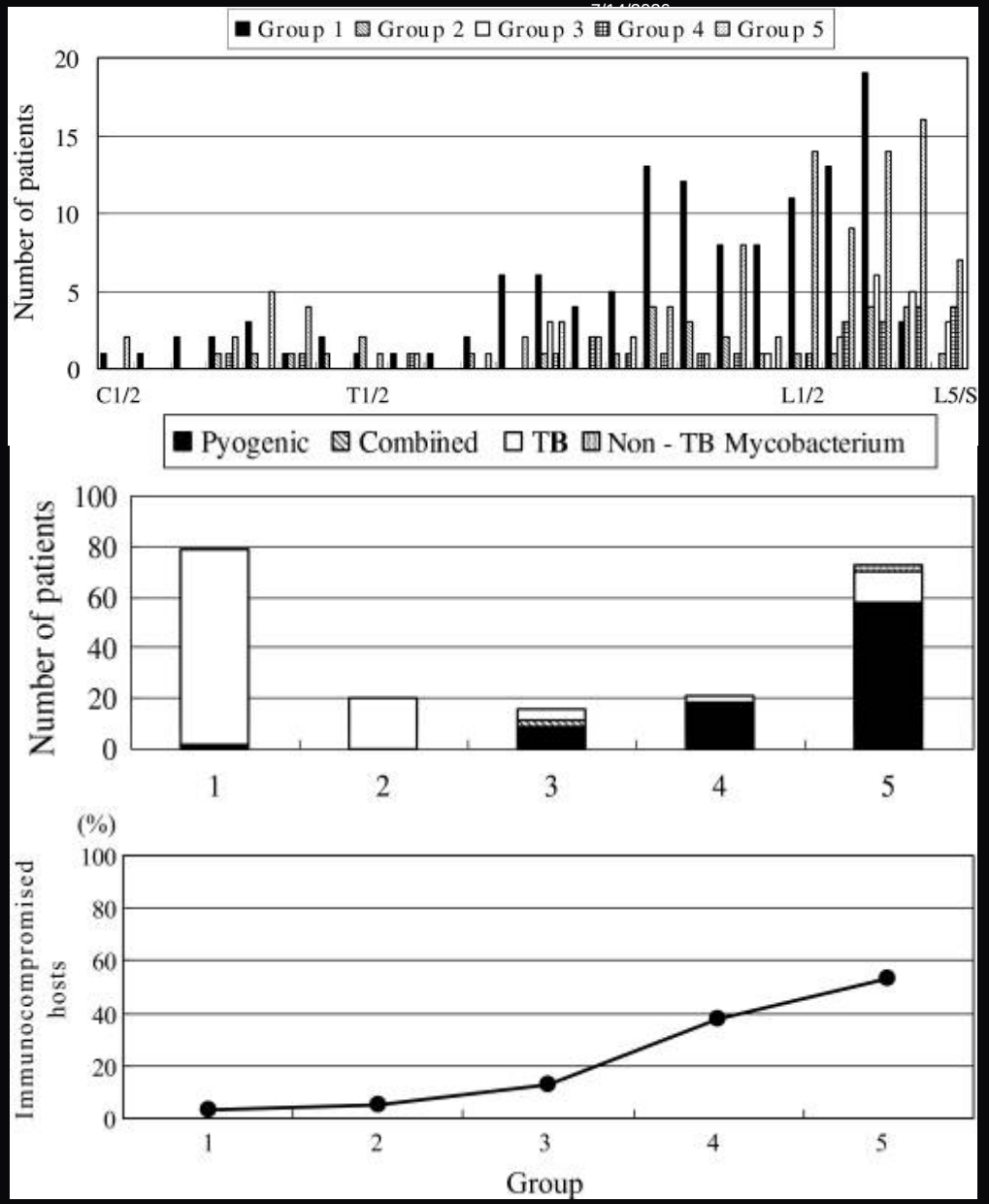
Often blunted clinical picture

Fever, Pain, Elevated WBC, ESR, CRP

Staph Aureus

Lumbar spine is the most commonly affected site

Immunosuppresion is a major concern



1956-1965 1966-1975 1976-1985 1986-1995 1996-2005

Nagashima, Int Orthop 2009

Referred pain

Pancreatic pathology: pancreatitis

Pain is often constant, deep, and may radiate to the mid-back (T10-L2 levels), exacerbated by lying flat, or partially relieved by leaning forward (fetal position)

Nausea, vomiting, or unexplained weight loss

Abdominal aortic dissection

Severe, sudden-onset pain in the lower back or abdomen

Often described as "stabbing" or "tearing" and is entirely unrelated to physical activity

Fever, drop in blood pressure, tachycardia. Palpable, pulsating mass in the abdomen. Murmur.

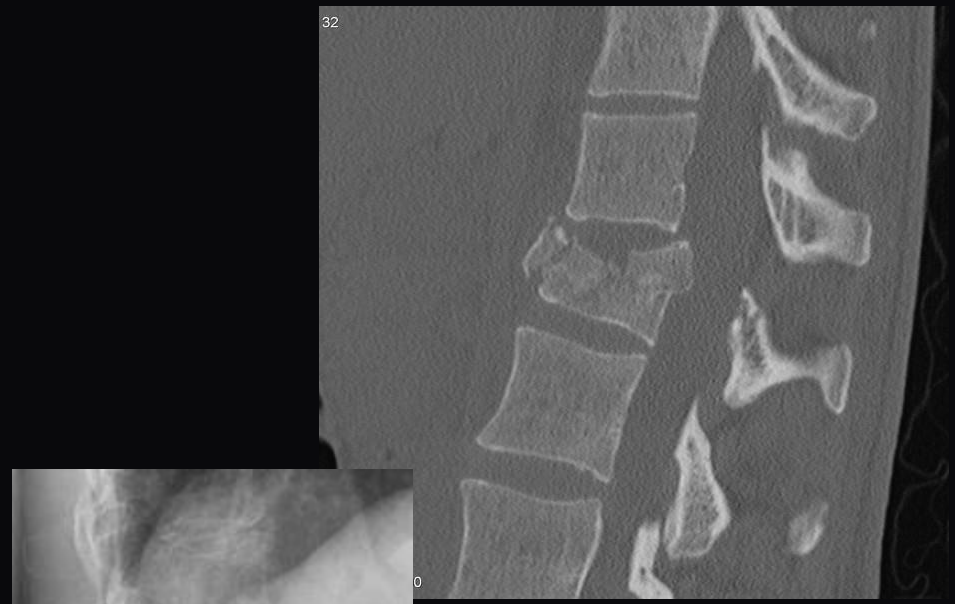
Vertebral fracture

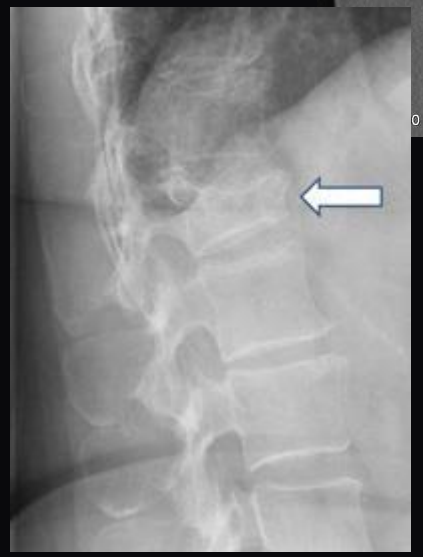
High burden in rheumatic diseases

RA: 20% *(Liu, Clin Rheumatol 2022)*

SLE: 20-50% *(Rotta, Lupus 2025)*

AS: 10-43% *(Zhang, Medicine 2017)*





Radiopedia, Orthoinfo.AOOS.org

Vertebral fracture: contributing factors

Chronic steroid use

Disease activity

Age and postmenopausal state

Reduced mobility

Frailty

Vertebral fracture: contributing factors

Chronic steroid use

Disease activity

Age and postmenopausal state

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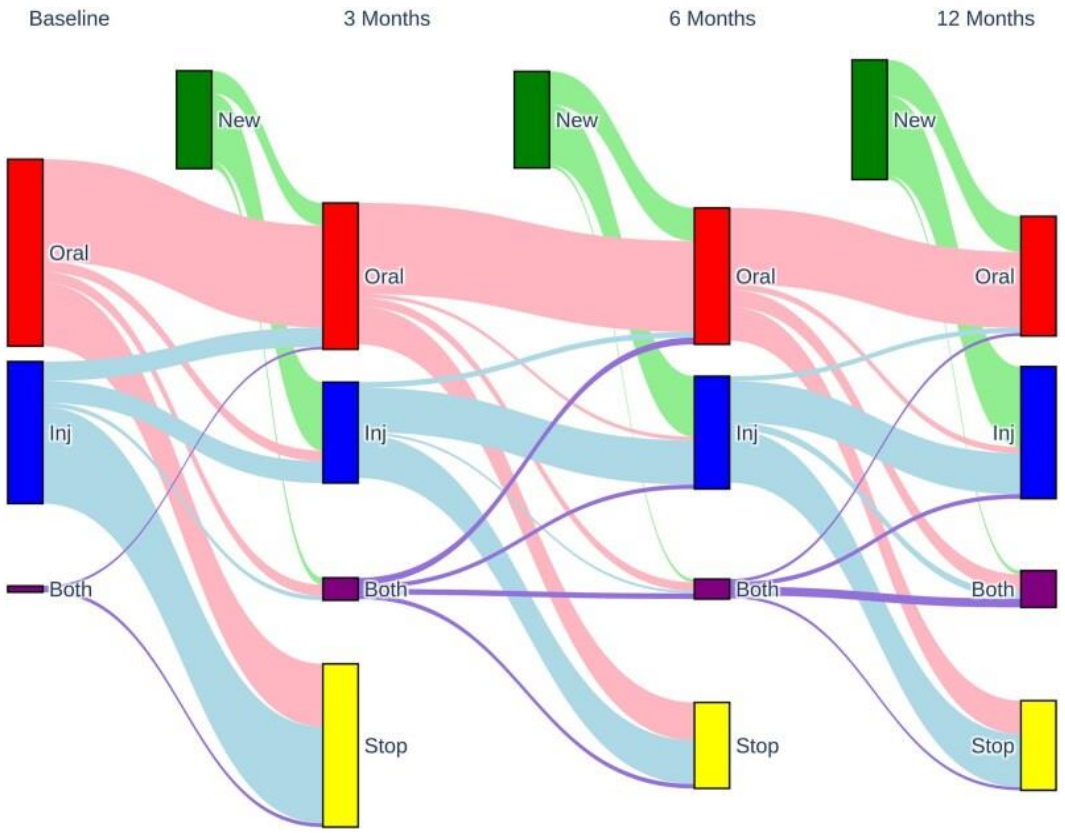
Frailty

Steroid use is *(still)* common in RMDs

RA



Stadler, Rheumatol Adv Pract 2025

Steroid use is *(still)* common in RMDs

RA

Clinical trials – 90% disontinue steroids within 12 months- 10% continue

Clinical practice – up to half of patients chronically treated with steroids

SLE

Almost all?

Vasculitis

Almost all?

Buttergeit and Tam, Lancet Rheumatol 2025, Smolen, Ann Rheum Dis 2023

Vertebral fractures are associated with steroid use

No safe dose

Caution in older, frail women.

Especially in pre-existent osteoporosis.

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Malignancy

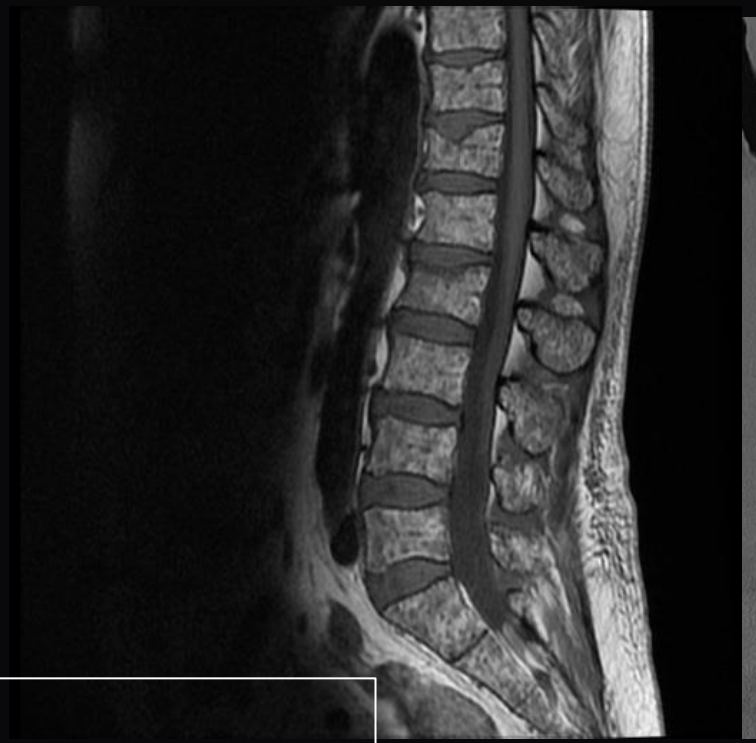
Multiple myeloma

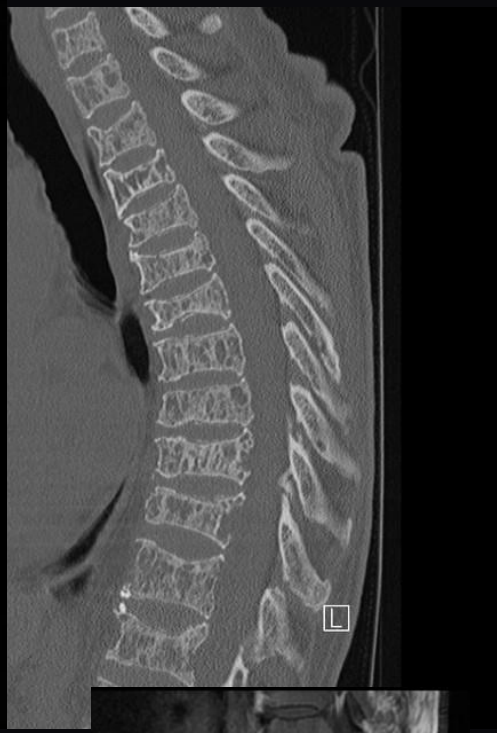
Metastatic disease

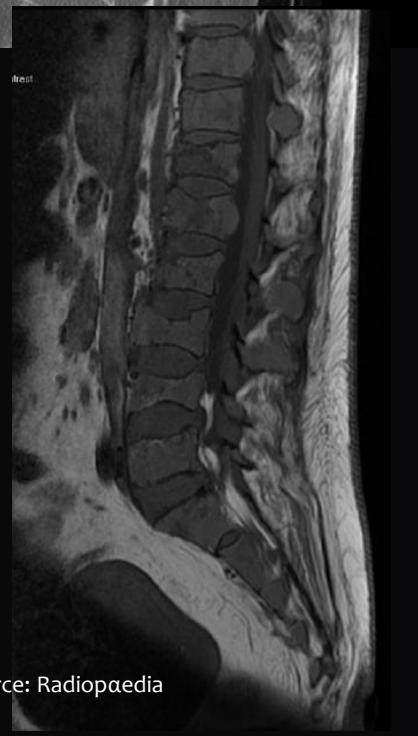
Malignancy

Multiple myeloma

Metastatic disease







T1
- typically low signal
- high-grade, diffuse involvement may become isointense to adjacent normal marrow

T2 with fat-suppression
- high signal
- infiltration of the ribs is probably best appreciated on T2 images with fat suppression, appearing bright

T1 C+ (Gd)
- hyperintense

DWI/ADC:
lesions usually exhibit restricted diffusion, with higher signal on high b-value DWI compared to the very low signal of normal background marrow

Source: Radiopaedia

Malignancy

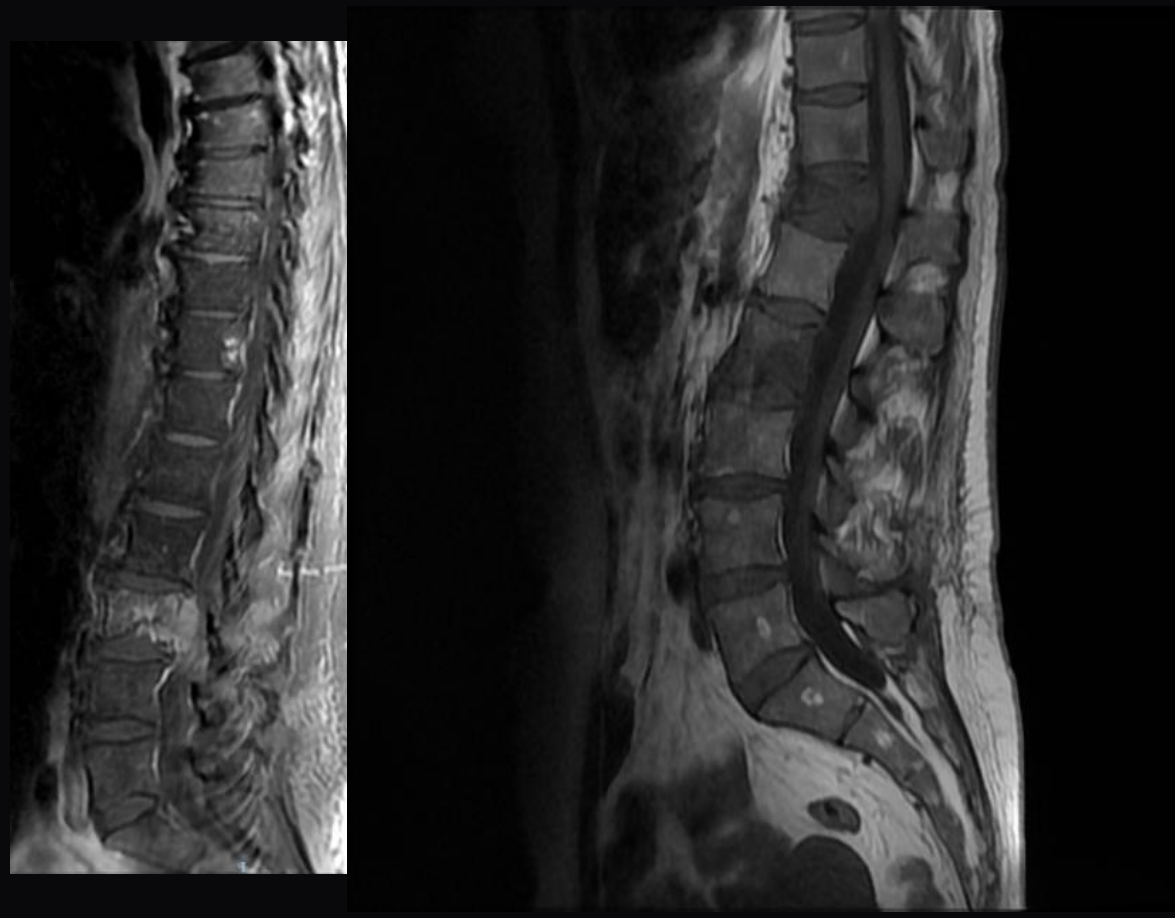
Multiple myeloma

Metastatic disease

Osteoblastic metastases
T1: hypointense
T2: hypointense

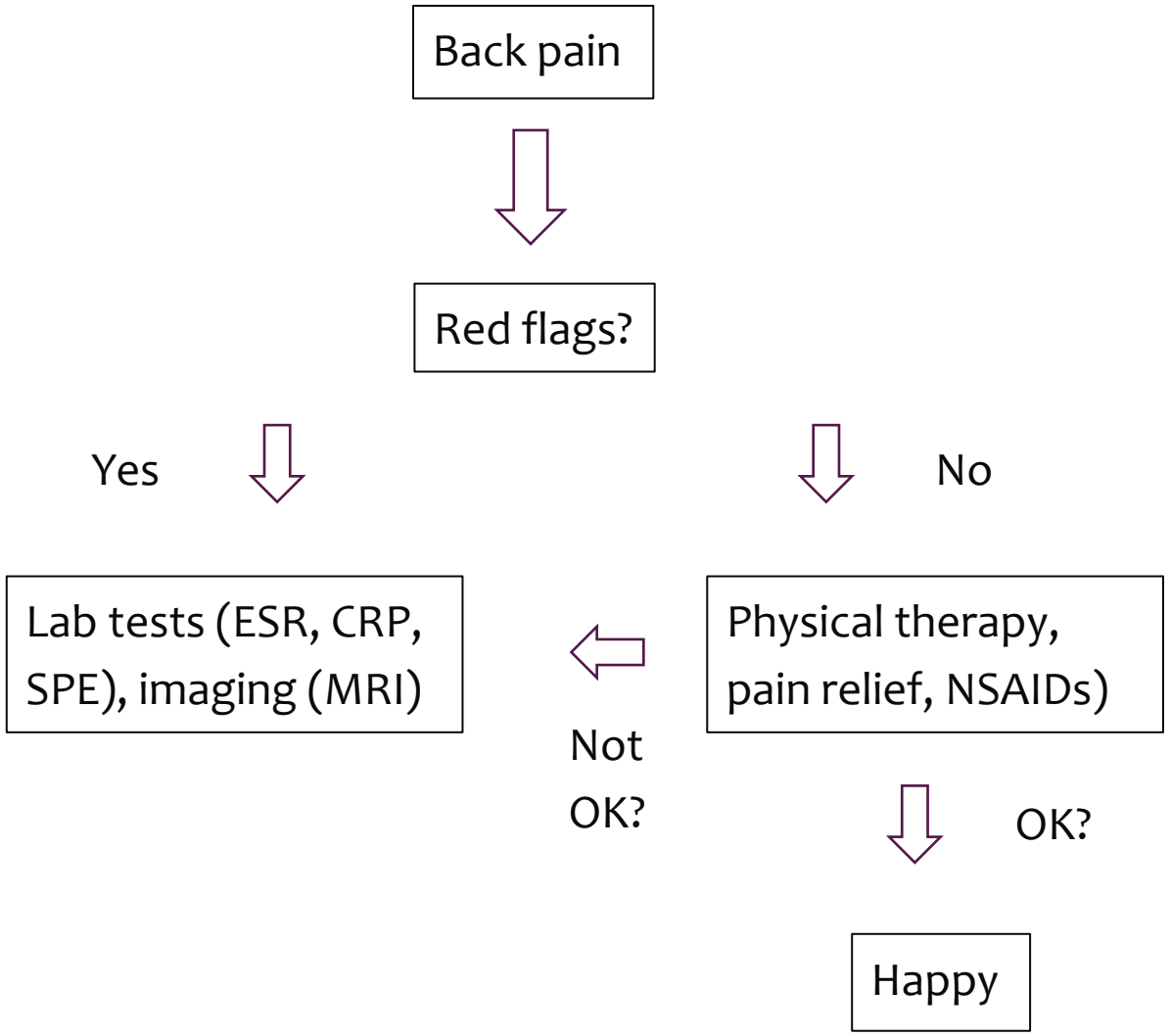
Mixed sclerotic and lytic extradural bone lesions
T1: hypointense
T2: hypo- and/or hyperintense

Lytic extradural bone lesions
T1: intermediate to hypointense
T2: hyper- or isointense
T1 C+ (Gd): enhancement usually present



Source: Radiopaedia

Diagnostic algorithm



Red flags:

Fever and constitutional symptoms

History of cancer

Unexplained weight loss

Loss of bladder/bowel control, saddle anesthesia, or progressive weakness