Μακροχρόνια θεραπεία με μικρές δόσεις κορτικοστεροειδών στις χρόνιες φλεγμονώδεις παθήσεις:

pros & cons –

70 χρόνια χρήσης και ακόμη ξέρουμε τόσο λίγα

ΣΠΥΡΟΣ Ν ΝΙΚΑΣ

ΡΕΥΜΑΤΟΛΟΓΟΣ

ΙΩΑΝΝΙΝΑ

70 ΧΡΟΝΙΑ…ΚΟΡΤΙΖΟΝΗ !

Οι «θαυματουργές» δράσεις των γλυκοκορτικοειδών (GC) στον άνθρωπο περιεγράφηκαν για 1η φορά από Philip S. Hench και συν. το **1949**

Σε μια εβδομάδα : η δυσκαμψία έφυγε πλήρως
σημαντική μείωση πόνου – οίδημα

Χορηγήθηκαν ημερήσιες **IM** injections 100 mg **17-**hydroxy-11-**dehydrocorticosterone** (compound E)

Ο 1ος ασθενής : 29 ετών γυναίκα , κλινήρης λόγω σοβαρής, παραμορφωτικής **PA** διάρκειας 4 ετών

Hench PS, Kendall EC, Slocumb CH, Polley HF. The effect of a hormone of the adrenal cortex (17-hydroxy-11-dehydrocorticosterone: Compound E) and of pituitary adrenocorticotropic hormone on rheumatoid arthritis. Proc Staff Meet Mayo Clin 1949;24:181-97.

PHILIP S. HENCH

The reversibility of certain rheumatic and non-rheumatic conditions by the use of cortisone or of the pituitary adrenocorticotropic hormone

Nobel Lecture, December 11, 1950.

It may be appropriate to discuss in this Nobel Lecture three general aspects of cortisone and pituitary adrenocorticotropic hormone (ACTH): (1) the development of the theory which eventually led to the use of cortisone and ACTH in rheumatic and certain other conditions; this I shall do in some detail, giving certain data not published heretofore; (2) the present status of cortisone and ACTH in general medicine; this topic I shall discuss summarily in view of the several current reports thereon; and (3) some major requirements for the orderly development of cortisone and ACTH as therapeutic agents; this aspect will be touched upon briefly.

Development of the Theory which Led to the Use of Cortisone and ACTH in Rheumatic Diseases

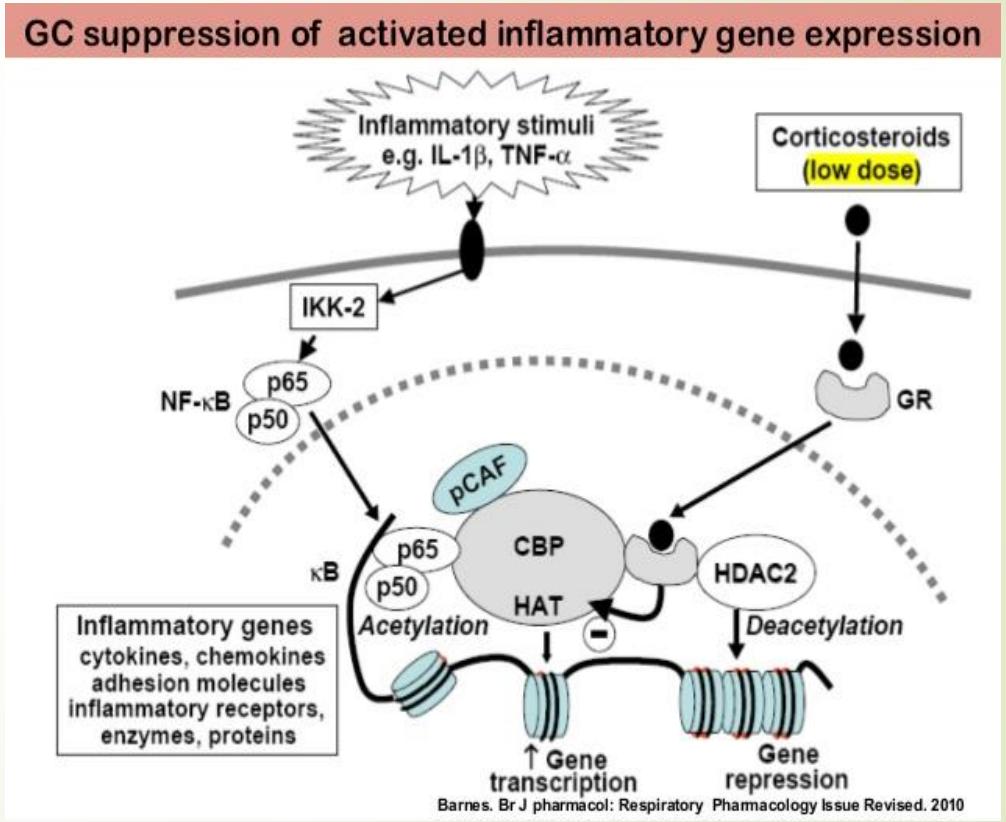
ΜΗΧΑΝΙΣΜΟΣ ΔΡΑΣΗΣ ΓΚ

μέσω διάχυσης, περνούν ελεύθερα την κυτταρική μεμβράνη -> κυτταρόπλασμα -> ενώνονται με τον υποδοχέα (glucocorticoid receptor)

Το σύμπλεγμα glucocorticoid/receptor -> μετακινείται στον πυρήμα

transcriptional **repression**=> to anti-inflmmatory effects

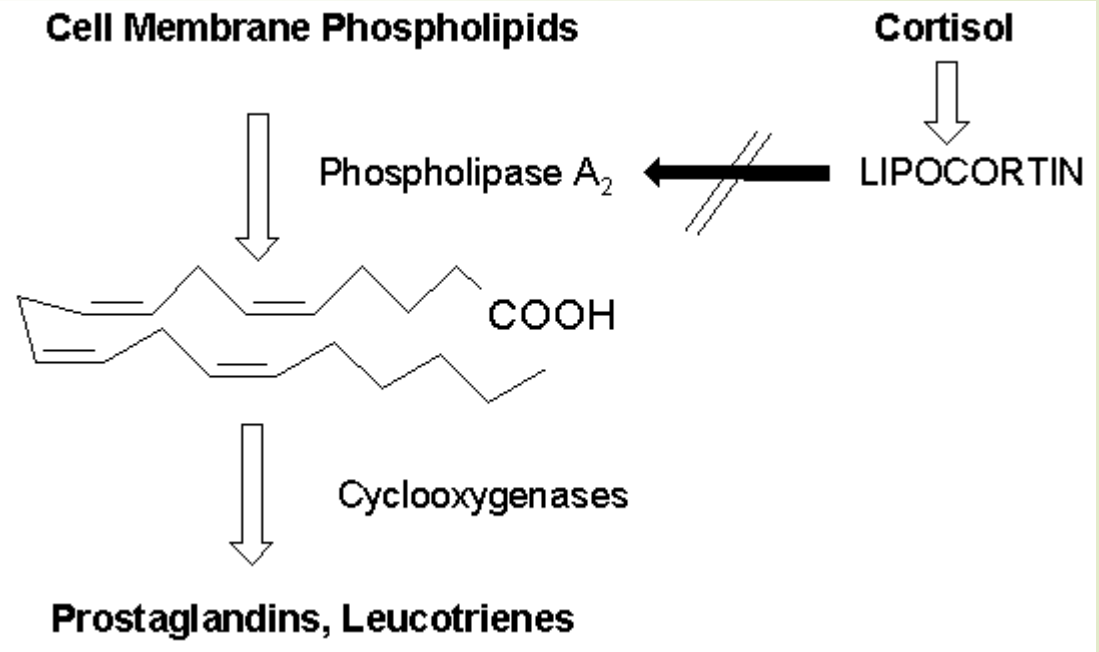
Transcriptional **activation** => to many of the recognised side-effects



ΜΗΧΑΝΙΣΜΟΣ ΔΡΑΣΗΣ ΓΚ

Μια από τις κύριες πρωτεΐνες που τα ΓΚ **αυξάνουν** την παραγωγή της είναι η **lipocortin**

Η οποία με τη σειρά της αναστέλλει την phospholipase A2



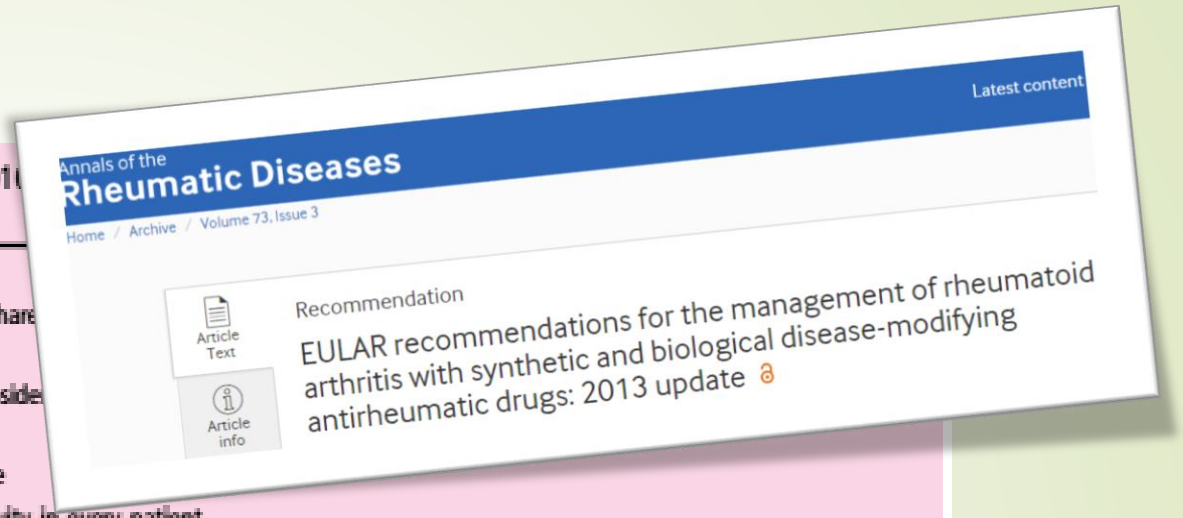


Table 1 2013 Update of the EULAR recommendations (the table of 201
original publication)

Overarching principles

A. Treatment of RA patients should aim at the best care and must be based on a share
B. Rheumatologists are the specialists who should primarily care for RA patients
C. RA incurs high individual, societal and medical costs, all of which should be conside

Recommendations

1. Therapy with DMARDs should be started as soon as the diagnosis of RA is made
2. Treatment should be aimed at reaching a target of remission or low disease activity in every patient
3. Monitoring should be frequent in active disease (every 1–3 months); if there is no improvement by at most 3 months after the start of treatment or the target has not been reached by 6 months, therapy should be adjusted
4. MTX should be part of the first treatment strategy in patients with active RA

7. Low-dose glucocorticoids should be considered as part of the initial treatment strategy (in combination with one or more csDMARDs) for up to 6 months, but should be tapered as rapidly as clinically feasible

9. In patients responding insufficiently to MTX and/or other csDMARD strategies, with or without glucocorticoids, bDMARDs (TNF inhibitors*, abatacept or tocilizumab, and, under certain circumstances, rituximab†) should be commenced with MTX
10. If a first bDMARD has failed, patients should be treated with another bDMARD; if a first TNF inhibitor therapy has failed, patients may receive another TNF inhibitor* or a biological agent with another mode of action
11. Tofacitinib may be considered after biological treatment has failed
12. If a patient is in persistent remission after having tapered glucocorticoids, one can consider tapering‡ bDMARDs§, especially if this treatment is combined with a csDMARD
13. In cases of sustained long-term remission, cautious reduction of the csDMARD dose could be considered, as a shared decision between patient and physician
14. When therapy needs to be adjusted, factors apart from disease activity, such as progression of structural damage, comorbidities and safety issues, should be taken into account

Recommendation

EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update

Josef S Smolen,[1,2] Robert Landewé,[3,4] Johannes Bijlsma,[5] Gerd Burmester,[6] Katerina Chatzidionysiou,[7] Maxime Dougados,[8] Jackie Nam,[9] Sofia Ramiro,[10] Marieke Voshaar,[11] Ronald van Vollenhoven,[3,4] Daniel Aletaha,[1] Martin Aringer,[12] Chris D Buckley,[14] Frank Buttgereit,[6] Vivian Bykerk,[15,16] Yvonne van Eijk-Hustings,[20] Kenneth Saag, Maarten de Wit, René Westhovens,[45,46]

6. Short-term glucocorticoids should be considered when initiating or changing csDMARDs, in different dose regimens and routes of administration, but should be tapered as rapidly as clinically feasible

Table 2 The 2016 EULAR updated recommendations

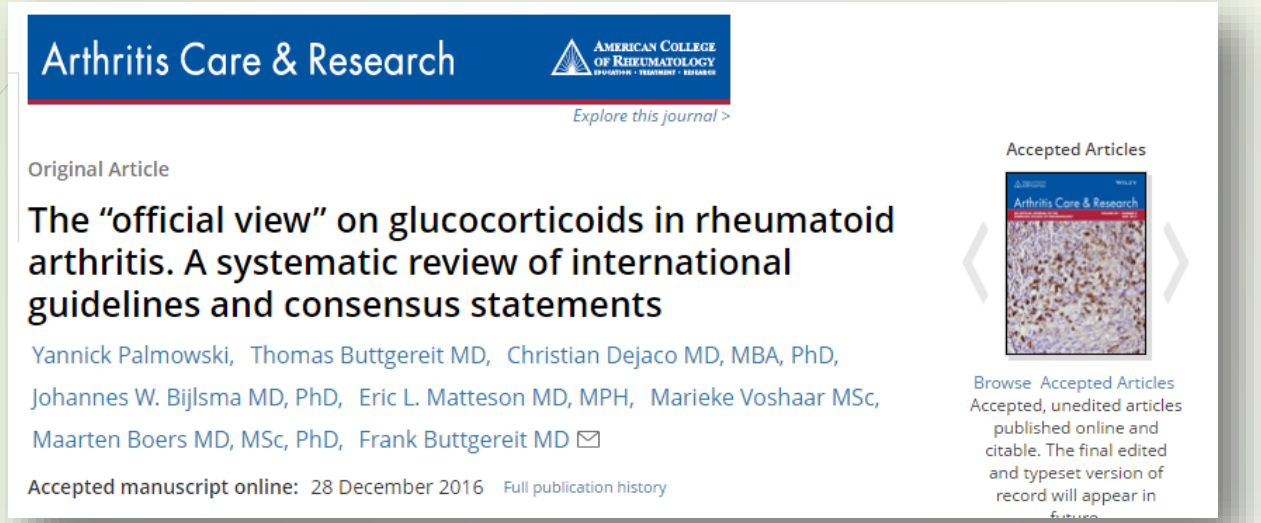
	Overarching principles
A	Treatment of patients with RA should aim at the best care and must be based on a shared decision between the patient and the rheumatologist
B	Treatment decisions are based on disease activity and other patient factors, such as progression of structural damage, comorbidities and safety issues
C	Rheumatologists are the specialists who should primarily care for patients with RA
D	RA incurs high individual, medical and societal costs, all of which should be considered in its management by the treating rheumatologist
	Recommendations
1.	Therapy with DMARDs should be started as soon as the diagnosis of RA is made
2.	Treatment should be aimed at reaching a target of sustained remission or low disease activity in every patient
3.	Monitoring should be frequent in active disease (every 1–3 months); if there is no improvement by at most 3 months after the start of treatment or the target has not been reached by 6 months, therapy should be adjusted
4.	MTX should be part of the first treatment strategy
	poor prognostic factors are present, addition of a bDMARD*[1,2] or a tsDMARD*[2] should be considered; current practice would be to start a bDMARD[5]
9.	bDMARDs*[1,2] and tsDMARDs[#9] should be combined with a csDMARD; in patients who cannot use csDMARDs as comedication, IL-6 pathway inhibitors and tsDMARDs may have some advantages compared with other bDMARDs
10.	If a bDMARD* or tsDMARD[5] has failed, treatment with another bDMARD or a tsDMARD should be considered; if one TNF-inhibitor therapy has failed, patients may receive another TNF-inhibitor or an agent with another mode of action
11.	If a patient is in persistent remission after having tapered glucocorticoids, one can consider tapering bDMARDs, especially if this treatment is combined with a csDMARD
12.	If a patient is in persistent remission, tapering the csDMARD could be considered

ΧΩΡΙΣ ΤΟ ΟΡΙΟ ΤΩΝ 6 ΜΗΝΩΝ (πρώιμη PA)

- Roubille C, Rincheval N, Dougados M, et al. Sevenyear tolerability profie of glucocorticoids use in early rheumatoid arthritis: data from the ESPOIR cohort. Ann Rheum Dis 2017

- Albrecht K, Callhoff J, Edelmann E, et al. [Clinical remission in rheumatoid arthritis. data from the early arthritis cohort study CAPEA]. Z Rheumatol 2016;75:90–6

ΟΛΕΣ ΟΙ ΣΥΣΤΑΣΕΙΣ συμφωνούν…



- GC, ειδικά σε **μικρές** δόσεις και για **βραχύ** χρονικό διάστημα => κατάλληλη θεραπεία RA

- many recommendations remain vague as reliable and detailed **evidence is scarce**

Οι περισσότερες μελέτες είναι αναδρομικές / παρατήρησης
selection bias

Arthritis Care & Research
DOI 10.1002/acr.23184

It is the best of treatments, it is the worst of treatments:

The continuing love hate relationship with glucocorticoids in RA

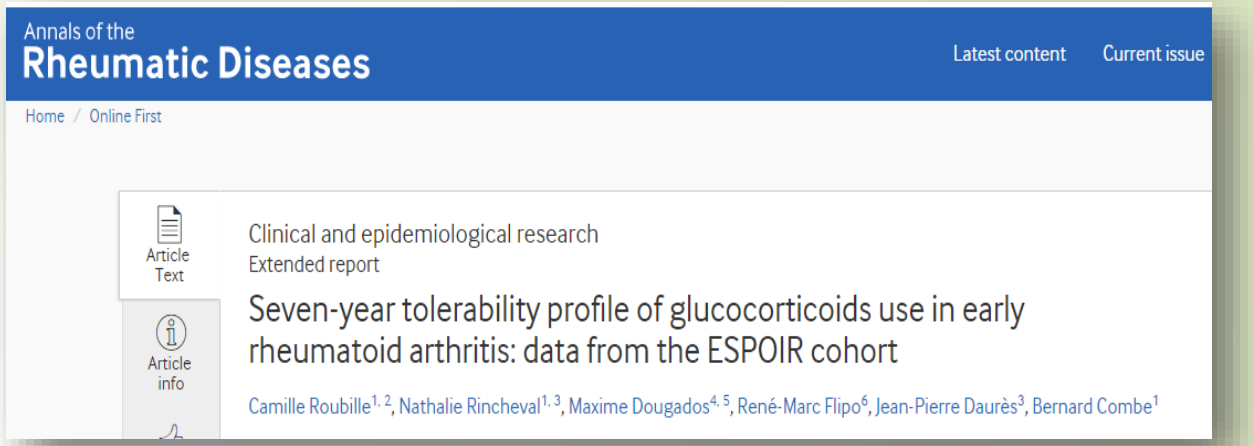
Corresponding Author: Tina D. Mahajan, M.D.

GCC are **old** drugs,

and therefore no company would consider the multi-million dollars

necessary to fund this much needed research

Μακροχρόνια ασφάλεια



65 AE (*7 θάνατοι, 14 CVD , 19 σοβ λοιμώξεις ,25 κατάγματα*)

- **44 Vs 21** σε ασθενείς με και χωρίς GC (p=**0.520**)
- Λοιμώξεις ήταν πιο συχνές σε ασθενείς με GC , όχι όμως σημαντικά (p=0.09)

On weighted Cox proportional-hazards analysis, with use of propensity score and inverse-probability-of-treatment weighting, and including age, gender, history of hypertension and GC treatment

ΔΙΑΦΟΡΕΣ ΣΤΙΣ ΕΚΒΑΣΕΙΣ ΔΕΝ ΦΑΝΗΚΑΝ

no significant difference in major **safety** events between early RA patients with and without low-dose glucocorticoid treatment

Seven-year tolerability profile of glucocorticoids use in early rheumatoid arthritis: data from the ESPOIR cohort" Ann Rheum Dis 2017

CS & λοιμώξεις

Ο αριθμός των λοιμώξεων

ήταν **παρόμοιος**

μεταξύ των 2 ομάδων και στις 3 μελέτες

*Wassenberg S, Rau R, Steinfeld P, Zeidler H, for the **Low-Dose** Prednisolone Therapy Study Group. Very low-dose prednisolone in early rheumatoid arthritis retards radiographic progression over two years. Arthritis Rheum 2005;52:3371-80.*

*Svensson B, Boonen A, Albertsson K, van der Heijde D, Keller C, Hafström I, for the BARFOT Study Group. **Low-dose** prednisolone in addition to the initial disease-modifying antirheumatic drug in patients with early active rheumatoid arthritis reduces joint destruction and increases the remission rate. A two-year randomized trial. Arthritis Rheum 2005;52:3360-70*

*van Everdingen AA, Jacobs JWG, van Reesema DRS, Bijlsma JWJ **Low-dose** prednisone therapy for patients with early active rheumatoid arthritis: clinical efficacy, disease-modifying properties, and side effects: a randomized, double-blind, placebo-controlled clinical trial. Ann Intern Med 2002;136:1-12*

Συχνές ΑΕ στην καθημέρα κλινική πράξη

- Εκχυμώσεις και λέπτυνση δέρματος
- Ήπια αύξηση ΑΠ
- ΣΔ
- Καταρράκτης

Long-term prednisone in doses of less than 5 mg/day for treatment of rheumatoid arthritis: personal experience over 25 years. Pincus T1, Castrejón I, Sokka T. Clin Exp Rheumatol. 2011 Sep-Oct;29(5 Suppl 68):S130-8.

Συχνές ΑΕ στην καθημέρα κλινική πράξη

Αύξηση ΣΒ ήταν πιο **σύνηθες** ΑΕ εύρημα (70%)

- prednisolone : 5 kg Vs 0.3 kg placebo group (1)

- Εκχυμώσεις δερμ (55 %), διαταραχές ύπνου (45 %) διαταραχές διάθεσης (45 %) (2)

*Wassenberg S, Rau R, Steinfeld P, Zeidler H, for the Low-Dose Prednisolone Therapy Study Group. **Very low-dose** prednisolone in early rheumatoid arthritis retards radiographic progression over two years. Arthritis Rheum 2005;52:3371-80*
*Curtis JR, Westfall AO, Allison J et al (2006) Population-based assessment of adverse events associated with **long-term** glucocorticoid use. Arthritis Rheum 55(3):420–426.*

Πιο ενοχλητικές (ασθενείς) ΑΕ στην καθημέρα κλινική πράξη

- Διαταραχές ύπνου
- Αύξηση ΣΒ
- Διαταραχές συναισθήματος
- Λέπτυνση δέρματος

Arthritis Care & Research

It is the best of treatments, it is the worst of treatments: The continuing love hate relationship with glucocorticoids in RA Tina D. Mahajan M.D., James R. O'Dell . 28 December 2016

Monitoring adverse events of low-dose glucocorticoid therapy: EULAR recommendations for clinical trials and daily practice

M C van der Goes,[1] J W G Jacobs,[1] M Boers,[2] T Andrews,[3] M A M Blom-Bakkers,[1] F Buttgereit,[4] N Caeyers,[5] M Cutolo,[6] J A P Da Silva,[7] L Guillevin,[8] J R Kirwan,[3] J Rovensky,[9] G Severijns,[10] S Webber,[3] R Westhovens,[10] J W J Bijlsma[1]

Standard care monitoring needs

NOT be extended for

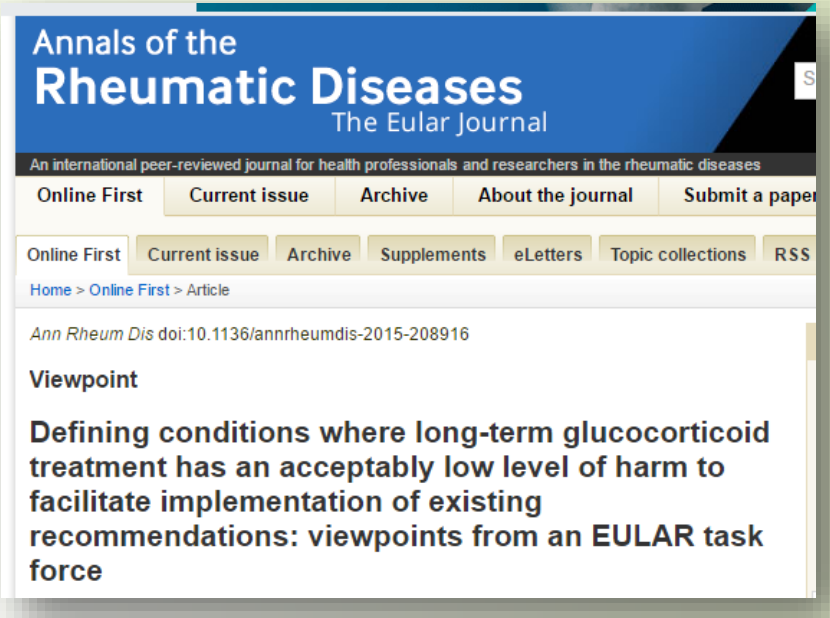
patients on **low-dose GC therapy**,

except for osteoporosis (follow national guidelines)

Ann Rheum Dis 2010;69:1913–1919.

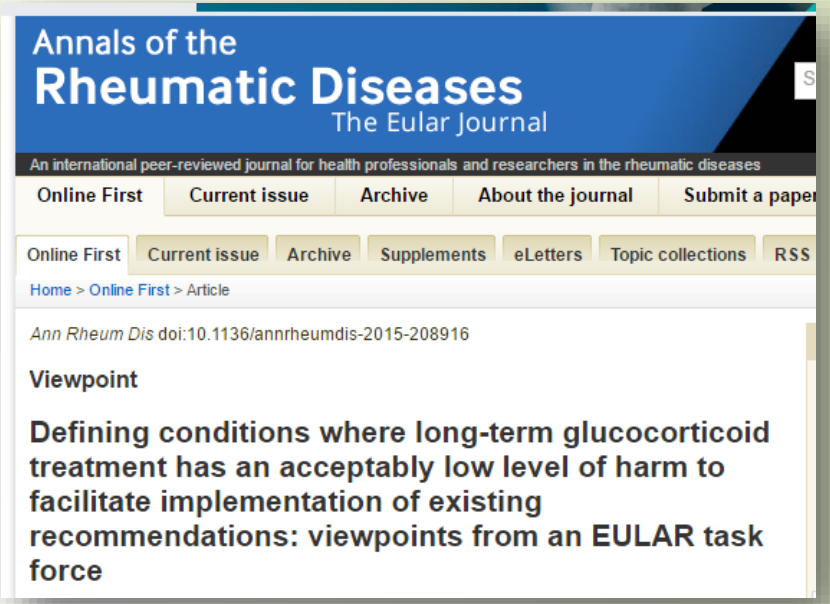
Ο κίνδυνος για πρόκληση «βλάβης»

- **Χαμηλός** για τους περισσότερους ασθενείς με μακροχρόνια χορήγηση σε δόση **≤5 mg prednisone** / day
  - Εξαίρεση : CVD
- Για δόσεις **>10 mg/day** ο κίνδυνος είναι **αυξημένος**
- Για δόσεις **>5 και ≤10** mg/day, ειδικά χαρακτηριστικά του ασθενούς -> καθορίζουν τον κίνδυνο



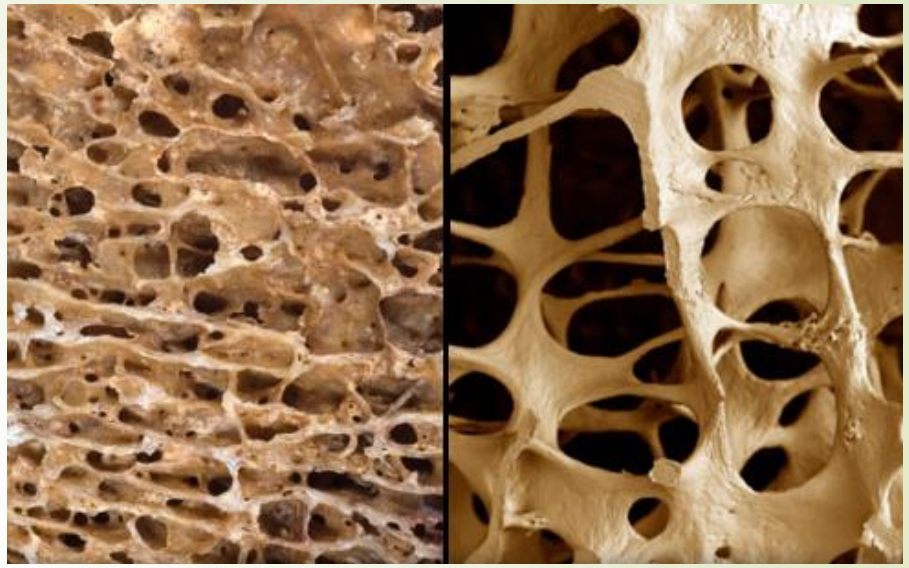
4 πιο **ανησυχητικές** ΑΕ των ΓΚ *(για όλες τις δόσεις)*

- Οστεοπόρωση
- Υπεργλυκαιμία
- CVD
- Λοιμώξεις



4 πιο ανησυχητικές ΑΕ των ΓΚ

οστεοπόρωση



- Ταχεία απώλεια BMD – ↑καταγματικός κίνδυνος
- Παράγοντες κινδύνου : ηλικία, χαμηλή BMI , Ηx κατάγματος ή ΟΠ , γυναικείο Φ

Fractures are the most **common serious** adverse event

It is the best of treatments, it is the worst of treatments: The continuing love hate relationship with glucocorticoids in RA
Tina D. Mahajan M.D., James R. O'Dell . 28 December 2016

Arthritis Care & Research
Vol. 62, No. 11, November 2010, pp 1515–1526
DOI 10.1002/acr.20295

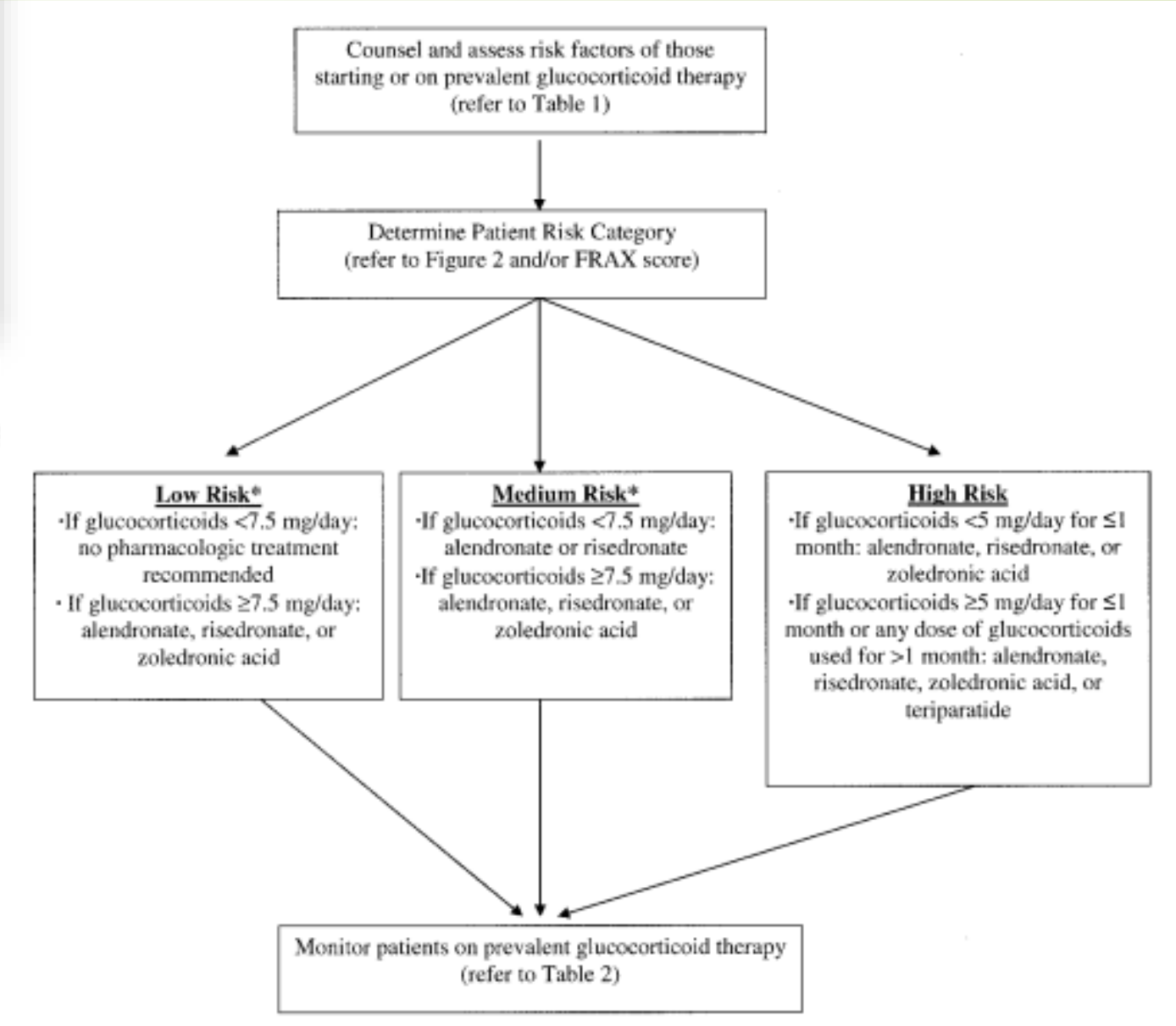
SPECIAL ARTICLE

American College of Rheumatology 2010 Recommendations for the Prevention and Treatment of Glucocorticoid-Induced Osteoporosis

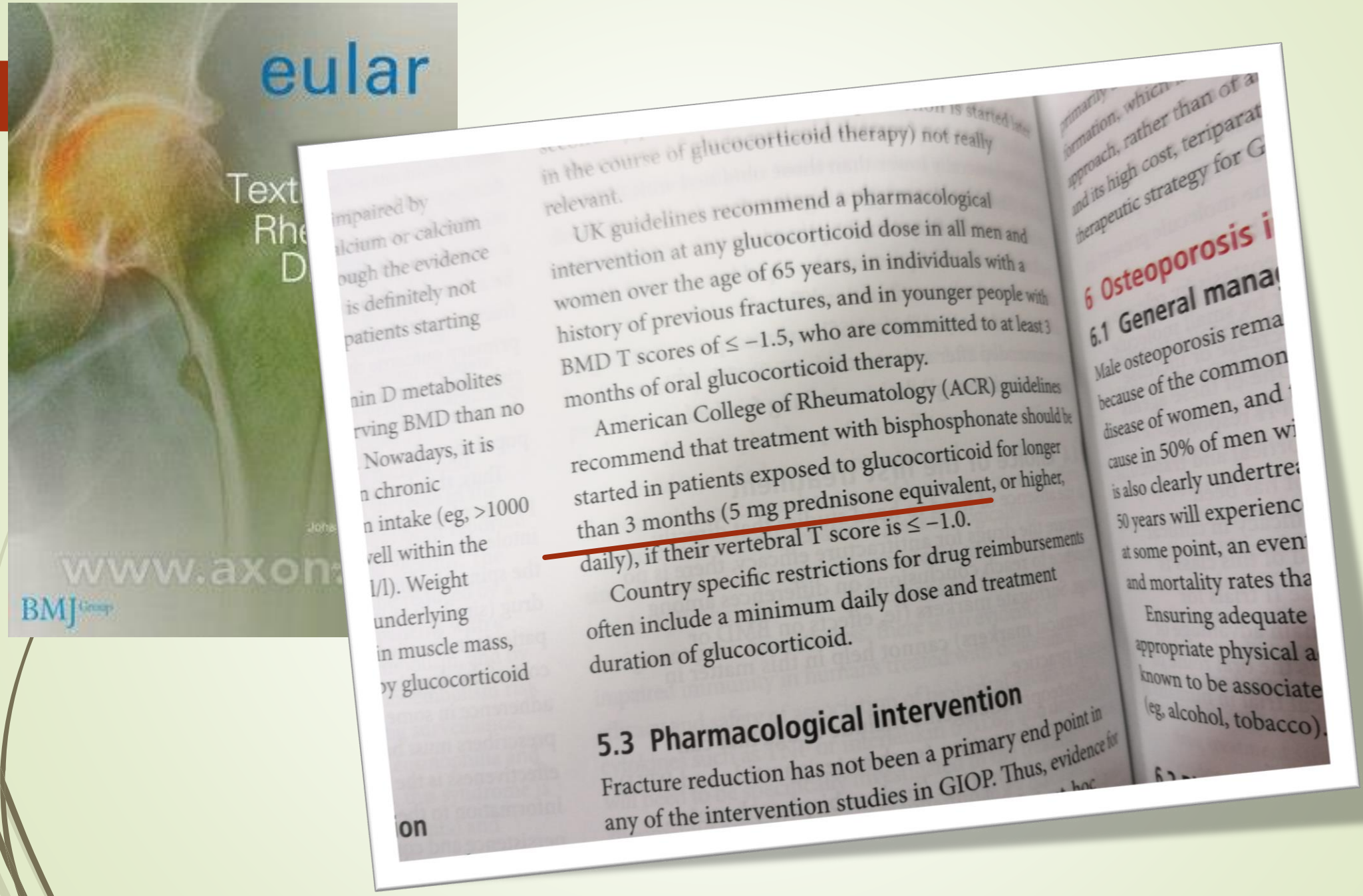
JENNIFER M. GROSSMAN,[1] REBECCA GORDON,[2] VEENA K. RANGANATH,[1] CHAD DEAL,[3] LIRON CAPLAN,[4] WEILING CHEN,[1] JEFFREY R. CURTIS,[5] DANIEL E. FURST,[1] MAUREEN McMAHON,[1] NIVEDITA M. PATKAR,[5] ELIZABETH VOLKMANN,[1] AND KENNETH G. SAAG[5]

Low risk: FRAX <10% for 10-year major osteoporotic fracture
Medium risk: FRAX 10---20% for 10-year major osteoporotic fracture
High risk: FRAX >20% for 10-year major osteoporotic fracture

Recommendations	Level of evidence
Low-risk patient	
Alendronate for ≥7.5 mg/day prednisone	A
OR	
Risedronate for ≥7.5 mg/day prednisone	A
OR	
Zoledronic acid for ≥7.5 mg/day prednisone*	B
Medium-risk patient	
Alendronate for any dose of glucocorticoids	A
OR	
Risedronate for any dose of glucocorticoids	A
OR	
Zoledronic acid for ≥7.5 mg/day prednisone*	B
High-risk patient†	
Alendronate	A
OR	
Risedronate	A
OR	
Zoledronic acid*	B
OR	
Teriparatide‡	B



Approach to postmenopausal women and men age **>50 years** initiating or receiving glucocorticoid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D
www.axon
BMJ Group
in the course of glucocorticoid therapy) not really
relevant.
UK guidelines recommend a pharmacological
intervention at any glucocorticoid dose in all men and
women over the age of 65 years, in individuals with a
history of previous fractures, and in younger people with
BMD T scores of ≤ −1.5, who are committed to at least 3
months of oral glucocorticoid therapy.
American College of Rheumatology (ACR) guidelines
recommend that treatment with bisphosphonate should be
started in patients exposed to glucocorticoid for longer
than 3 months (5 mg prednisone equivalent, or higher,
daily), if their vertebral T score is ≤ −1.0.
Country specific restrictions for drug reimbursements
often include a minimum daily dose and treatment
duration of glucocorticoid.
5.3 Pharmacological intervention
Fracture reduction has not been a primary end point in
any of the intervention studies in GIOP. Thus, evidence for
6 Osteoporosis i
6.1 General mana
Male osteoporosis rema
because of the common
disease of women, and
cause in 50% of men wi
is also clearly undertrea
50 years will experienc
at some point, an even
and mortality rates tha
Ensuring adequate
appropriate physical a
known to be associate
(eg, alcohol, tobacco).

4 πιο ανησυχητικές ΑΕ των ΓΚ
οστεοπόρωση

α) συνιστάται η χρήση **FRAX** για άνδρες και γυναίκες ηλικίας > 40 ετών (για δόσεις 2.5-7.5 mg/day η εκτίμηση κρίνεται ικανοποιητική)

β) για άτομα < 40 ετών, ασθενείς με Z score < -3 θεωρούνται πλέον μέτριου κινδύνου

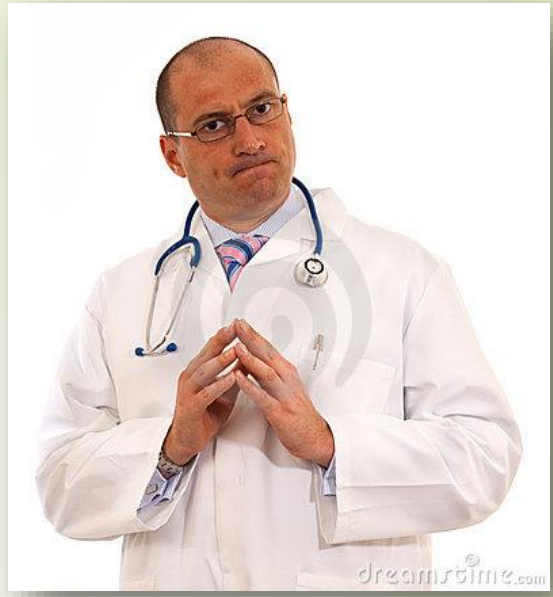
γ) η εκτίμηση κινδύνου πρέπει να γίνεται στους πρώτους 6 μήνες αγωγής και BMD εκτίμηση κάθε 2-3 χρόνια, σε όσους συνεχίζουν στεροειδή

δ) θεραπευτικά, αντιμετώπιση πρέπει να γίνεται με bisphosphonates, teriparatide και **denosumab**, ενώ

ε) ΟΛΟΙ οι ασθενείς θα πρέπει να λαμβάνουν **Ca & βιτ D3**, ανεξαρτήτως κινδύνου

ACR recommendations for glucocorticoid-induced osteoporosis unveiled. Publish date: November 18, 2016

ΚΑΠΟΙΟΣ ΔΕΝ ΚΑΝΕΙ ΣΩΣΤΑ ΤΗ ΔΟΥΛΕΙΑ ΤΟΥ



- Λιγότεροι από το 1/3 => **BMD** έλεγχος
- Λιγότεροι από το 1/3 : λήψη **calcium + vitamin D**
- Χορήγηση **bisphosphonate** είναι χαμηλή (ιδίως σε πιο νέες ηλικίες)

American College of Rheumatology 2010 recommendations for the prevention and treatment of glucocorticoid-induced osteoporosis. Grossman JM1, Gordon R, Ranganath VK, Deal C, Caplan L, Chen W, Curtis JR, Furst DE, McMahon M, Patkar NM, Volkmann E, Saag KG. Arthritis Care Res (Hoboken). 2010 Nov;62(11):1515-26

4 πιο ανησυχητικές ΑΕ των ΓΚ

Λοιμώξεις

- Παράγοντες κινδύνου : ηλικία (> 60) – άνδρες (γεν. πληθυσμό)
- Προσοχή : ΧΑΠ, ΧΝΑ, ΣΚΑ, ΣΔ, νευρολογικές διαταραχές
- ΗΧ λοιμώξεων
- Εμβολιασμός : influenza, pneumococci , herpes zoster

4 πιο ανησυχητικές ΑΕ των ΓΚ

Υπερ-γλυκαιμία

Εξέλιξη **ήδη** υπάρχουσας δυσ-ανοχής γλυκόζης

- Παράγοντες κινδύνου : γενετική προδιάθεση, ηλικία, ΣΒ
- Φλεγμονή
- Plaqeunil

4 πιο ανησυχητικές ΑΕ των ΓΚ

CVD

- Παράγοντες κινδύνου : Age, male sex, obesity, hypertension, diabetes , dyslipidaemia
- Φλεγμονή (RA: RF/CCP, εξωαρθρικές εκδηλώσεις)

Literature did **not** show
an increased risk for **hypertension** in patients
on **low-dose** GC treatment

FEATURE ARTICLE FREE

Osteonecrosis Following Short-term, Low-dose Oral Corticosteroids: A Population-based Study of 24 Million Patients

Matthew F. Dilisio, MD

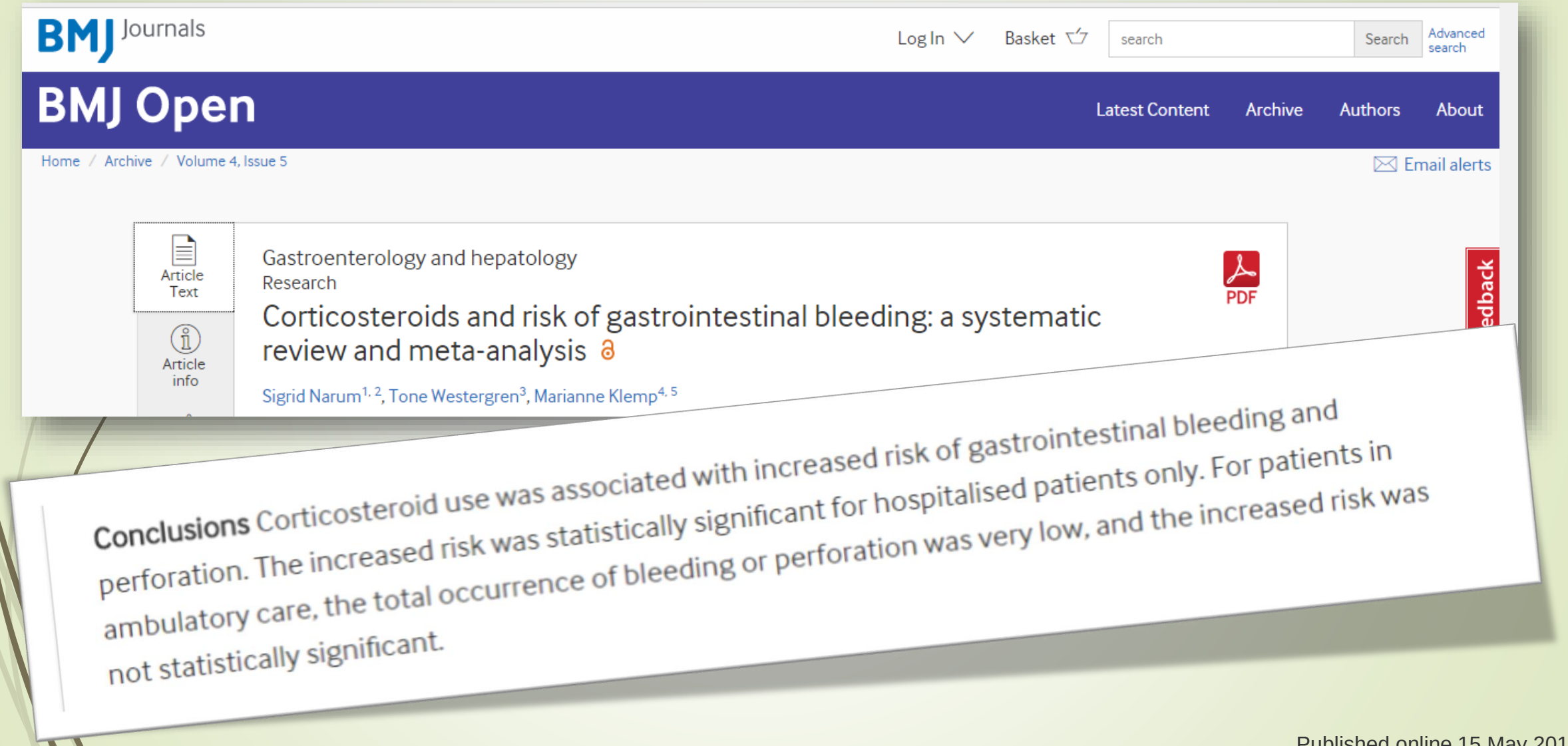
Orthopedics

July 2014 - Volume 37 · Issue 7: e631-e636

Posted July 1, 2014

DOI: 10.3928/01477447-20140626-54

Short-term, **low-dose** oral corticosteroid administration may be associated with a **low** but statistically **significant** increased incidence of osteonecrosis when compared with patients who have never been prescribed a steroid product.



Published online 15 May 2014.

Αποτελεσματικότητα CS RA *(τελευταία δεδομένα)*

218 με ΠΡΩΙΜΗ PA έγινε έναρξη με methotrexate + 10 mg prednisone (MTX+pred) ή placebo (MTX+plac) => **12 χρόνια** !

- **Λιγότεροι ξεκίνησαν bDMARD** στο σχήμα MTX+pred Vs MTX +plac strategy group: (31% vs 50%, p=0.003.)

- Στα 2 χρόνια : median **erosion score σημαντικά μικρότερο** στην ομάδα MTX+pred versus MTX+plac strategy group: (p=0.002)

Long-term outcome is better when a methotrexate-based treatment strategy is combined with 10 mg prednisone daily: follow-up after the second Computer-Assisted Management in Early Rheumatoid Arthritis trial. Safy M1, et al Ann Rheum Dis. 2017 Apr 27.

Ακτινολογική εξέλιξη στους 6 μήνες

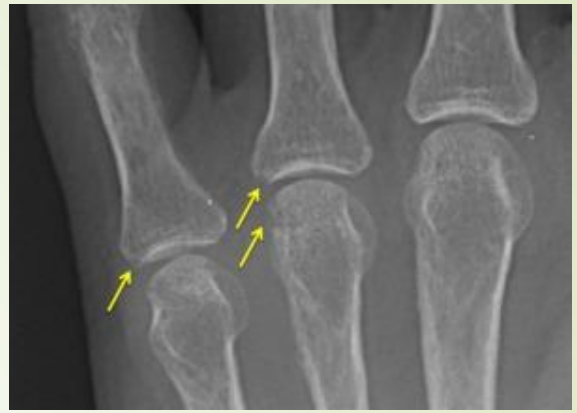


Table 2. Radiographic damage and 6-month progression in placebo groups of 3 biologics trials. Values are mean (SD) unless specified otherwise.

Variables	ATTRACT		ASPIRE		LITHE	
Baseline damage[†], mean (SD)/mean (range)	82.0 (77.0)		11.3 (15.9)		28.5 (0–190.5)	
Progression						
1 yr, trial report	7.0 (10.3)		3.7 (9.6)		1.1[‡]	
6 mos, interpolated	3.5 (6.2)		1.8 (4.8)		0.6	
6 mos, current dataset	4.8 (9.1)		2.4 (7.4)		0.5 (1.3)	
Glucocorticoid use	–	+	–	+	–	+
Baseline damage	92.5 (80.6)	80.6 (80.9)	11.6 (15.7)	10.3 (16.3)	25.3 (29.0)	31.0 (33.9)
Progression	7.7 (13.1)	2.9 (4.9)	3.2 (7.9)	0.9 (6.4)	0.5 (1.4)	0.5 (1.3)

Glucocorticoid Effect on Radiographic Progression in Placebo Arms of Rheumatoid Arthritis Biologics Trials

Maarten Boers, Daniel Aletaha, Christopher M. Mela, Daniel G. Baker, and Josef S. Smolen

ΣΥΜΠΕΡΑΣΜΑΤΑ

Η αγωγή με **ΓΚ έχει ευεργετική δράση στη α/α εξέλιξη ,** σε 2 /3 placebo-biologic arms of biologics trials

LITHE trial :

- overall low progression rate
- Genant score *: a lower maximum and a different handling of erosions*

ΔΕΝ ΕΙΝΑΙ Η ΜΟΝΗ ΜΕΛΕΤΗ !

- Kirwan JR and the Arthritis and Rheumatism Council Low-Dose Glucocorticoid Study Group. The effect of glucocorticoids on joint destruction in rheumatoid arthritis. The Arthritis and Rheumatism Council Low-Dose Glucocorticoid Study Group. N Engl J Med 1995;333:142-6. [MEDLINE]

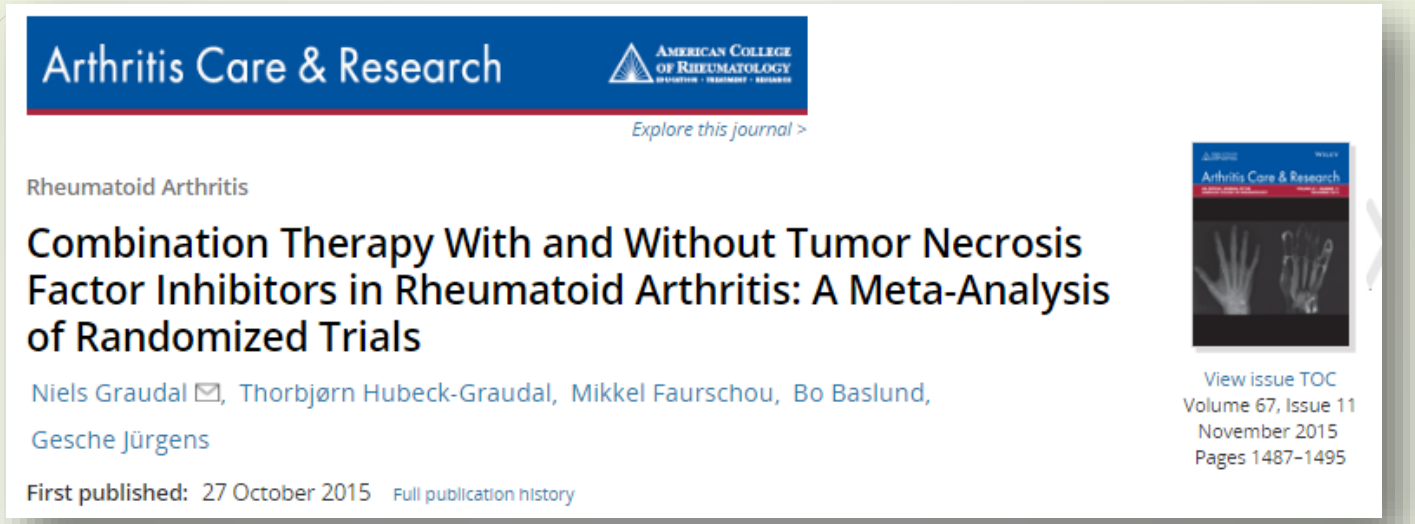
- Boers M, Verhoeven AC, Markusse HM, et al. Randomised comparison of combined step-down prednisolone, methotrexate and sulphasalazine with sulphasalazine alone in early rheumatoid arthritis. Lancet 1997;350:309-18. [MEDLINE]

- Dougados M, Combe B, Cantagrel A, et al. Combination therapy in early rheumatoid arthritis: a randomised, controlled, double blind 52 week clinical trial of sulphasalazine and methotrexate compared with the single components. Ann Rheum Dis 1999;58:220-5. [MEDLINE]

- Landewe RB, Boers M, Verhoeven AC, et al. COBRA combination therapy in patients with early rheumatoid arthritis: long term structural benefits of a brief intervention. Arthritis Rheum 2002;46:347-56. [MEDLINE]

- van Everdingen AA, Jacobs JWG, van Reesema DRS, Bijlsma JWJ. Low-dose prednisone therapy for patients with early active rheumatoid arthritis: clinical efficacy, disease-modifying properties, and side effects: a randomized, double-blind, placebo-controlled clinical trial. Ann Intern Med 2002;136:1-12. [MEDLINE]

ΙΣΧΥΡΑ ΔΕΔΟΜΕΝΑ



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Rheumatoid Arthritis

Combination Therapy With and Without Tumor Necrosis Factor Inhibitors in Rheumatoid Arthritis: A Meta-Analysis of Randomized Trials

Niels Graudal, Thorbjørn Hubeck-Graudal, Mikkel Faurschou, Bo Baslund, Gesche Jürgens

First published: 27 October 2015 Full publication history

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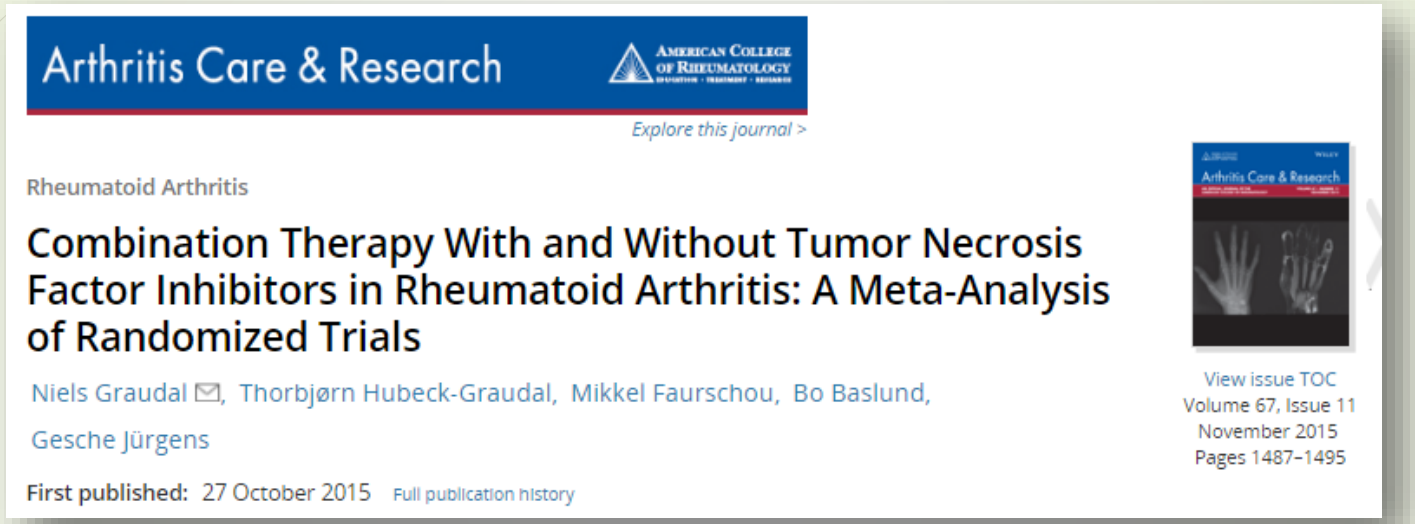
Volume 67, Issue 11
November 2015
Pages 1487–1495

Σημαντικές διαφορές , υπερ της TNFi αγωγής

- ακτινολογική εξέλιξη
- ACR50 & ACR70

Στους **6 μήνες** αγωγής

Βιολογικός Vs 3πλής συνδυαστικής αγωγής



ΟΜΩΣ

Οι διαφορές αυτές :

- **Δεν** φάνηκαν στους ασθενείς με **αρχική χορήγηση κορτικοστεροειδών**
- Εξαφανίστηκαν στους 24 μήνες, ανεξάρτητα της λήψης ΚΣ

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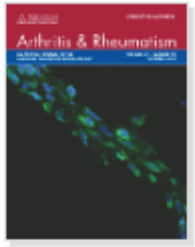
Rheumatoid Arthritis

Similar effects of disease-modifying antirheumatic drugs, glucocorticoids, and biologic agents on radiographic progression in rheumatoid arthritis: Meta-analysis of 70 randomized placebo-controlled or drug-controlled studies, including 112 comparisons



View issue TOC
Volume 62, Issue 10
October 2010
Pages 2852–2863

A direct comparison between the

combination of a biologic agent plus MTX

And

the combination of 2 DMARDs plus initial glucocorticoids

revealed

no difference

- 15 μελέτες /1.414 ασθενείς

- Κυρίως πρώιμη RA (μέχρι 2 χρόνια) / επιπρόσθετα DMARD

The standardised mean difference στην α/α εξέλιξη ήταν 0.40 υπερ glucocorticoids (95% CI 0.27, 0.54) vs placebo

Η ευεργετική δράση : Σε συνδυασμό με DMARD

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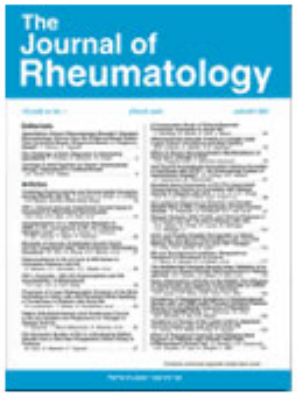

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Editorial

All Patients with Rheumatoid Arthritis Should Receive Corticosteroids as Part of Their Management

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http://www.jrheum.com/subscribers/07/04/656.html

- ο κίνδυνος για λέμφωμα είναι **αυξημένος στην PA** (*HR 1.6 (95% confidence interval [95% CI] 1.2–2.1)* / συσχέτιση με ενεργότητα

- ο κίνδυνος αυτός **δεν** φαίνεται να έχει αλλάξει στη διάρκεια του χρόνου

- η χορήγηση **κορτικοστεροειδών τον πρώτο χρόνο σχετίστηκε με μείωση** του κινδύνου (HR 0.5 [95% CI 0.3–0.9])

First published: 29 March 2017

γλυκοκορτικοειδη στην ΡΑ

ΣΥΜΠΕΡΑΣΜΑΤΑ

Τοξικότητα των ΓΚ

- Ηλικία
- ΣΒ
- δόση
- Διάρκεια θεραπείας

Οι μικρότερες δόσεις για το μκρότερο χρονικό διάστημα

Ο φόβος των ΑΕ των μεγάλων δόσεων έχει «επεκταθεί» και στις μικρές

It is the best of treatments, it is the worst of treatments: The continuing love hate relationship with glucocorticoids in RA. Tina D. Mahajan M.D.1, andJames R. O'Dell M.D.2 Arthritis Care & Research. DOI: 10.1002/acr.23184*

γλυκοκορτικοειδη στην PA

ΣΥΜΠΕΡΑΣΜΑΤΑ

- Η μακροχρόνια χορήγηση ΜΙΚΡΩΝ δόσεων CS φαίνεται ΠΛΕΟΝ να είναι ασφαλής

- Ίσως είναι λάθος να ΜΗ δώσει κανείς , τουλάχιστον στην αρχή (PA)

Είναι βέβαιο
ότι θα βοηθήσει

Είναι απίθανο
ότι θα βλάψει

γλυκοκορτικοειδη στην PA

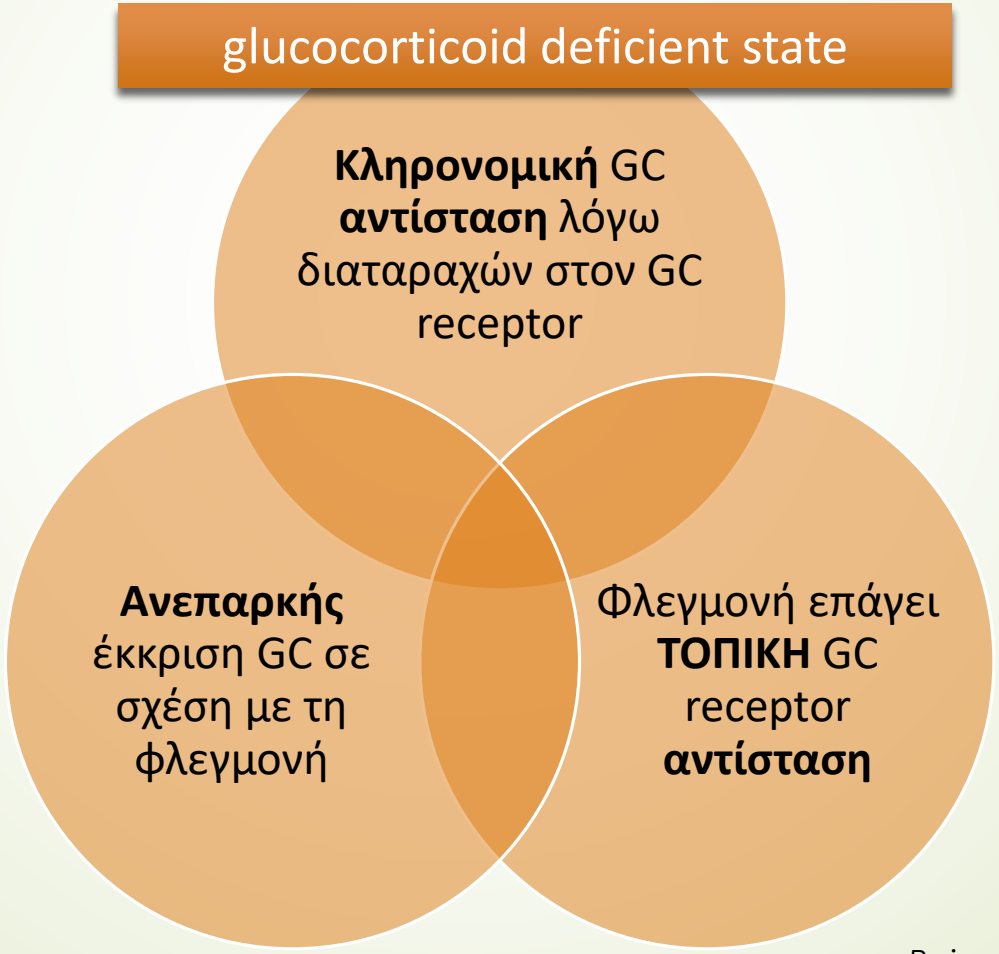
ΣΥΜΠΕΡΑΣΜΑΤΑ

Κατά τη διάρκεια αντιμετώπισης της RA, ο κίνδυνος για ΑΕ από τα GC μπορεί να **ελαχιστοποιηθεί** :

- Ακολουθεί τις συστάσεις
- Εξατομίκευση ασθενούς : παρουσία ή απουσία συγκεκριμένων παραγόντων κινδύνου

*Buttgereit F, Bijlsma JW Glucocorticoids in rheumatoid arthritis: the picture is shaping up Annals of the Rheumatic Diseases Published Online First: **04 May 2017**.*

ΤΑ ΝΟΣΗΜΑΤΑ ΑΥΤΑ….ΧΡΕΙΑΖΟΝΤΑΙ ΚΟΡΤΙΖΟΝΗ !



Rainer H Straub, Arthritis Res Ther. 2014; 16(Suppl 2): I1.


Ιωάννινα