Rheumatology Update

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Agenda

- Case presentation by MW
- Top tips on gout and osteoporosis
- GCA protocol
- Q&A

Case presentation (1)

- BACKGROUND
-
- 28 year old man
- Usually fit and well
- Keen runner
-
- PMH
- Hiatus hernia
- Gastric ulcer
-
- DH
- Omeprazole
- no OTC meds
-
- SH
- - No alcohol, smoking or drugs

Case presentation (2)

- Symptoms

- Pains
- shoulders
- forearms
- dorsum hands
- thumb bases
- shins

- Some recent stress but not overly significant

- Denies:
- any joint swellings
- skin problems
- eye problems
- cardiac symptoms
- respiratory symptoms
- snoring or sleep apnoea

Case presentation (3)

- Investigations

- Bloods NAD by GP
- FIT test positive secondary to recent anal pain – CT and colonoscopy NAD

- Further Investigations with me
- FBC – neuts 1.5 (isolated)
- usual bloods
- auto-antibody screen negative
- Rheum factor negative

Case presentation (4)

- Post bloods review:
- Symptoms largely settled so agreed in absence of any significant findings to monitor and repeat FBC with GP in 3-4 weeks.
- 9 months later returns with ongoing symptoms + muscle twitching (able to feel)
- Now seen Rheumatologist and Neurologist - no answers from either.

Case presentation (5)

- Additional results from specialists (negative)

- thyroid, renal, liver, Vit d, b12, ccp, crp, immunoglobulins, various neuro/muscle antibodies, IGF-1, bone profile ……
- NCS normal
- – EMG – some fasciculations noted ? benign ?? peripheral nerve hyperexcitability disorder
- – Isotope bone scan NAD
- MRI body – no myositis

- Additional results (positive)

- CK 407 – 1312 (3 days abstaining exercise)
- HLA B27 + (no symptoms to suggest AS)

Case presentation (6)

- Other Ix to be considered

- PTH (Ca normal, vit D normal but on supplement, no phosphate)
- Mg, phosphate
- Repeat CK after 7 days abstaining exercise ? significance
- Lyme's disease

Discussion on case – Dr Fernandes

- Initial investigation of myalgia
- What was appropriate to be done by primary care
- What we would expect to happen in secondary care
- Other differentials to consider
- Any specialist services/clinics for these kind of patients?

Top tips (1)

- Gout
  - Common errors made in primary care
    - Diagnosis and ongoing monitoring/management
  - Options on management of difficult cases
  - When to refer to secondary care

Top tips (2)

- Osteoporosis
  - Thoughts on the different risk calculators available in primary care
  - Summary of when to request DEXA scans and when we can start treatment without access to DEXA, particularly in view of covid-19
  - Thoughts on referral patterns for DEXA scans – ?any that aren't felt to be necessary?
  - Overview of treatment options
    - Calcium/Vit D supplementation
    - Bisphosphonates
    - When to refer

Top tips (3)

- GCA

Diagnostic Criteria – American College Rheumatology

Presence of 3 or more symptoms yields sensitivity 93.5% and specificity 91.2%:

1. > 50 years old.
2. New onset headache.
3. Temporal artery abnormality (e.g. thickened/beaded, reduced/absent pulse, tenderness).
4. ESR > 50 mm/hr (Westergren method).
5. Abnormal arterial biopsy demonstrating a necrotizing vasculitis with predominance of

mononuclear cells and granulomatous inflammation.

Top tips (4)

Management If A Diagnosis of GCA Has Been Made[2-5] - ALL PATIENTS

Investigations (should be done/requested immediately)

1. Observations - BP, pulse, weight (if patient unsure).
2. Bloods - CRP, ESR, FBC, LFTs, U&Es, blood glucose, HbA1c.
3. Imaging – CXR.

Basic Management (should be started immediately)

1. PO Adcal D3 (or equivalent) once tablet daily – continue whilst on steroids.
2. PO Lansoprazole 30mg (or equivalent) once daily – continue whilst on steroids.
3. Consider starting PO Aspirin 75mg once daily if no contraindications.
4. Follow glycaemic management (see attached) as per Trust guidelines.

Referrals (should occur immediately in ALL cases)

1. Urgent letter faxed to Rheumatology (– call Calderdale Royal Hospital (CRH) Rheumatology secretaries to confirm receipt.

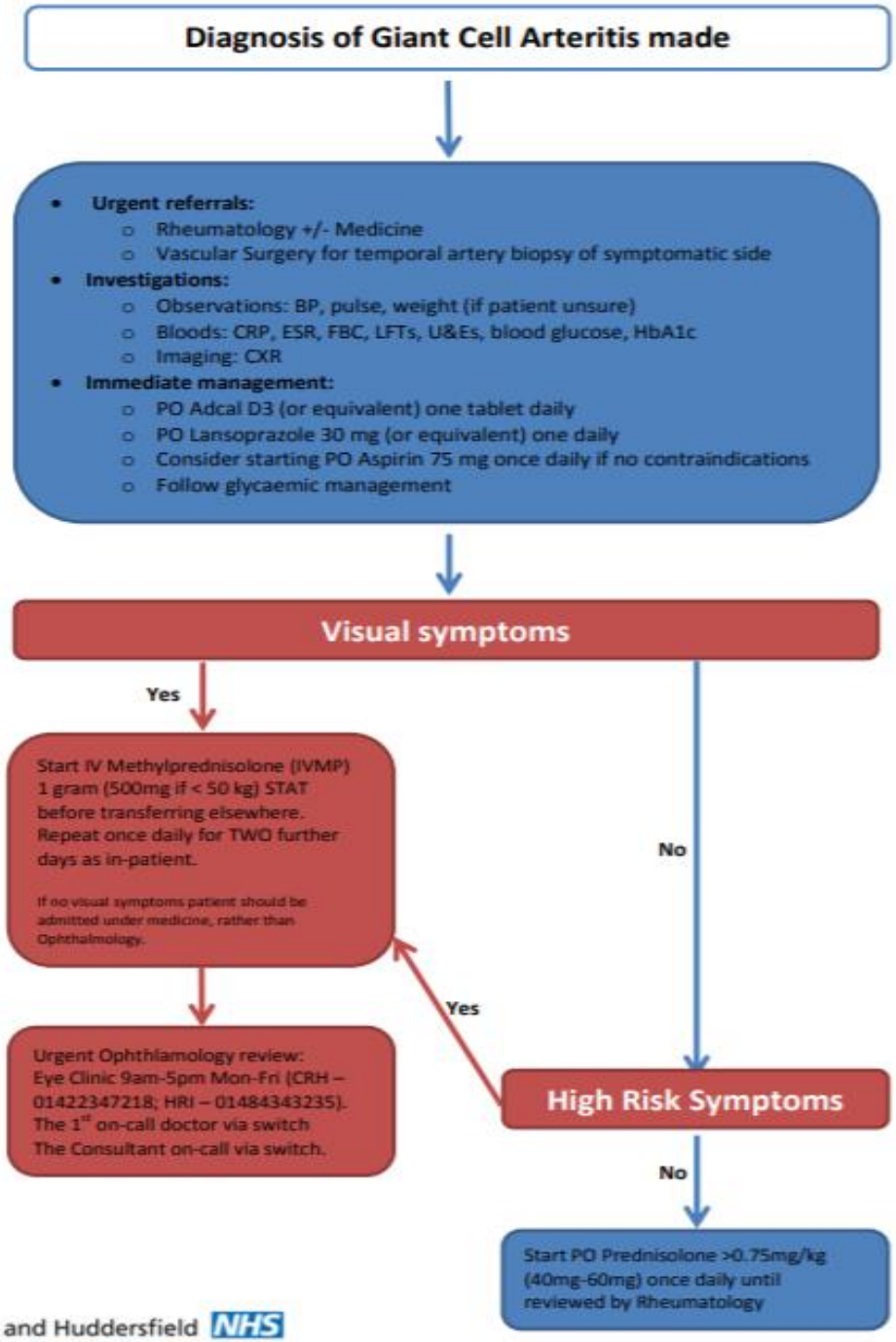
AND

2. Urgently referral faxed to Vascular Surgery for temporal artery biopsy of symptomatic side (TAB) – form available later in this document.

Steroids (start immediately)

If no high risk symptoms AND no visual symptoms:

1. Start PO Prednisolone 0.75 mg/kg (minimum 40mg, maximum of 60mg) once daily (without delay). This should continue until reviewed by Rheumatology.



Calderdale and Huddersfield NHS
NHS Foundation Trust

Referral Form to Vascular Surgery for Temporal Artery Biopsy
(for inpatient and outpatient use)

Patient Sticker		Date & Time of Referral:	
		Referring Doctor:	
		Consultant:	
Patient contact number:		Copy Histology results to:	
Type of Transport, if Required?			
This procedure is carried out using Local Anaesthestic. Is the patient suitable?			
Please tick:			
Anticoagulant			
If yes, which one:			
Antiplatelet			
If yes, which one:			
Steroid			
If yes, date started:			
Co-morbidities			
Allergies			
If yes, please state:			
Infection risk			
If yes, please state:			
Which side is the biopsy to be performed	Left	Right	

For Hospital Use:

Appointment on: at:

Please send completed form to Email VascularSecs.HRI@cht.nhs.uk or Fax Number 01484 347218

If you need to speak to someone please call the Secretary on 01484 355415 or 01484 342481

Should there be any complex issues or concerns then please contact the secretaries or Vascular Surgery Team directly on the above numbers

Q&A