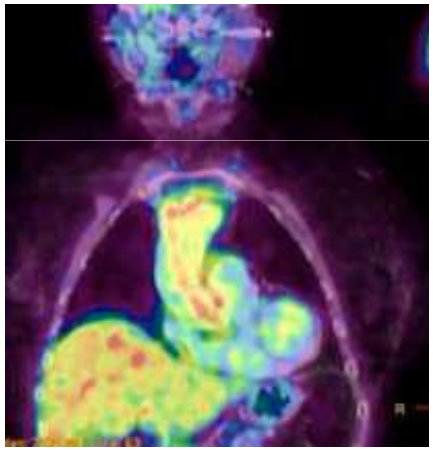
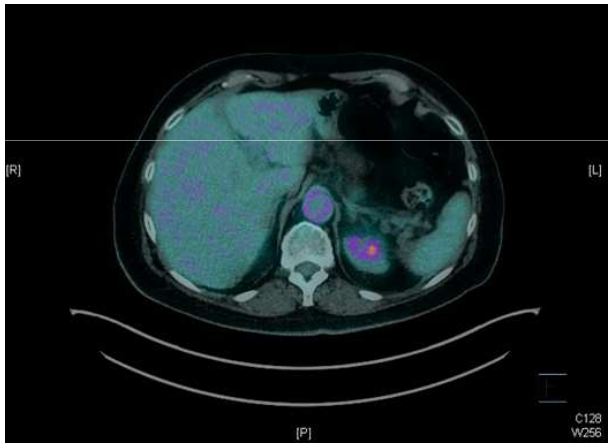
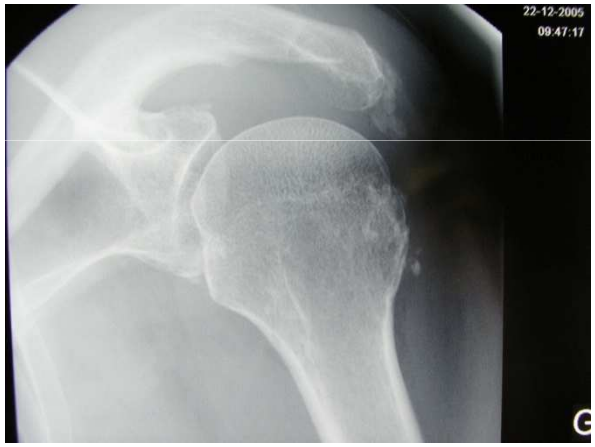
La PPR en 2016







A Saraux, CHU Brest

Cas clinique

- Femme 61 ans
- Douleur inflammatoire des ceintures
- Vague gêne de la région temporale
- Vous faites une CRP qui est élevée
- A peur d'avoir un cancer…..

Quel diagnostic évoquez vous?

Quelle comorbidité recherchez vous?

Quels examens faites vous?

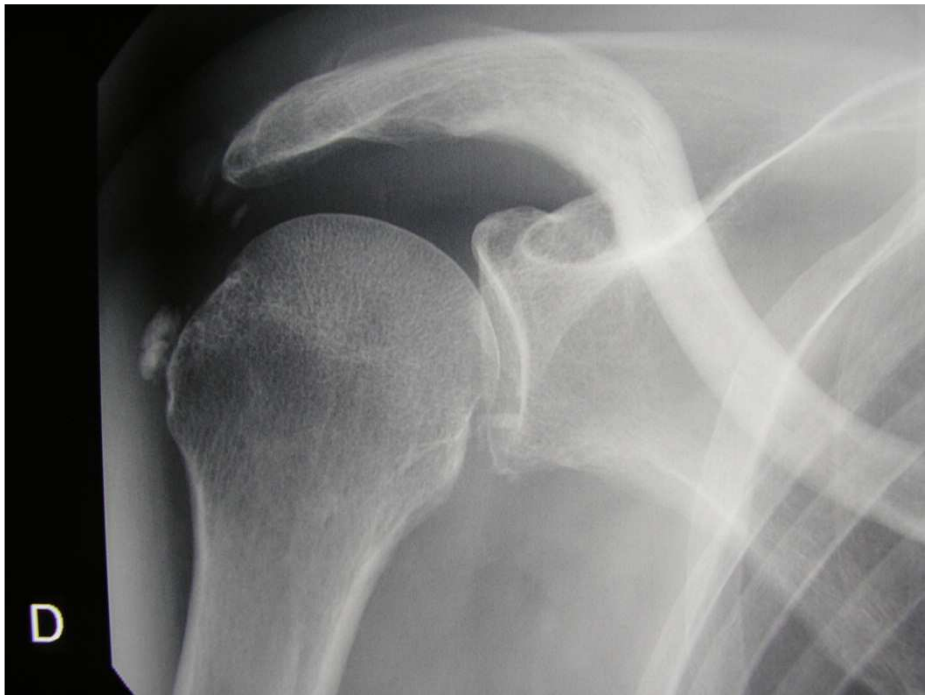
Quels traitements proposez vous?

Des critères de classification actualisés
Critères ACR/EULAR

age≥ 50 years, douleur d'épaule bilatérale, et VS ou CRP

	Points sans échographie (4)	**Points avec échographie (5)**
Raideur matinale > 45 min	2	2
Douleur des hanches ou limitation de la mobilité	1	1
Absence de facteurs rhumatoïdes ou d'anticorps anti CCP	2	2
Absence d'autre atteinte articulaire	1	1
Atteinte d'au moins une épaule avec bursite deltoïdienne et/ou ténosynovite du long biceps et/ou synovite gléno-humérale ou d'au moins une hanche avec synovite ou ténosynovite trochantérienne	NA	1
Atteinte des 2 épaules avec bursite deltoïdienne, ténosynovite du long biceps ou synovite gléno-humérale	NA	1

Dejaco C et al. Ann Rheum Dis. 2015 Oct;74(10):1799-807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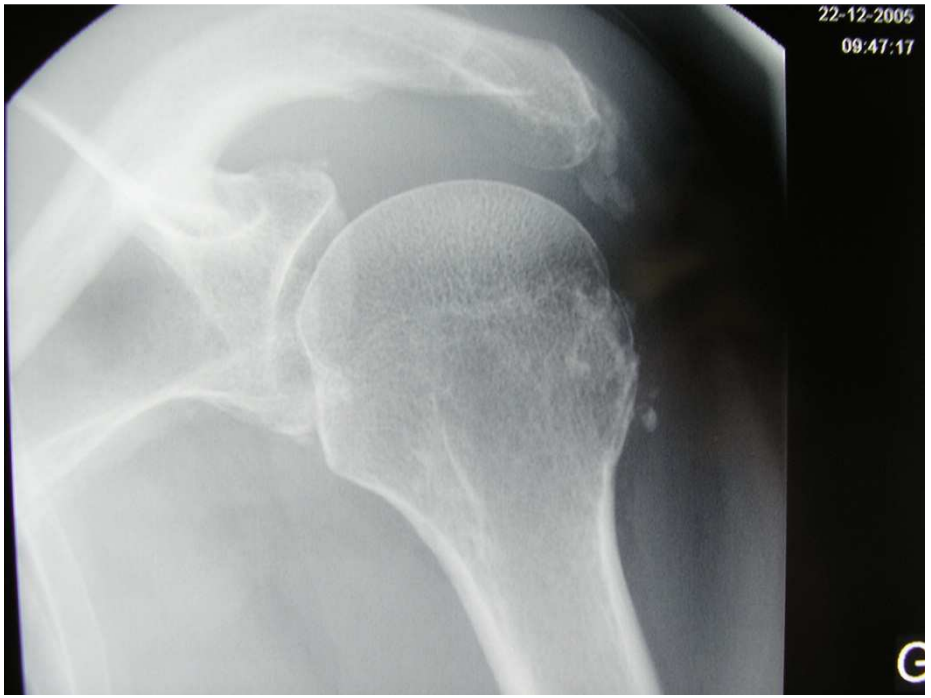
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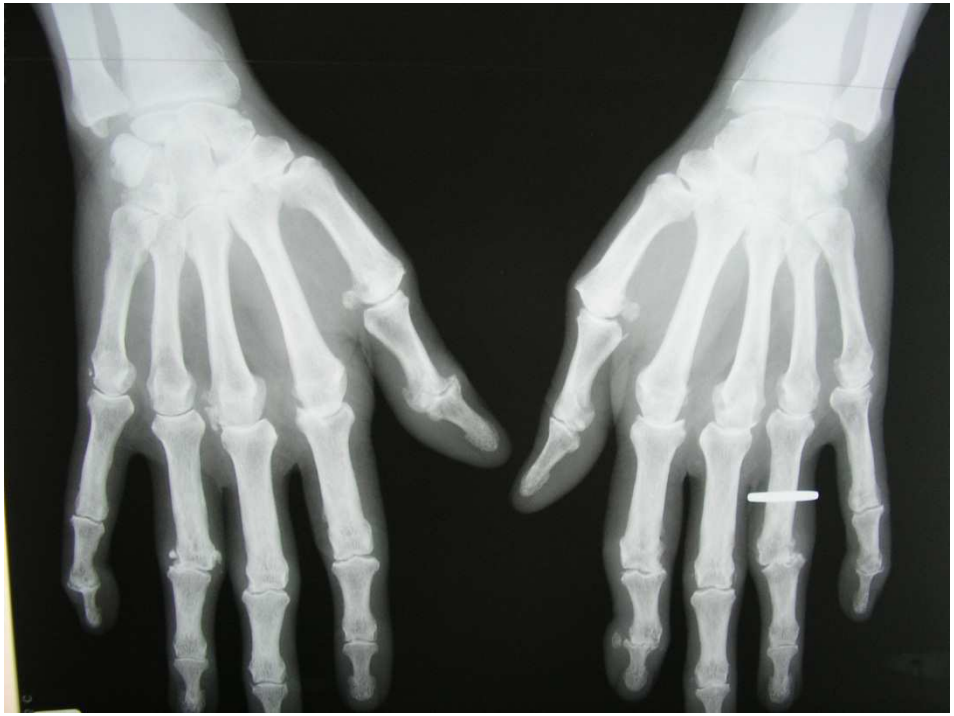

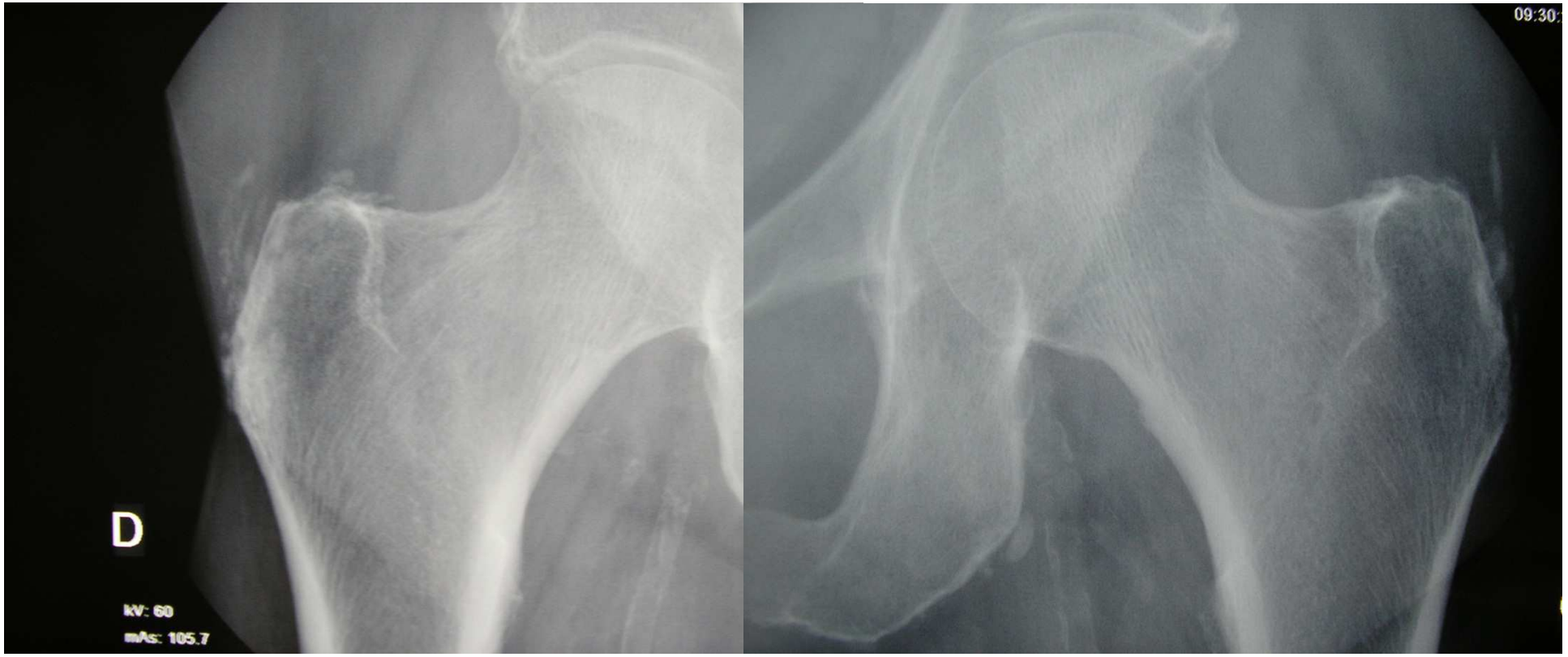
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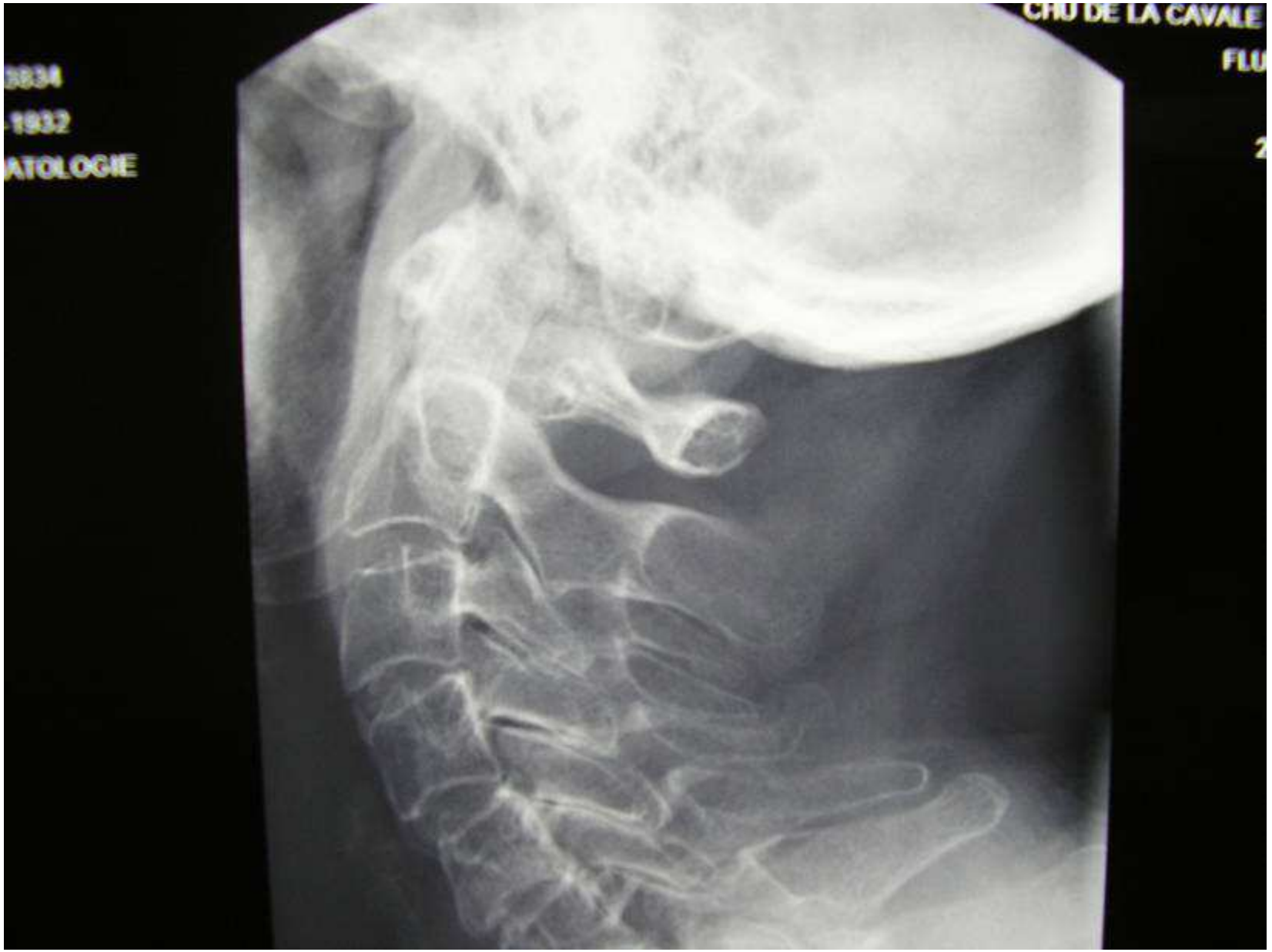
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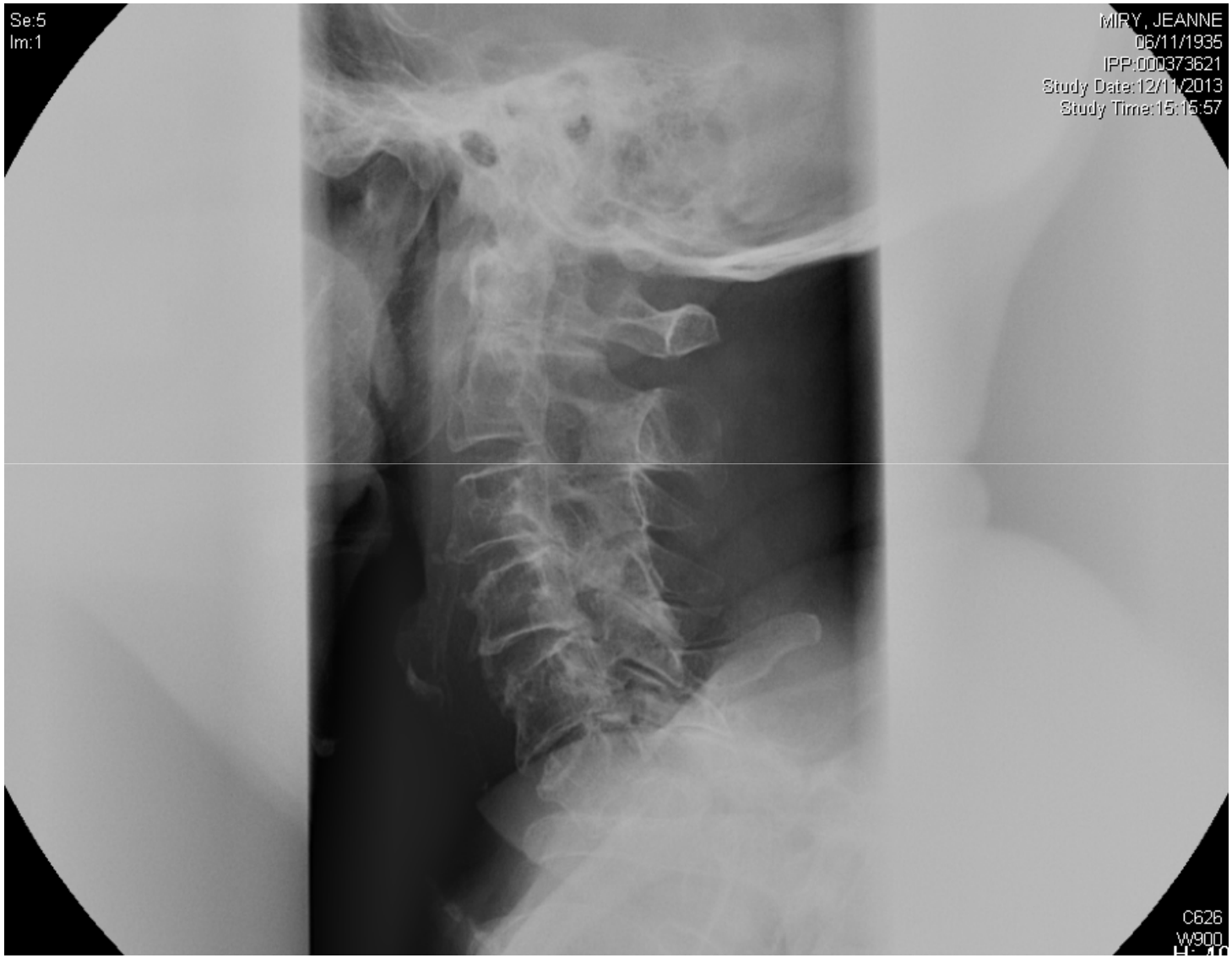
FLU
ATOLOGIE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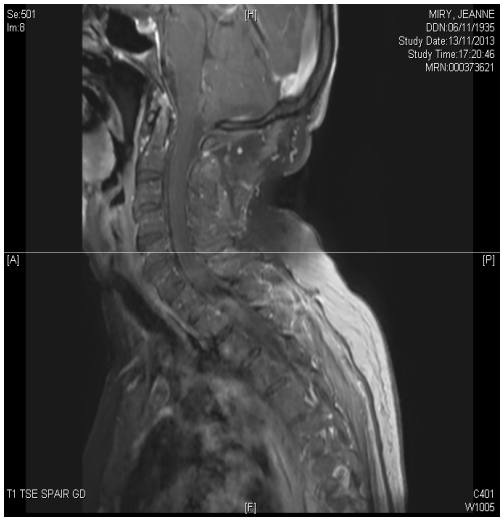
W900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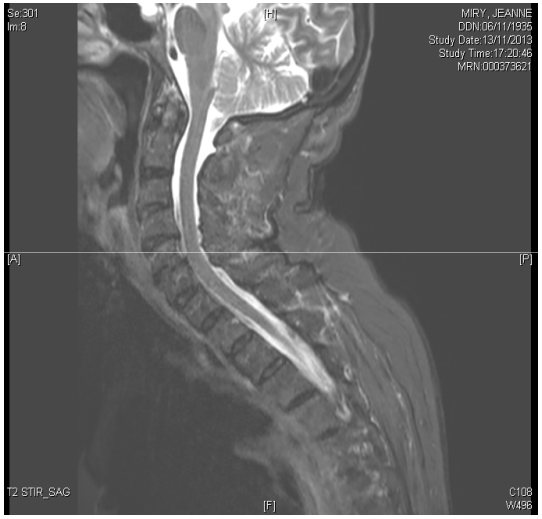
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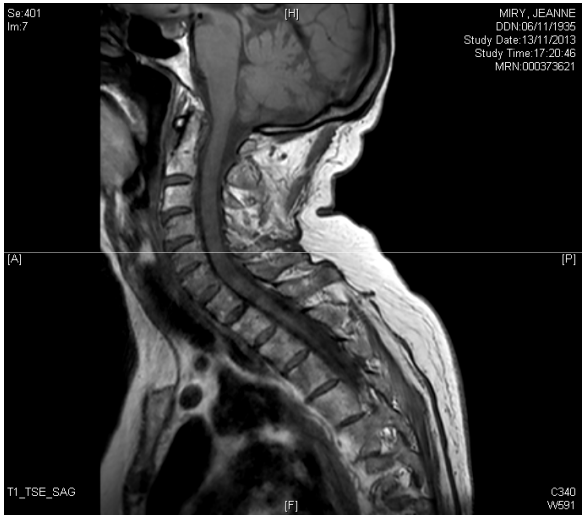
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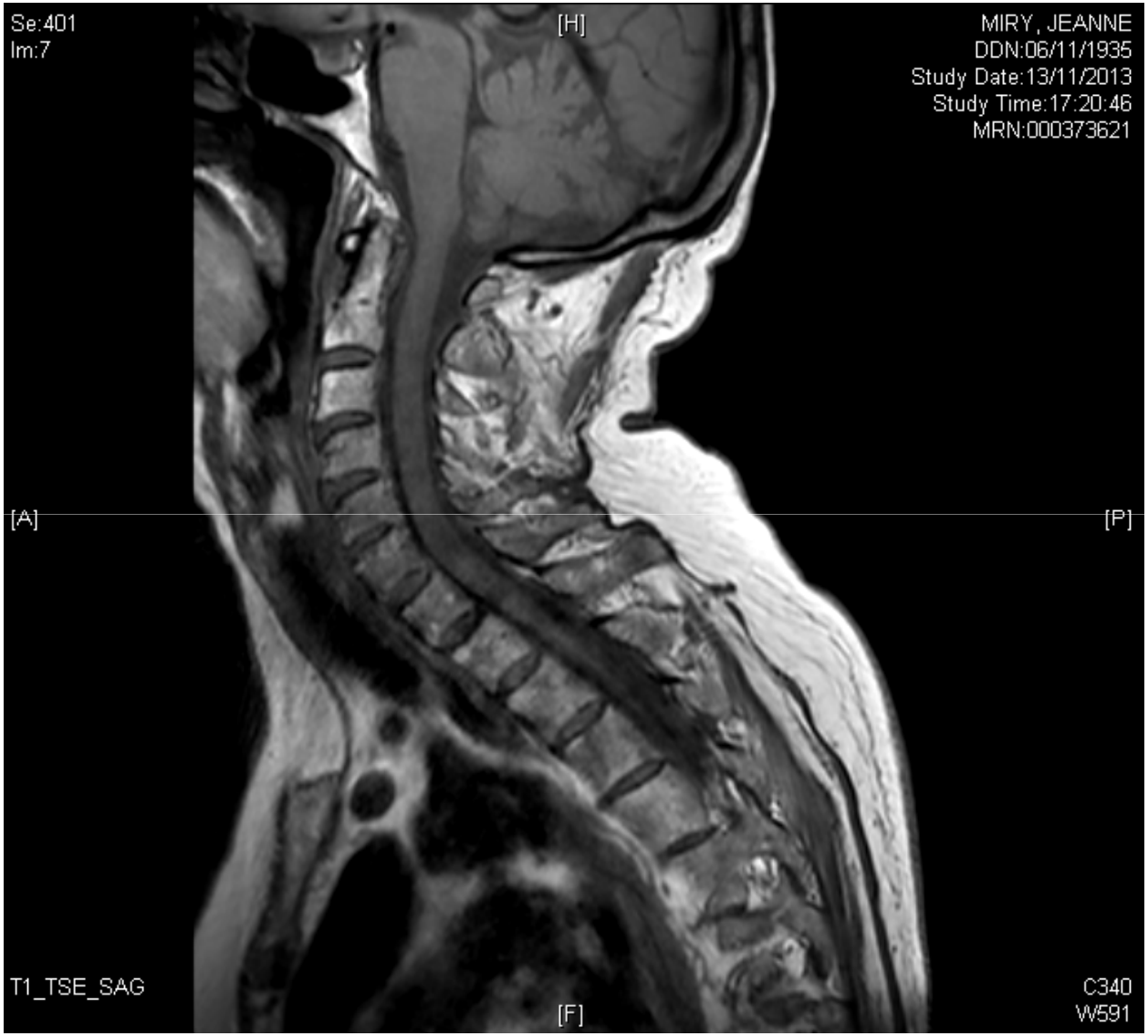
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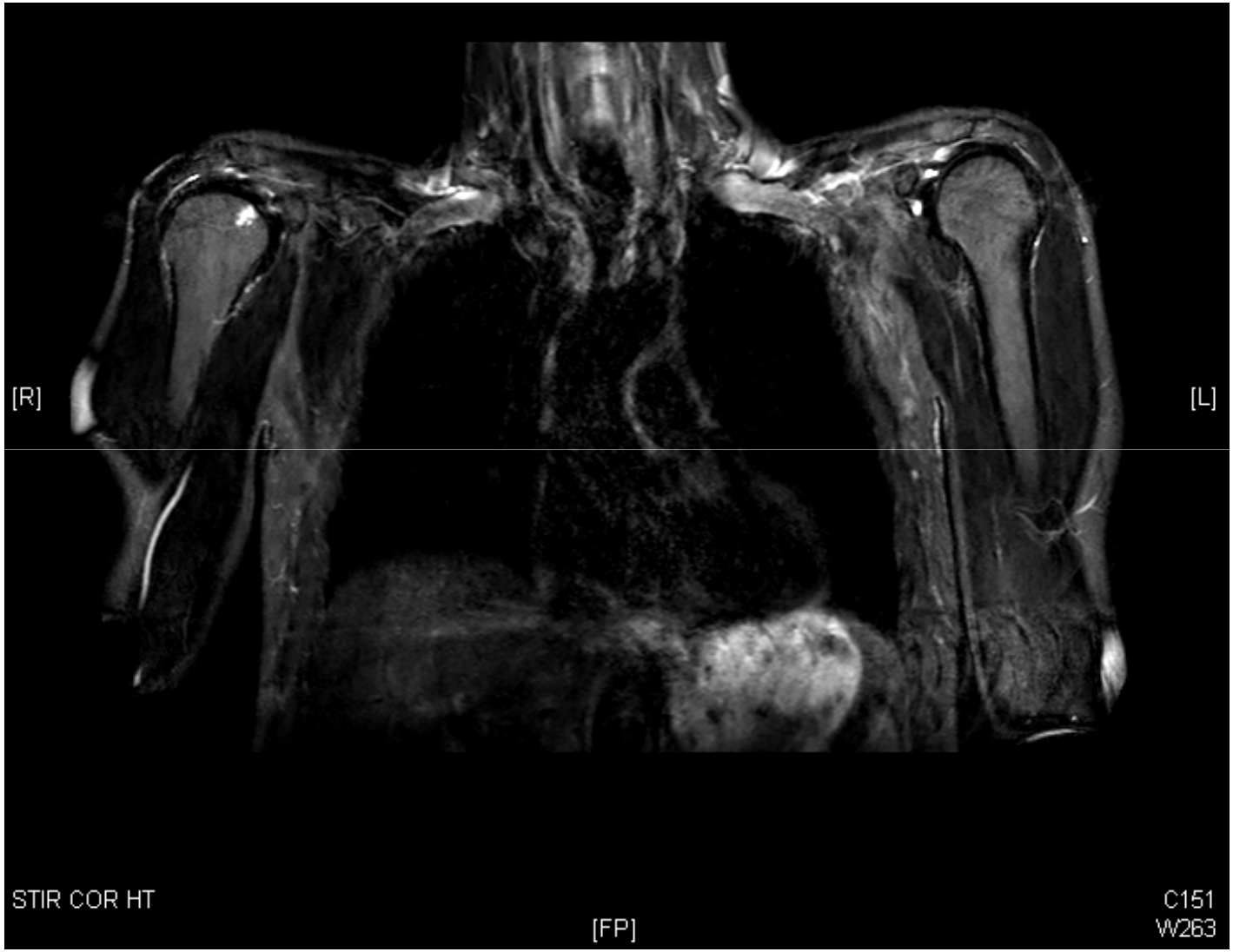
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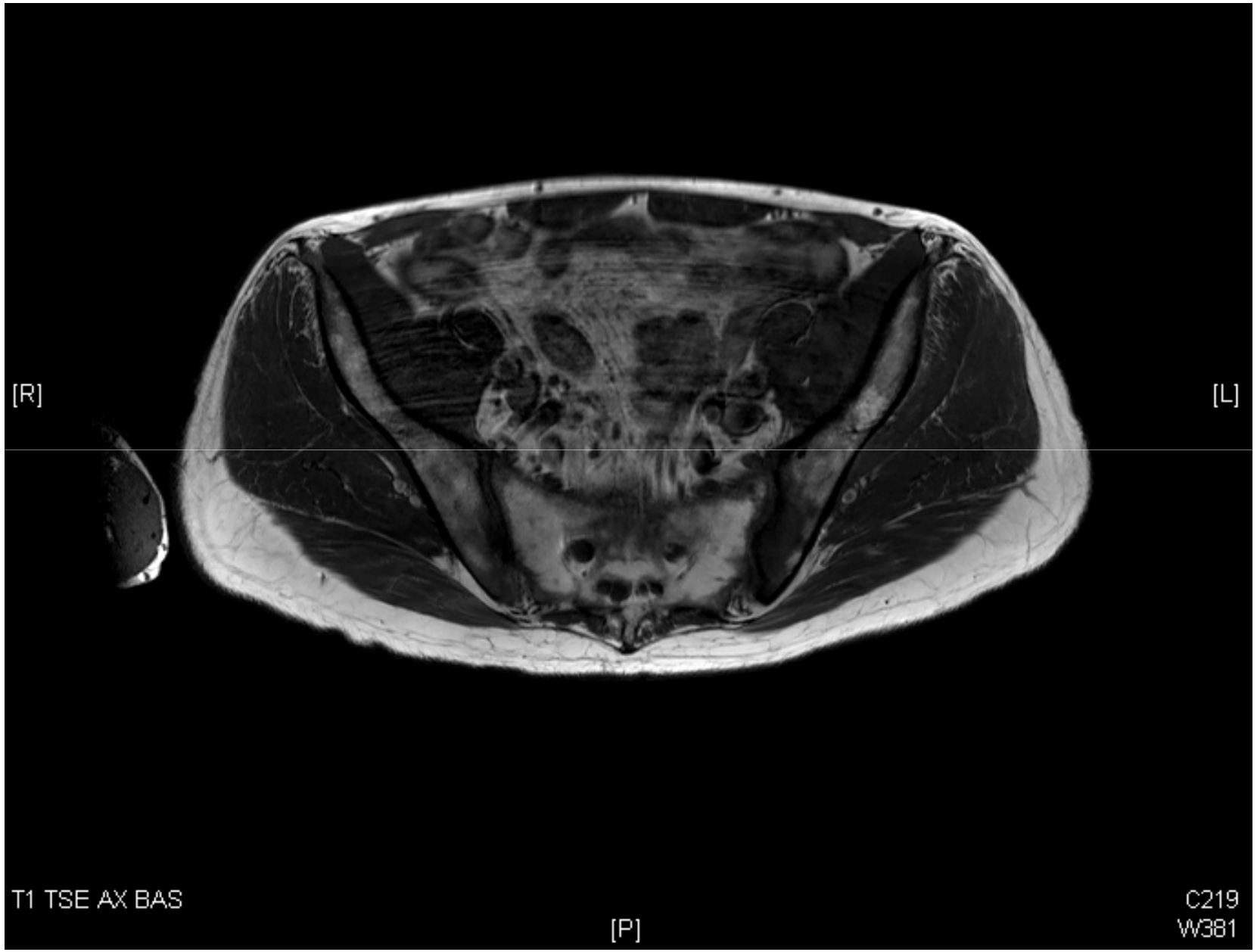
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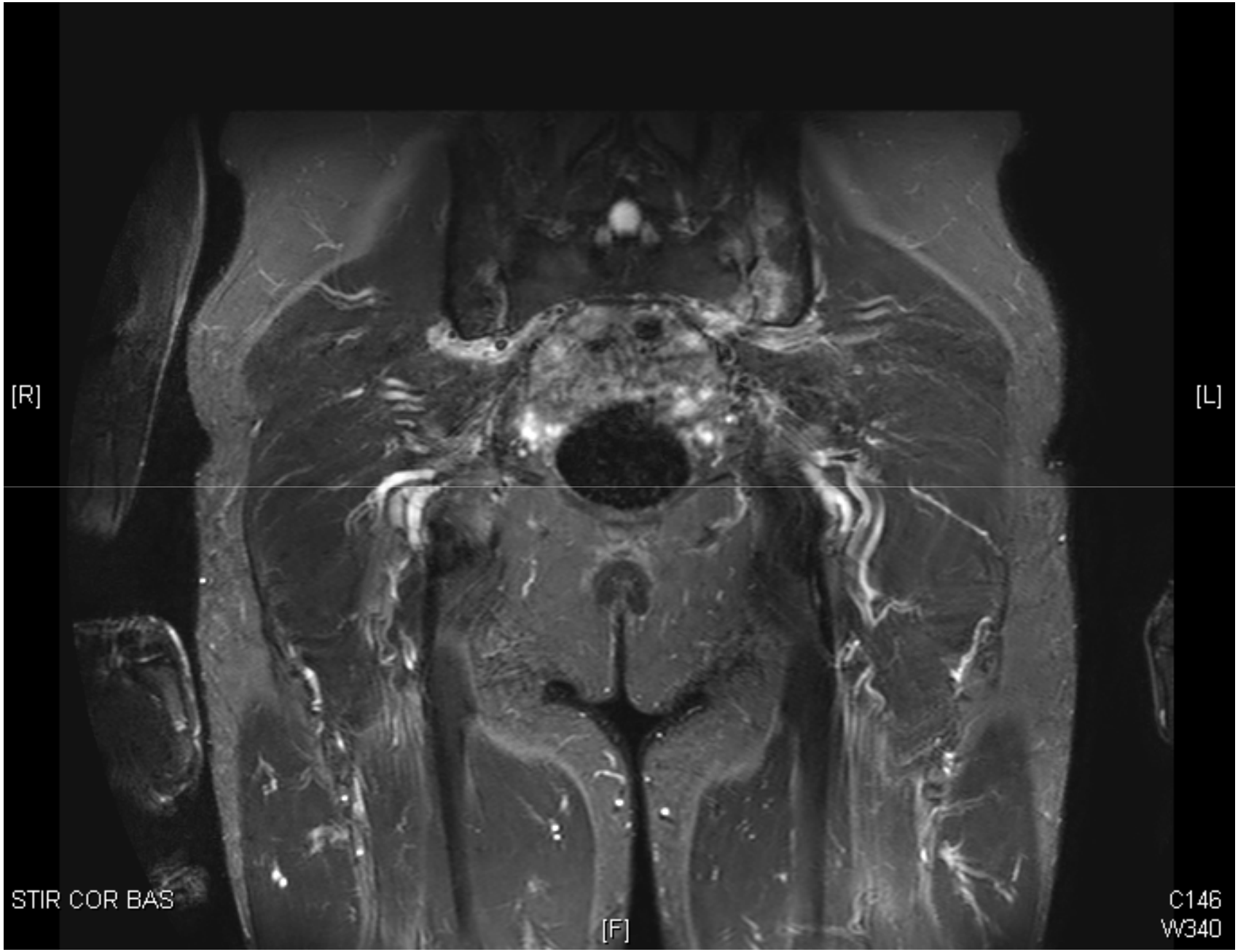
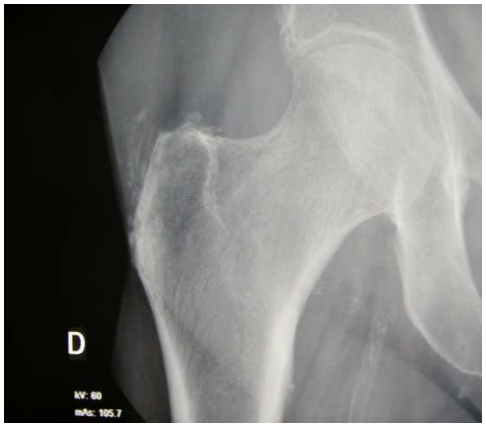
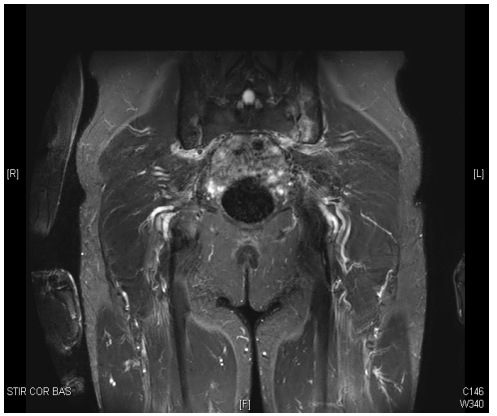

[R]
[L]
STIR COR BAS
[F]
C146
W340

Des diagnostics différentiels

- Rhumatismes inflammatoires microcristallins et primitifs
  - Chondrocalcinose
  - Hydroxyapatite
  - Spondyloarthrite
  - Polyarthrite rhumatoïde
- Mais éventuellement, surtout si signes associés:
  - Polymyosite, Connectivites
  - Paranéoplasique (myélodysplasie)
  - néoplasique (myélome, lymphome…)
  - Infection
  - Médicamenteux (rare, ex ipilimumab)
- Et si pas de syndrome inflammatoire
  - Mécanique (« fibromyalgie », arthrose, coiffe, capsulite…)
  - Parkinson, myélome, hypothyroïdie





In the Clinic®

Polymyalgia Rheumatica

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Annals of Internal Medicine®

Differential Diagnosis of Polymyalgia Rheumatica

- Inflammatory arthritis, myositis, vasculitis
- Elderly-onset rheumatoid arthritis
- Spondyloarthropathy
- Vasculitis (giant cell arteritis; antineutrophil cytoplasmic antibody–associated vasculitis, including microscopic polyangiitis and granulomatous polyangiitis)
- Inflammatory myopathies (dermatomyositis, polymyositis)
- Crystalline arthritis (gout, calcium pyrophosphate dihydrate deposition disease)
- Noninflammatory musculoskeletal disorders
- Rotator cuff disease
- Adhesive capsulitis
- Degenerative joint disease of the glenohumeral joint
- Fibromyalgia
- Endocrinopathies
- Thyroid diseases
- Disorders of the parathyroid gland
- Infection
- Viral syndromes, such as parvovirus B19, hepatitis B, HIV
- Bacterial infections, such as endocarditis or disk space infection
- Mycobacterial infections, such as tuberculosis
- Cancer
- Other
  - Parkinsonism
  - Depression
  - Vitamin D deficiency
  - Drug-induced myopathy, such as from statins

Polymyalgia Rheumatica

Table 2. **Clinical Features of Polymyalgia Rheumatica and Giant Cell Arteritis***

Sign/Symptom	*Polymyalgia Rheumatica*	*Cranial Giant Cell Arteritis*	*Large Vessel Giant Cell Arteritis*
Polymyalgia symptoms of shoulder and hip; neck stiffness	++	+	++
Elevated CRP/ESR	++	++	++
Peripheral arthritis/RS3PE syndrome	++	+	+
Wasting syndrome (fever, anorexia, weight loss, night sweats, depression)	++	++	++
Headache	-	++	-
Scalp tenderness	-	++	-
Arterial swelling/tenderness, bruits	-	+	+
Jaw claudication/tongue pain and claudication	-	++	-
Vision symptoms/complications	-	++	-
Painful dysphagia	-	++	-
Limb claudication, absent or asymmetrical pulses, asymmetrical blood pressure readings, Raynaud phenomenon	-	+	++
Aortic regurgitation	-	+	++

CRP = C-reactive protein; ESR = erythrocyte sedimentation rate; RS3PE = remitting seronegative symmetrical synovitis with pitting edema.

* *++ = Very common; + = common; - = uncommon.*

Quel bilan selon ACR/EULAR?

- Hémogramme,
- VS ou préférentiellement CRP,
- ionogramme plasmatique, urée et créatininémie,
- bilan hépatique,
- électrophorèse des protéines sériques,
- CPK,
- TSH,
- Radiographie de thorax,
- bandelette urinaire,
- Facteurs rhumatoïdes, anti-CCP/ACPA et anticorps antinucléaires.

Dejaco C, Singh YP, Perel P, et al. Ann Rheum Dis. 2015;74:1799-807

Table 3. **Tests for Evaluation of Patients With Polymyalgia Rheumatica**

Type of Test/Disorder	*Name of Test*
Laboratory tests to assess inflammatory activity (i.e., tests helpful in differential diagnosis)	
General	Complete blood count; liver function tests, including alkaline phosphatase, age- and sex-appropriate cancer screening
Thyroid disease	Thyroid-stimulating hormone
Rheumatoid arthritis	Rheumatoid factor, anti–citrullinated peptide, radiographs of hands, shoulders, feet
Connective tissue diseases, lupus, myositis, vasculitis	Antinuclear antibody, anticytoplasmic neutrophil antibodies
Gout	Uric acid
Pseudogout	Calcium and phosphorus
Prostate cancer	Prostate-specific antigen (men)
Myositis/myopathy	Creatine kinase
Multiple myeloma, dysproteinemia	Protein electrophoresis
Procedures and imaging tests for diagnosis	
Giant cell arteritis	Ultrasonography or other imaging, alternatively temporal artery biopsy
Polymyalgia rheumatica	Musculoskeletal ultrasonography of the shoulders and hips
Assessment of treatment-related adverse events	
Diabetes mellitus	Serum glucose
Osteoporosis	Bone densitometry
Latent tuberculosis	Tuberculosis testing according to national guidelines

Quel bilan selon ACR/EULAR?

Une des meilleures preuves…

l'effet spectaculaire de la corticothérapie d'épreuve

Elle fait passer de PPR syndrome à PPR maladie

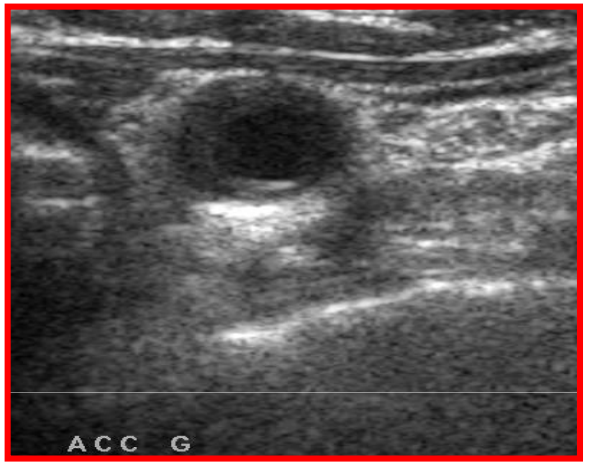
Dasgupta B, Borg FA, Hassan N, et al. Rheumatology (Oxford). 2010;49:186-90.

Des pathologies associées

Horton: Examens complémentaires que si orientation car seulement 15% des PPR…et traitement identique sans symptôme

- Echo (plus pour guider) mais peut éventuellement suffire si halo typique
- Biopsie reste référence
- TEP si biopsie négative ou impossible

Cancer: Non sauf point d'appel si typique



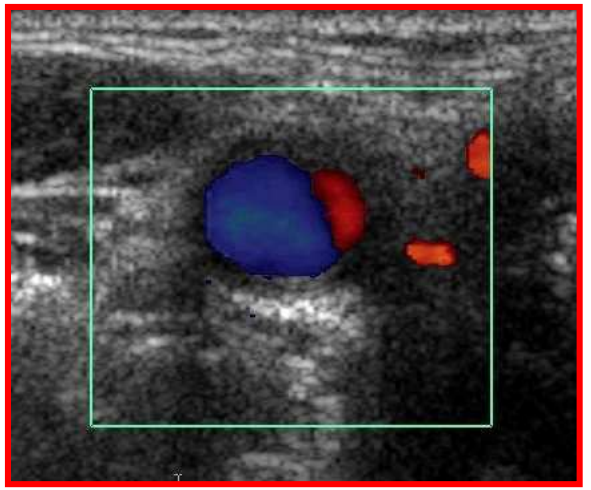
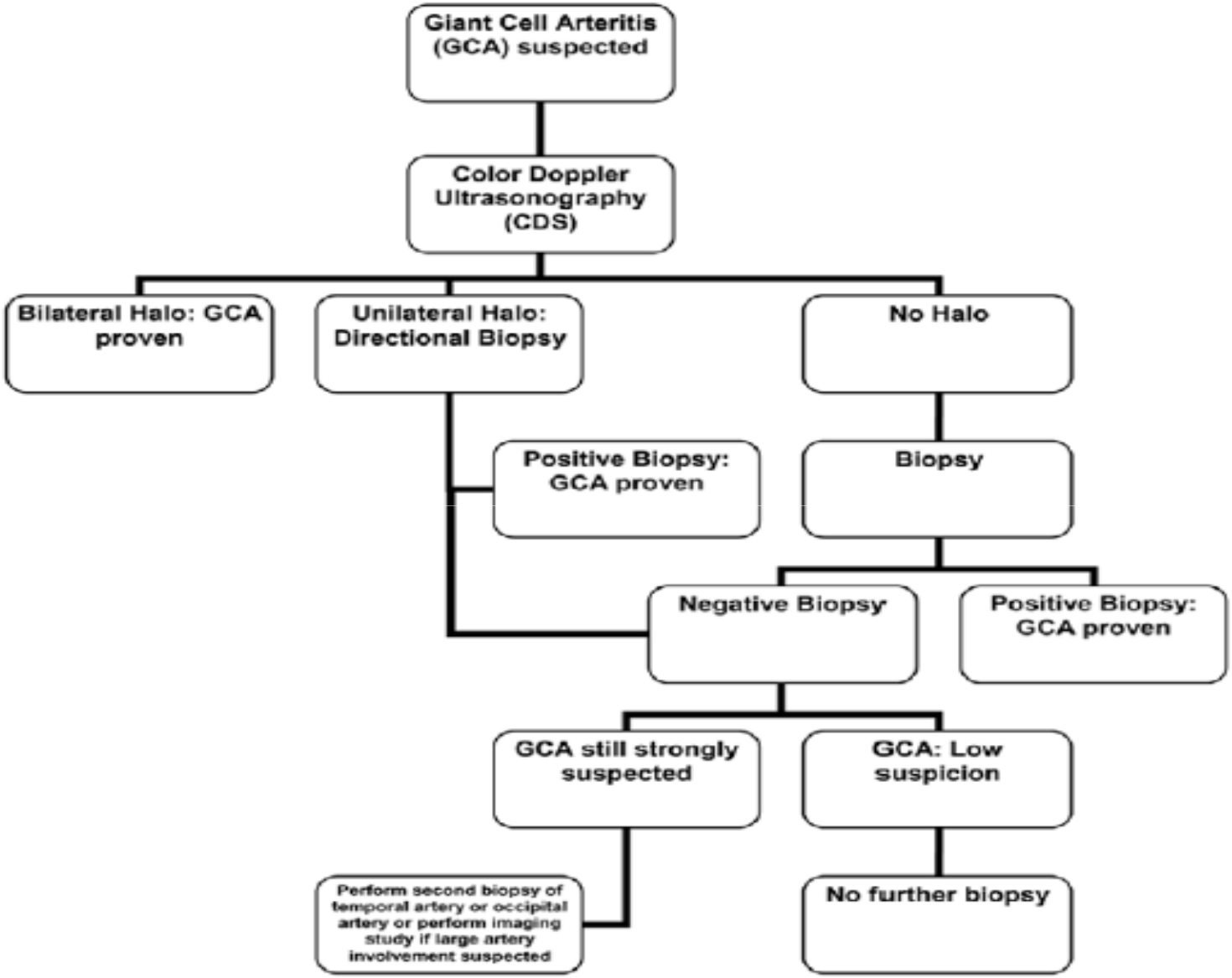
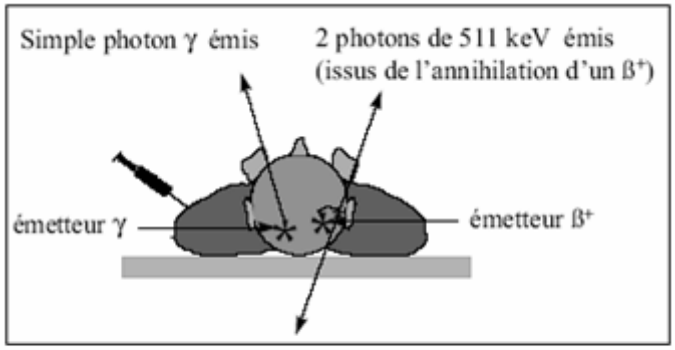


Image Sandrine Jousse-Joulin



Algorythme décisionnel en cas de suspicion de MH. Karahaliou M (Arthritis Res Ther. 2006;8(4):R116).

La TEP



- FIGURE 1 -
Différence entre émetteur de positons et émetteur simple photon

- **La TEP: imagerie isotopique.**

  Radio traceur = vecteur + isotope radio-actif

- **La TEP: imagerie fonctionnelle in vivo.**

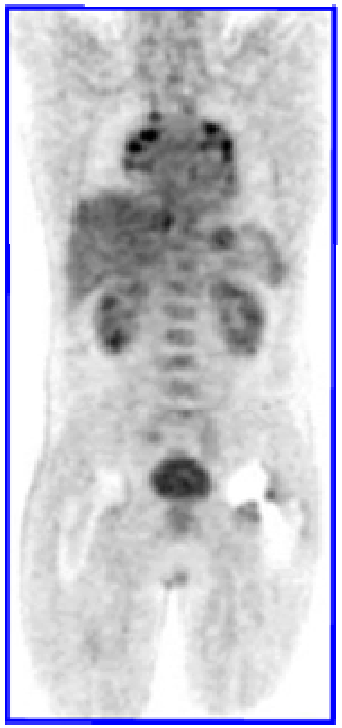
  Selon le vecteur, une fonction de l'organisme va être explorée

- **La TEP : imagerie quantitative.**

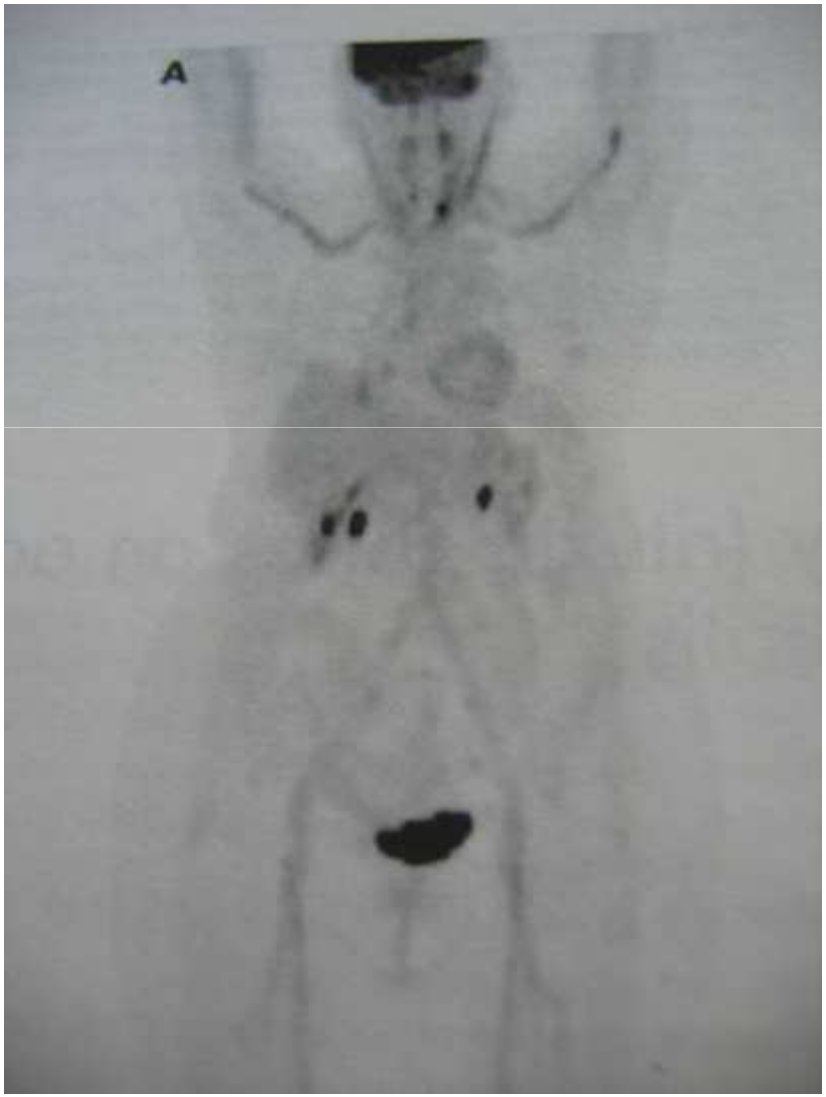
  Détection du rayonnement gamma issu de l'annihilation du positon émis par ces isotopes.

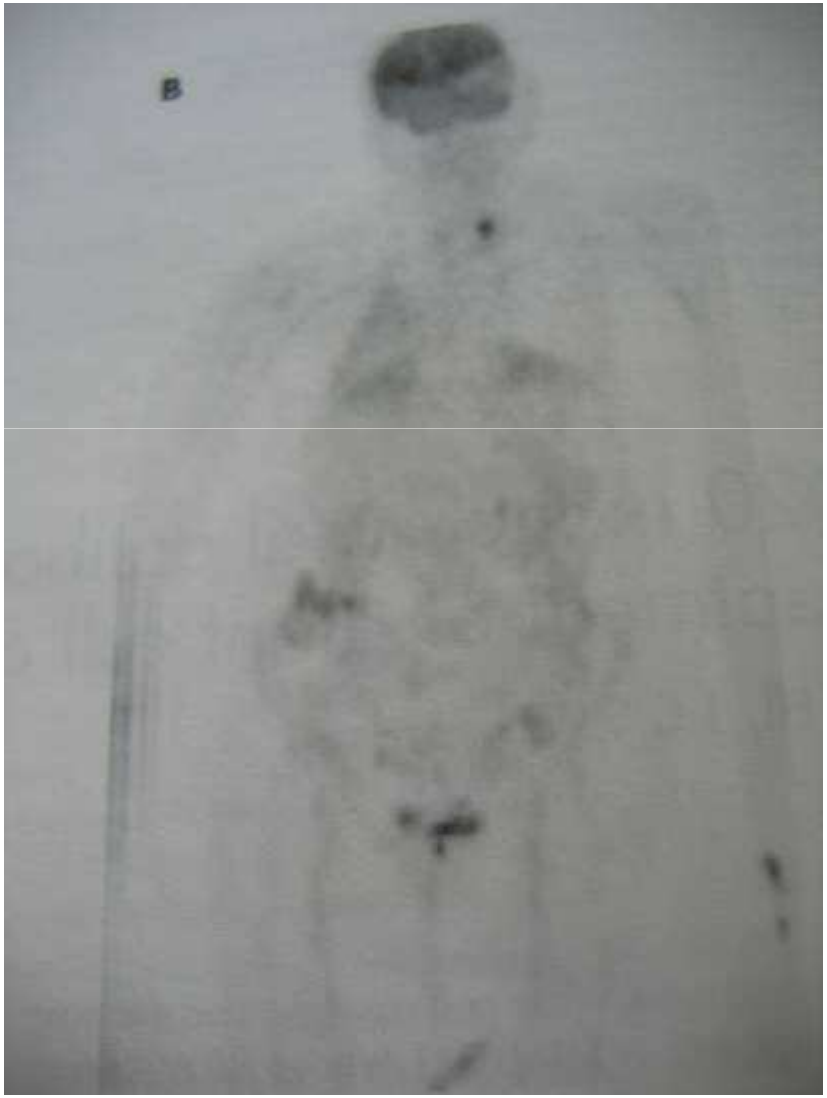
- **La TEP : imagerie tomographique 3D.**

  Image = empilement de coupes sur 15 cm de longueur, Précision de quelques millimètres cube.

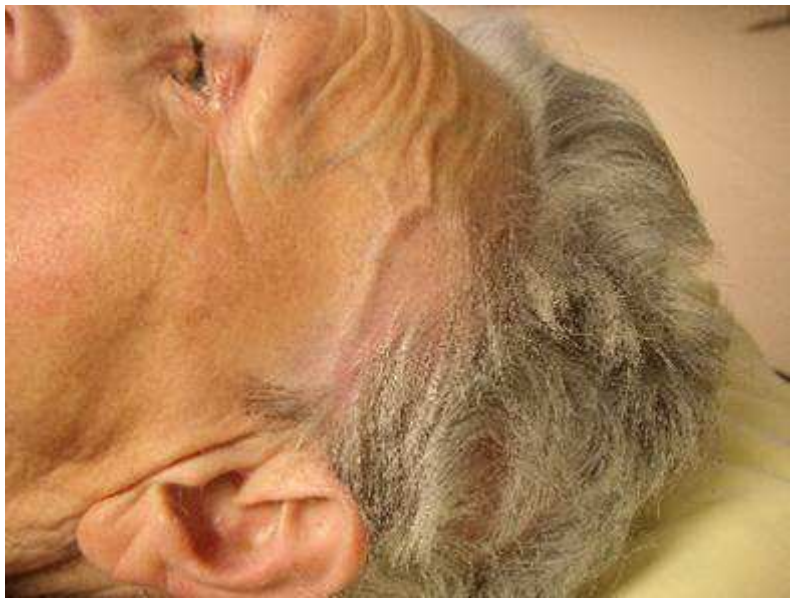


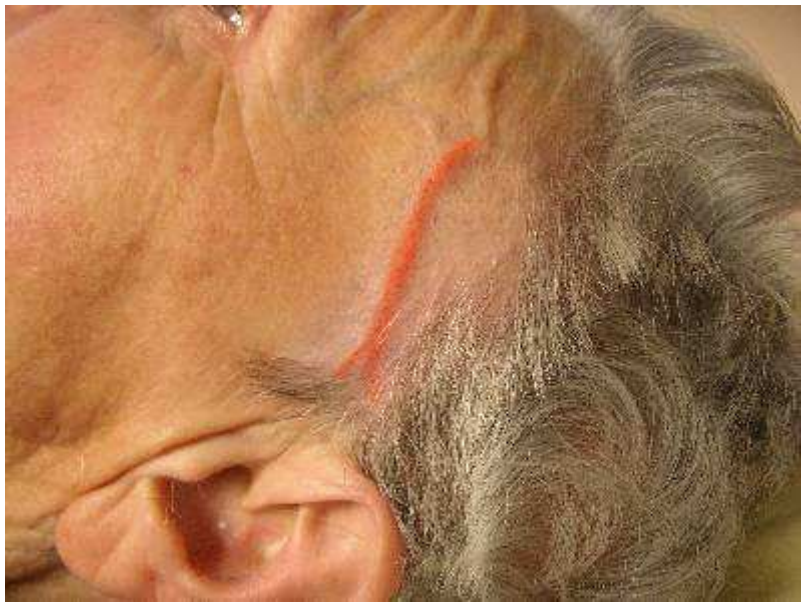
Des pathologies associées

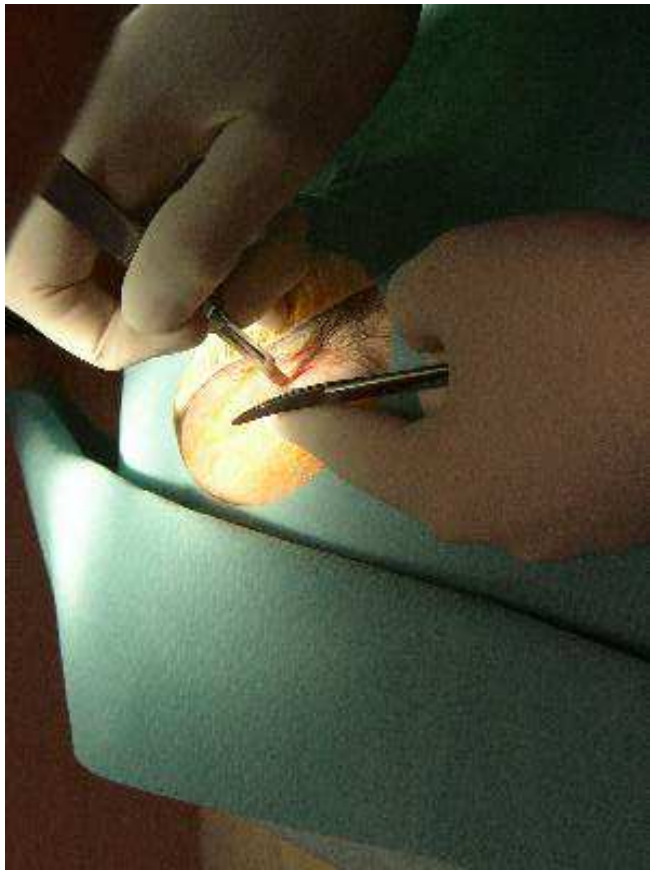


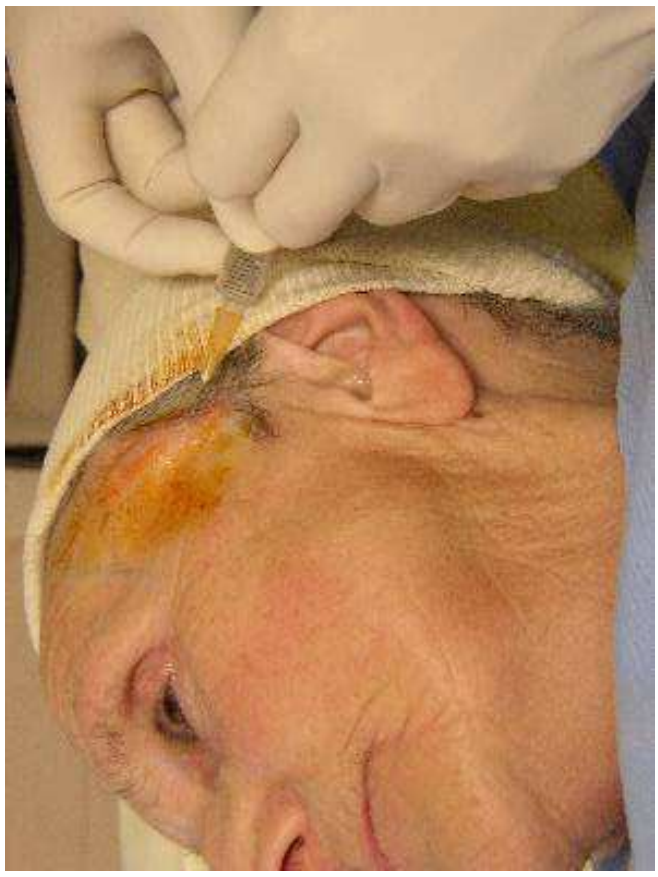


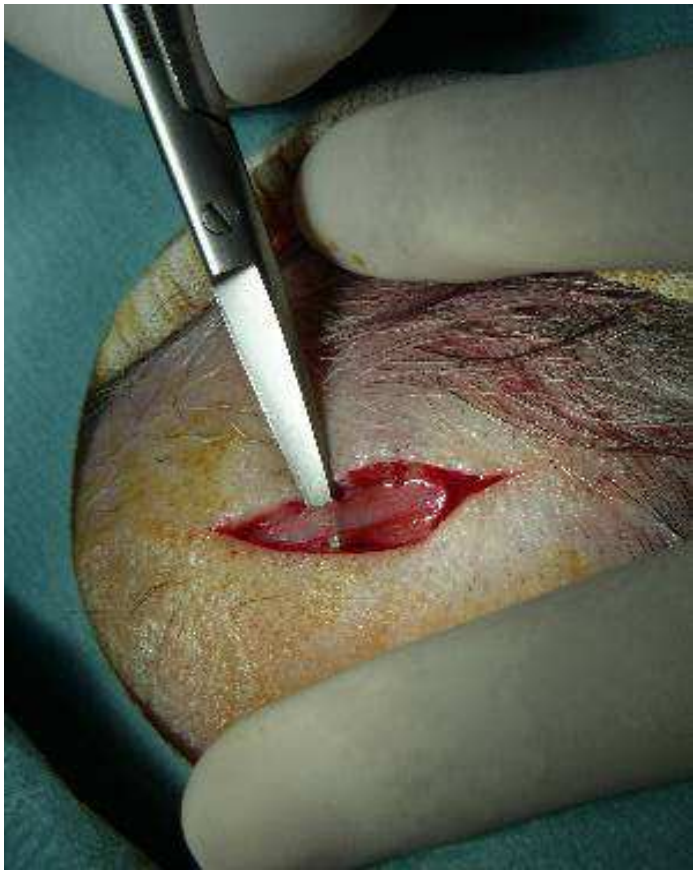
Biopsie d’artère temporale

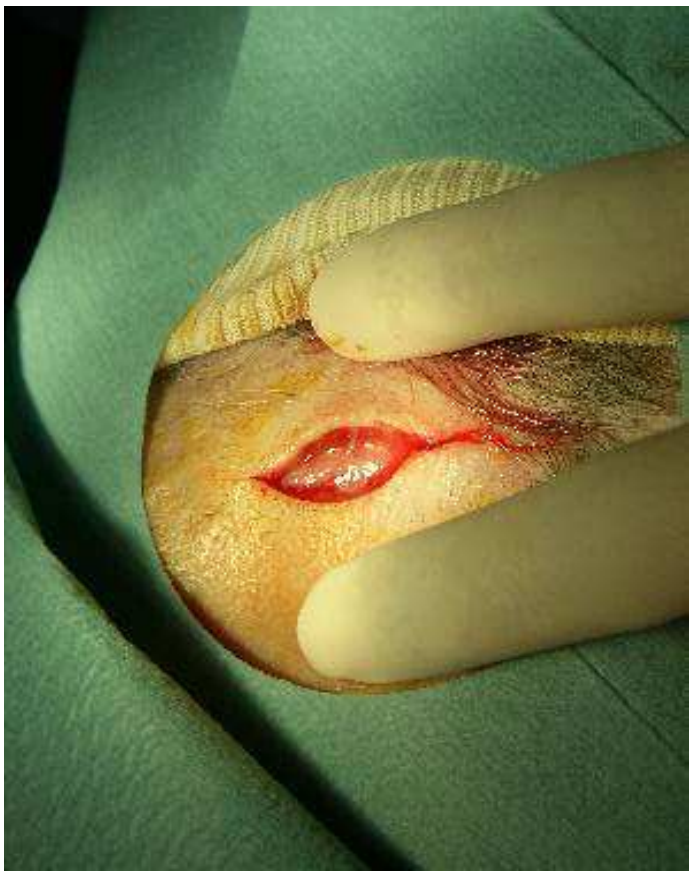


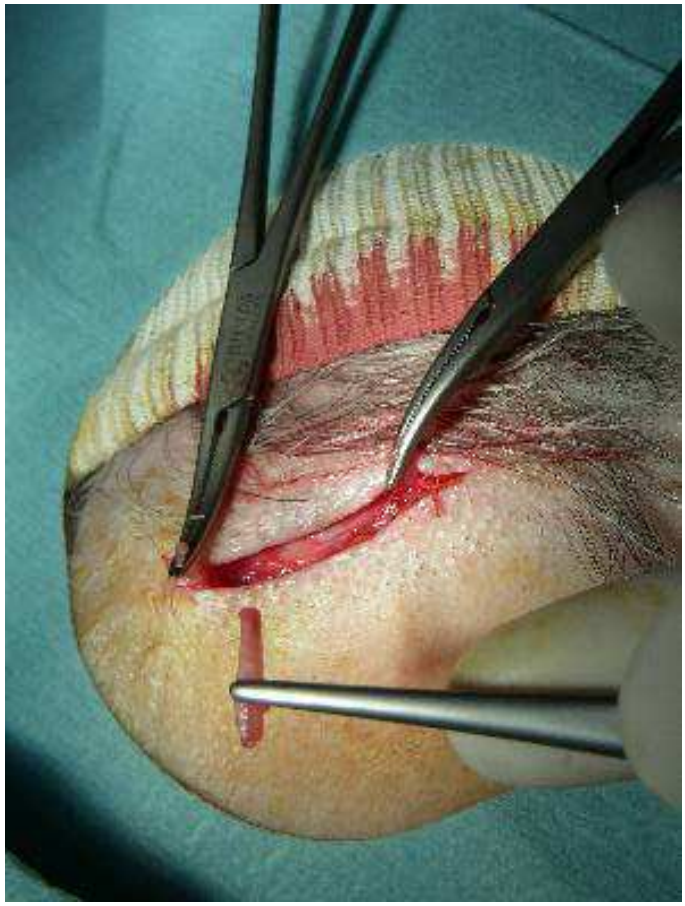












Risk of malignancy in patients with giant cell arteritis and polymyalgia rheumatica: A systematic review and meta-analysis

Patompong Ungprasert, MD[a,b,*], Anawin Sanguankeo, MD[c], Sikarin Upala, MD[c], Eric L. Knight, MD, MPH[a]

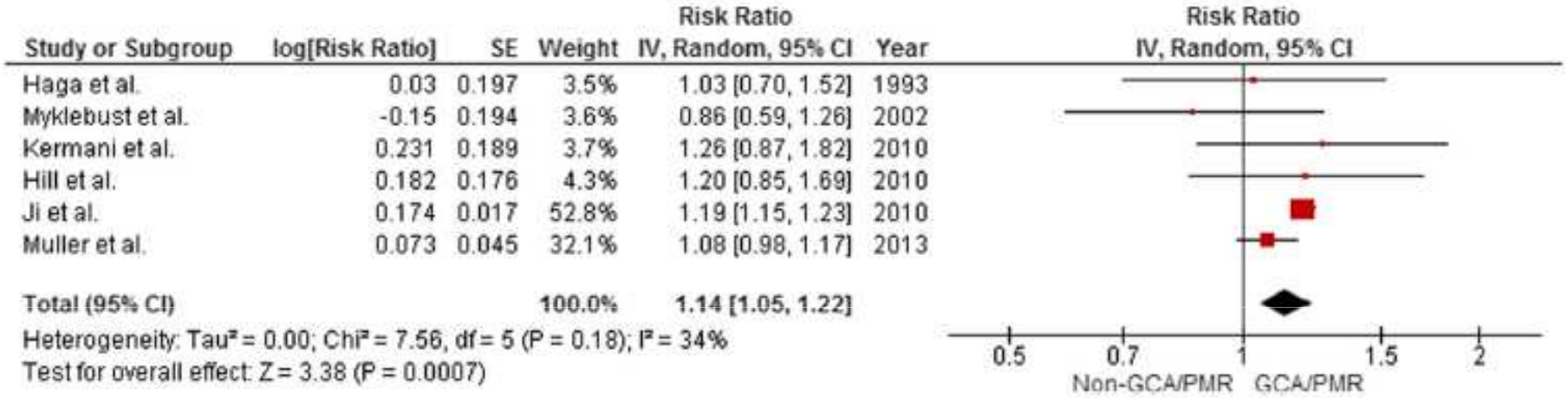


Fig. 2. A forest plot of overall malignancy risk.

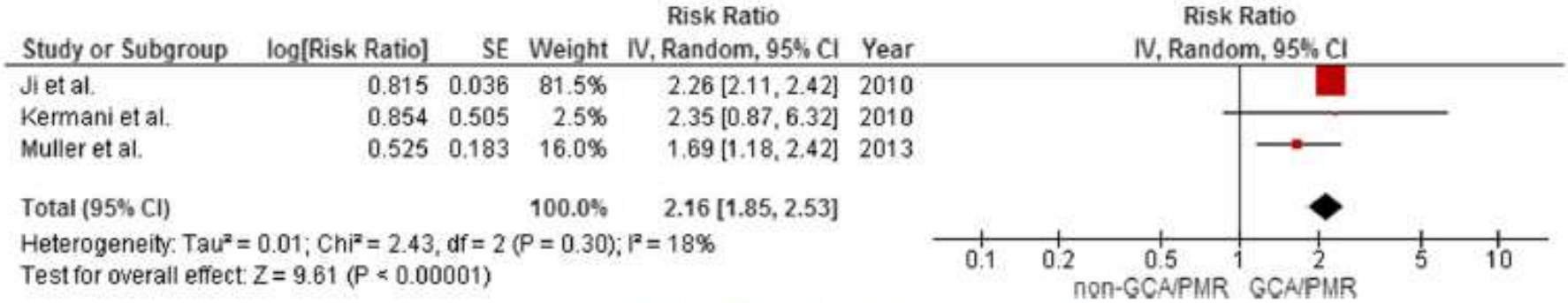


Fig. 3. A forest plot of malignancy risk in the first 6–12 months.

Ungprasert P, Semin Arthritis Rheum. 2014 Dec;44(3):366-70

Current evidence for therapeutic interventions and prognostic factors in polymyalgia rheumatica: a systematic literature review informing the 2015 European League Against Rheumatism/American College of Rheumatology recommendations for the management of polymyalgia rheumatica

Christian Dejaco,[1,2] Yogesh P Singh,[2] Pablo Perel,[3] Andrew Hutchings,[4] Dario Camellino,[5] Sarah Mackie,[6] Eric L Matteson,[7] Bhaskar Dasgupta[2]

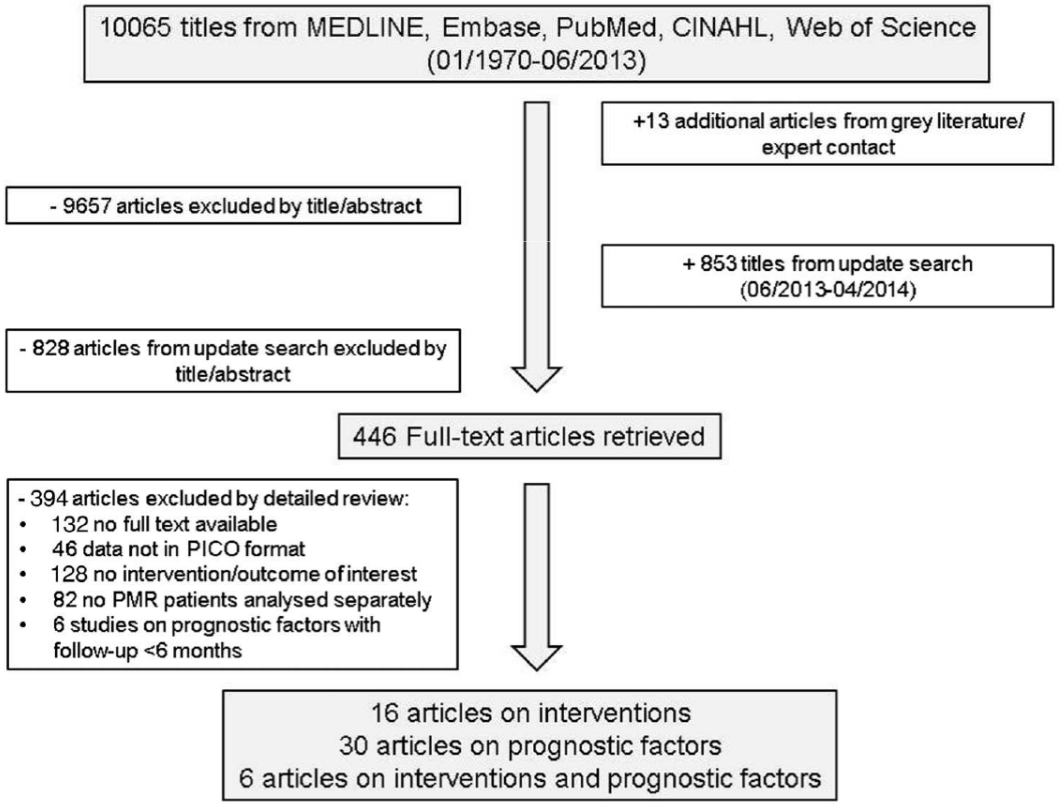


Figure 1 Study flow diagram detailing the literature search. PICO, Population, Intervention, Comparator, Outcome; PMR, polymyalgia rheumatica.

Dejaco C, *et al*. *Ann Rheum Dis* 2015;**74**:1808–1817. doi:10.1136/annrheumdis-2015-207578

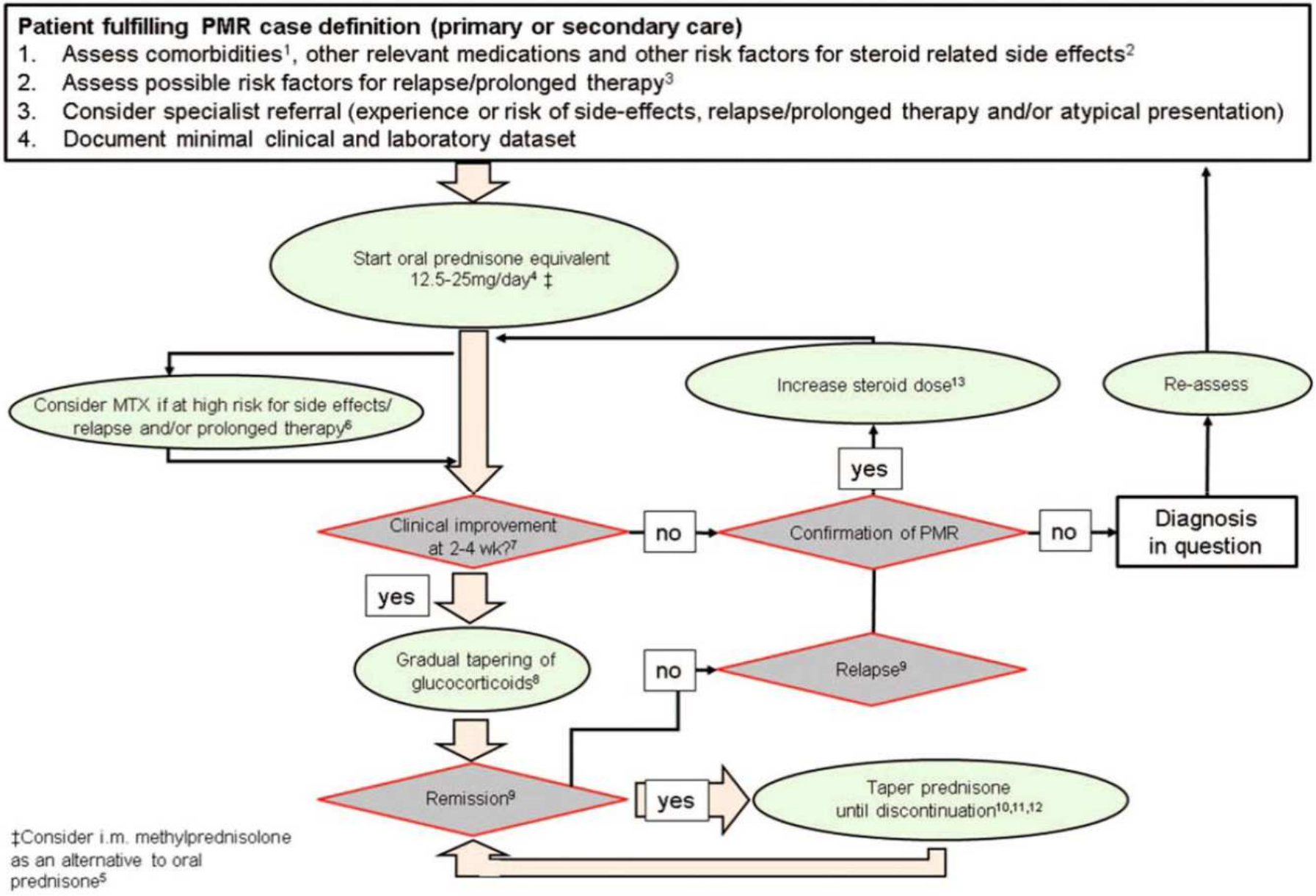
Table 1 Continued

Study ID	PICO	Design	Duration	Follow-up	PMR criteria	Intervention	Control	No pt.	No female patients (%)	No patients with complete follow-up (%)	Outcomes (time point)
2013 Nazarina[27]	9	R		44 w	Chuang	MTX 10 mg+OP 15 mg	OP 15 mg	58	30 (52)	47 (81)	Remission (44 w) Relapse (44 w) Cumul GC (44 w)
2007 Salvarani[28]	10	R, DB, Mul.		52 w	Healey	IFX 3 mg/kg+OP 15 mg	OP 15 mg	51	31 (61)	47 (92)	Relapse (22, 52 w) Disc GC (22, 52 w) GC-sides (52 w)
1996 van der Veen[29]	9	R, DB, Mul.		2 y	Descript.	MTX 7.5 mg+OP 20 mg	OP 20 mg	40	30 (75)	21 (53)	Remission (104 w) Relapse (24 m) GC-sides (24 m)
2009 Wang[30]	12	R		12 w	Bird	Biqi+OP 10 mg	OP 10 mg	39	28 (72)	NR	Response (12 w)

Articles containing both data on interventions and prognostic factors are shown in bold.
Studies are listed in alphabetical order; †mean, ‡median; #, & or ¥ multiple papers on partially the same cohort; *patients with first relapse analysed; †mean, ‡median; §number of patients with complete follow-up data depends on the outcome, ¶number of patients as reported in the study of Dasgupta *et al.*
Case–control (retro.), Case–control study with retrospective design; Control, control treatment; CRP, C-reactive protein; Cumul, cumulative; d, days; DB, double blind; Descript., description of symptoms and laboratory criteria defining PMR (no formal criteria used); Devel. GCA, development of giant cell arteritis during follow-up; Disc, discontinuation; dur., total duration of study; ESR, erythrocyte sedimentation rate; ETN, etanercept; Follow-up, length of follow-up; GC, glucocorticoid; GC-sides, glucocorticoid-related side effects; HCQ, hydroxychloroquine; HealthC, healthcare resource use; IFX, infliximab; IMP, intramuscular methylprednisone; inc., increased; m, months; MTX, methotrexate; Mul., multicenter; No pt., number of patients; No, number of; NR; not reported; NSAIDs; non-steroidal anti-inflammatory drugs; Obs. (prosp), observational prospective follow-up; OP, oral prednisone (equivalent); Outcome (time points), outcomes (out of the list of critical outcomes listed in online supplementary table S1) addressed in the corresponding study and the time points at which the outcome was investigated in parentheses; PICO, Population, Intervention, Comparator, Outcome (number of PICO question); PMR, polymyalgia rheumatica; PMR-AS, PMR activity score; PV, plasma viscosity; R, randomised; RS3PE, remitting seronegative symmetrical synovitis with pitting oedema; SF-36, short form 36 questionnaire; stiff, stiffness; Study ID, study identifier; sympt. Dur., symptom duration; varT, variable time point/no exact date reported; w, weeks; y, years.

Conventional synthetic disease-modifying antirheumatic drugs (PICO 9)

We identified four RCTs and one retrospective study testing the use of methotrexate (MTX) at doses of 7.5–10 mg/week.[10 11 15 24 27 29] In addition, a retrospective analysis on the use of hydroxychloroquine was found.[24]



Dejaco C, Singh YP, Perel P, et al. Ann Rheum Dis. 2015;74:1799-807

Un traitement codifié

Instauration de la corticothérapie dans la PPR
- 15-25 mg/j pendant 3 semaines (predinone=prednisolone)* - Methotrexate à discuter si risque de corticothérapie, risque de traitement prolongé, risque de récidive
Modalités de décroissance de la corticothérapie dans la PPR
- Descendre à 10 mg en 4 à 8 semaines - Décroissance de 1 mg toutes les 4 semaines
Modalités en cas de rechute clinique lors de la décroissance
-Réaugmenter à la posologie précédente

Dejaco C, Singh YP, Perel P, et al. Ann Rheum Dis. 2015;74:1799-807

Un suivi simplifié

- **DAS PPR: 5 paramètres**

1. Protéine C réactive (CRP, mg/dl)
2. Echelle visuelle analogique du patient (EVAp, 0 à 10)
3. Echelle visuelle analogique du médecin (EVAm, 0 à 10)
4. Dérouillage matinal (DM, minutes)
5. Capacité d'élévation des épaules (CAE; 0≥90°, 1=90°, 2≤90°, 3=pas d'élévation des épaules).

- **Calcul selon la formule de Leed et Bird (2004)**

DAS-PPR= CRP (mg/dl) + EVAp (0-10)+ EVAm (0-10) + DM (min ×0,1)+ CAE (3-0)

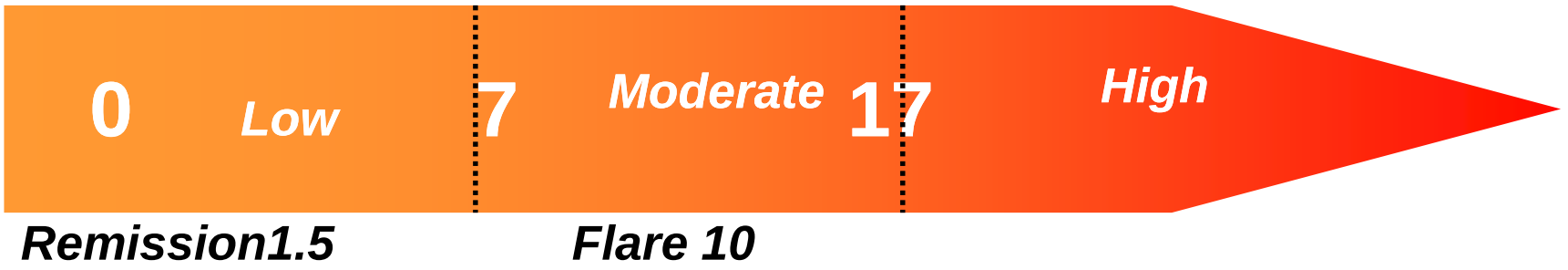
Un suivi simplifié

•Score d'activité de la maladie de 0 à 50

•Activité ≥7 (<7= faible activité, de 7 à 17=activité modérée,>17 forte activité)

•Rémission de la maladie: 0 à 1,5

•Rechute: >9,35 ou ayant augmentation ≥ 6,6 entre 2 visites



Leeb BF, Bird HA. Ann Rheum Dis 2004; 63,1279-83. Leeb BF et al. Ann Rheum Dis 2003; 62, 1189-94. Binard A, Arthritis Rheum. 2008 Feb 15;59(2):263-9. Cleuziou et al. J Rheumatol 2012, 39:310-313

Table 5. **Calculation of the Polymyalgia Rheumatica Activity Score* and Suggested Cutoffs for Disease Activity States**

*CRP (mg/dL) + patient's pain assessment (visual analogue scale, 0-10)† + physician's global assessment (visual analogue scale, 0-10)‡ + [morning stiffness (min) × 0.1)] + EUL (0-3)§	
Disease Activity	**Suggested Cutoff**
Remission	0–1.5
Low	1.6–6.9
Medium	7.0–17.0
High	>17.0
Relapse	Actual score ≥9.35 or change in score ≥6.6

CRP = C-reactive protein; EUL = ability to elevate the upper limbs.
† 0 = no pain; 10 = unbearable pain.
‡ 0 = no disease activity; 10 = highest activity possible.
§ 0 = above shoulder girdle; 1 = up to shoulder girdle; 2 = below shoulder girdle; 3 = no elevation possible.

Efficacy of first-line tocilizumab therapy in early polymyalgia rheumatica: a prospective longitudinal study

Valérie Devauchelle-Pensec[1,3], Jean Marie Berthelot[2], Divi Cornec[1,3], Yves Renaudineau[3], Thierry Marhadour[1], Sandrine Jousse-Joulin[1,3], Solène Querellou[4], Florent Garrigues[5], Michel De Bandt[6], Maelenn Gouillou[7], Alain Saraux[1,3] doi:10.1136/annrheumdis-2015-208742

Eur J Nucl Med Mol Imaging
DOI 10.1007/s00259-015-3287-z

ORIGINAL ARTICLE

Value of ^{18}F-FDG PET/CT for therapeutic assessment of patients with polymyalgia rheumatica receiving tocilizumab as first-line treatment

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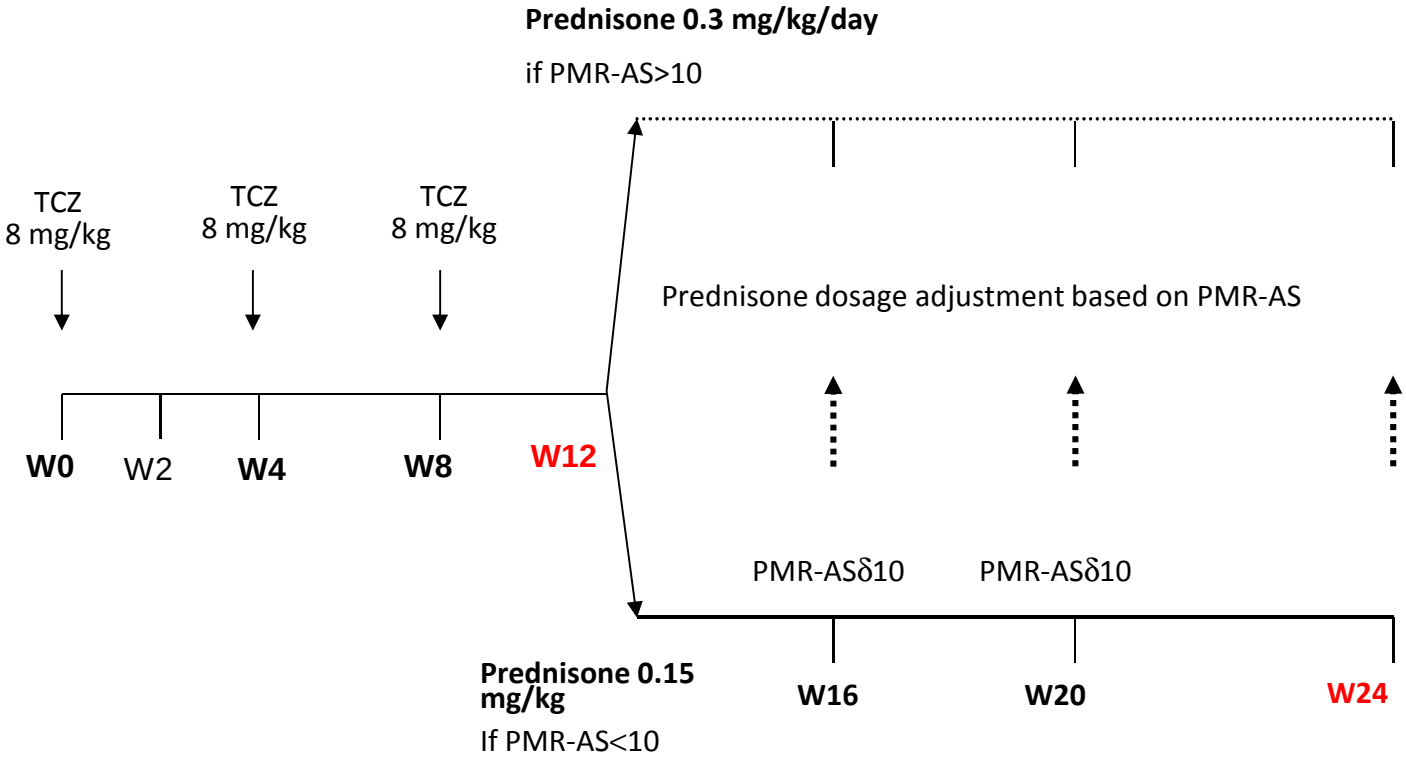

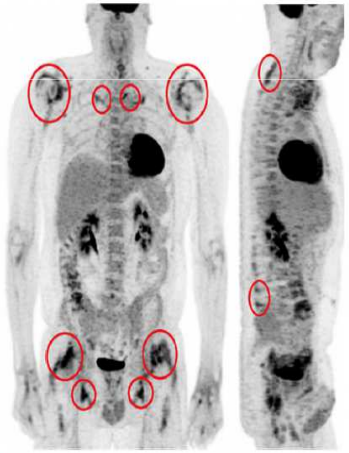

Fig. 1 Maximum intensity projection ^{18}F-FDG PET/CT images. SUVmax measurements were obtained in the ten regions of interest (*red circles*)

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Median, IQR	Week 0	Week 2	Week 4	Week 8	Week 12	p Value Week 0 vs week 12
PMR-AS	36.6 (30.4–43.8)	19.7 (14.9–27.7)	11.0 (7.9–19.3)	5.8 (3.7–11.6)	4.5 (3.2–6.8)	<0.001*
CRP, mg/dL	65.1 (21.6–127.8)	0.5 (0.3–1.4)	0.6 (0.3–3.5)	0.6 (0.2–1.2)	0.2 (0.1–1.0)	<0.001*
ESR, mm/h	51.0 (34.0–79.5)	7.5 (4.0–9.5)	5.0 (4.0–10.0)	4.5 (2.0–5.0	2.00 (2.0–4.5)	<0.001*
Patient VAS for pain	6.4 (4.6–7.8)	5.4 (3.8–6.9)	4.5 (3.2–5.4)	2.2 (1.5–4.2)	1.7 (0.6–2.7)	<0.001*
Patient VAS for fatigue	5.4 (2.9–6.9)	5.3 (3.0–6.2)	4.5 (2.0–5.1)	2.8 (1.0–4.8)	2.1 (0.7–4.4)	<0.001*
Patient VAS for disease activity	6.6 (4.8–7.5)	5.45 (3.8–6.9)	4.5 (3.1–5.4)	2.2 (1.5–4.2)	2.0 (0.9–3.6)	<0.001*
Physician VAS for disease activity	6.8 (6.0–7.9)	4.4 (2.8–6.6)	2.7 (1.7–4.5)	2.1 (0.5–3.1)	1.1 (0.8–1.8)	<0.001*
MST (min)	180.0 (75.0–180.0)	60.0 (60.0–120.0)	30.0 (7.50–60.0)	5.0 (0.0–22.5)	4.0 (0.0–10.0)	<0.001*
EUL	0.5 (0.0–2.0)	0.0 (0.0–2.0)	0.0 (0.0–1.0)	0.0 (0.0–0.0)	0.0 (0.0–0.0)	0.002*
0	10 (50.0%)	11 (55.0%)	13 (65.0%)	17 (85.0%)	18 (90.0%)	
1	2 (10.0%)	3 (15.0%)	4 (20.0%)	2 (10.0%)	2 (10.0%)	
2	8 (40.0%)	6 (30.0%)	3 (15.0%)	1 (5.0%)	0 (0.0%)	
3	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	
PMR-AS (ESR)	35.6 (30.4–39.9)	20.8 (15.3–29.4)	13.7 (9.3–22.0)	5.8 (3.5–11.8)	4.7 (3.5–6.6)	<0.001*

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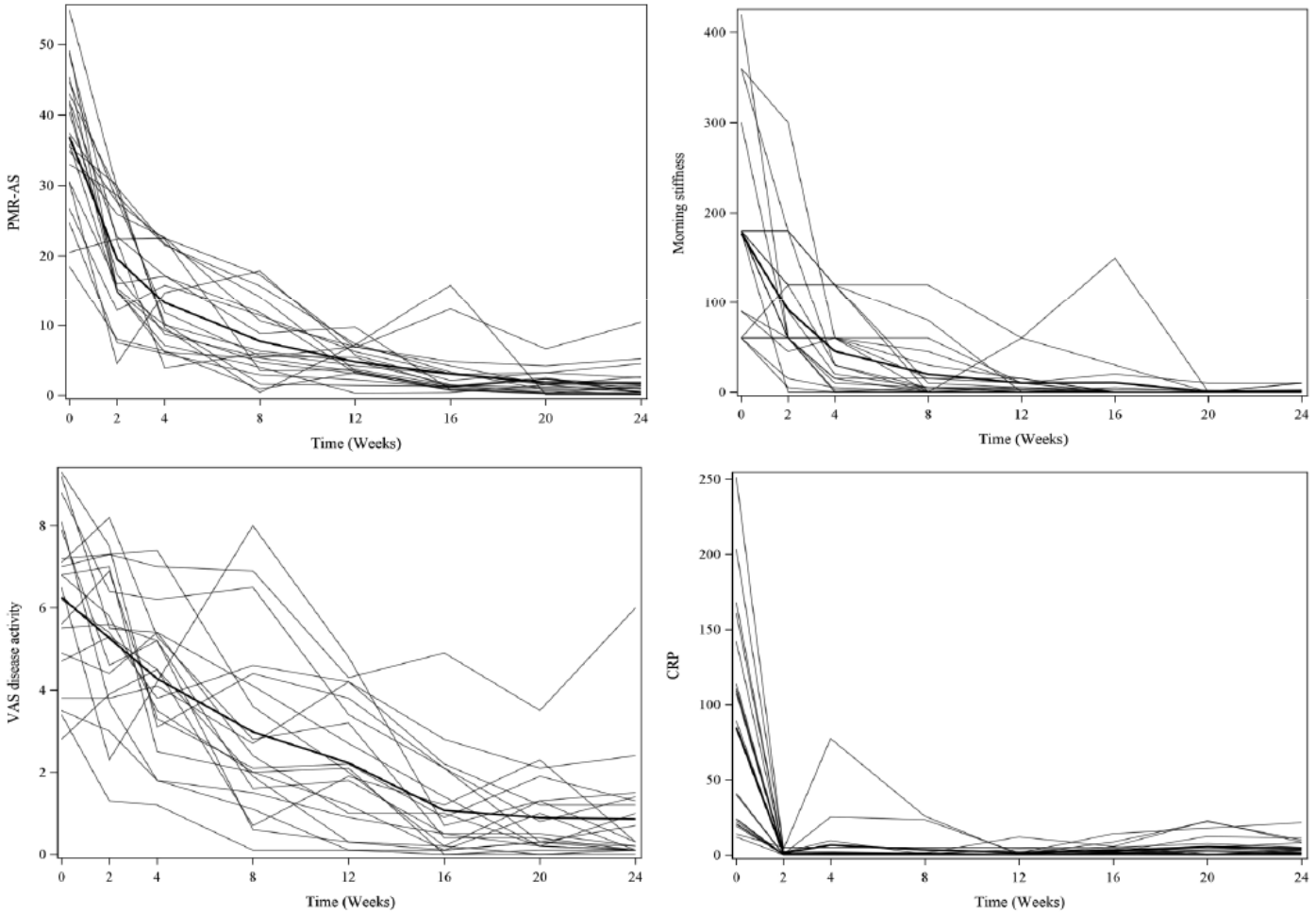
Efficacy of first-line tocilizumab therapy in early polymyalgia rheumatica: a prospective longitudinal study



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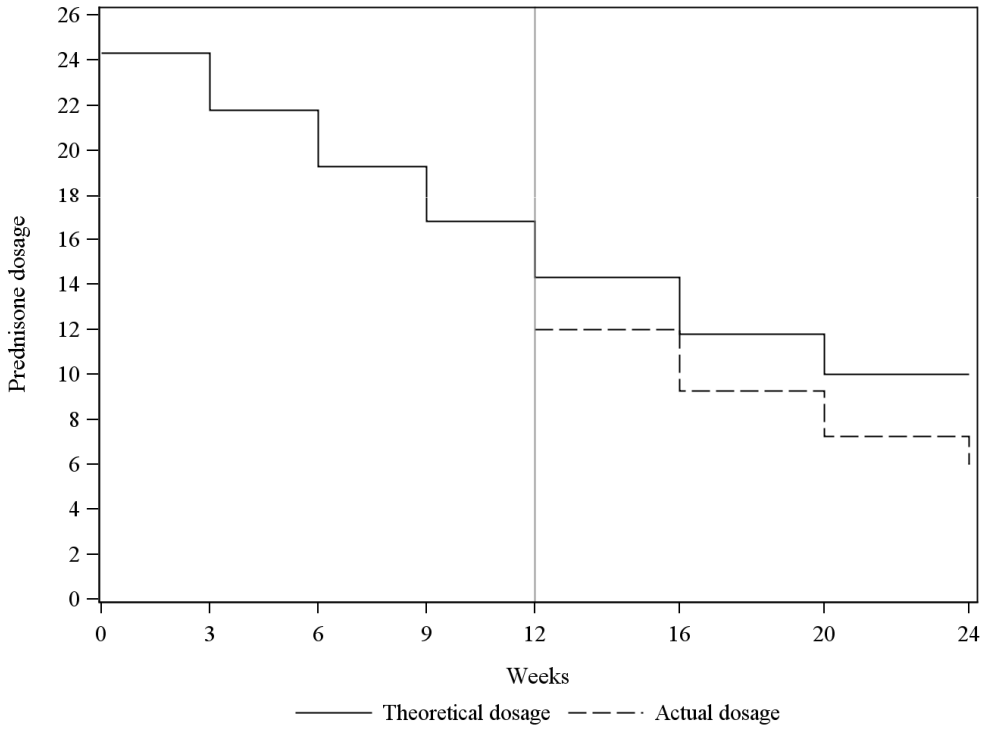

V Devauchelle-pensec et al, Ann Rheum Dis 2016

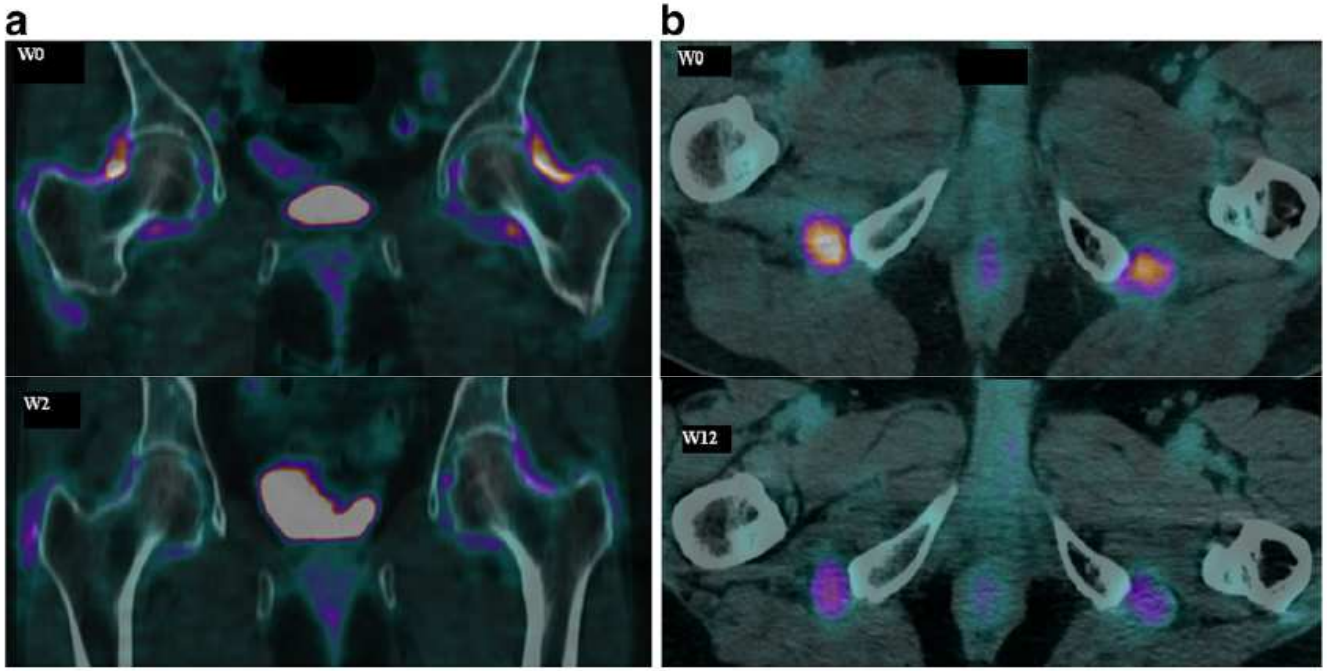

Fig. 2 Changes in FDG uptake on follow-up PET/CT imaging. **a** Coronal images of the hip region before treatment (week 0, *W0*) and after one infusion of tocilizumab (week 2, *W2*) in a 73-year-old woman with polymyalgia rheumatica. At week 0, the right hip SUVmax is 12.3 and the left hip SUVmax is 9.7. At week 2, the right hip SUVmax is 10.1 and the left hip SUVmax is 9.4. **b** Axial images of the ischial tuberosity region before treatment (week 0, *W0*) and after two infusions of tocilizumab (week 12, *W12*) in a 60-year-old man with polymyalgia rheumatica. At week 0, the right ischial tuberosity SUVmax is 8.5 and the left ischial tuberosity SUVmax is 9.8. At week 2, the right ischial tuberosity SUVmax is 5 and the left ischial tuberosity region SUVmax is 5.5

Tocilizumab is effective against polymyalgia rheumatica: experience in 13 intractable cases

Keisuke Izumi,[1,2] Harumi Kuda,[2] Mari Ushikubo,[2] Masataka Kuwana,[1,3] Tsutomu Takeuchi,[1] Hisaji Oshima[2]

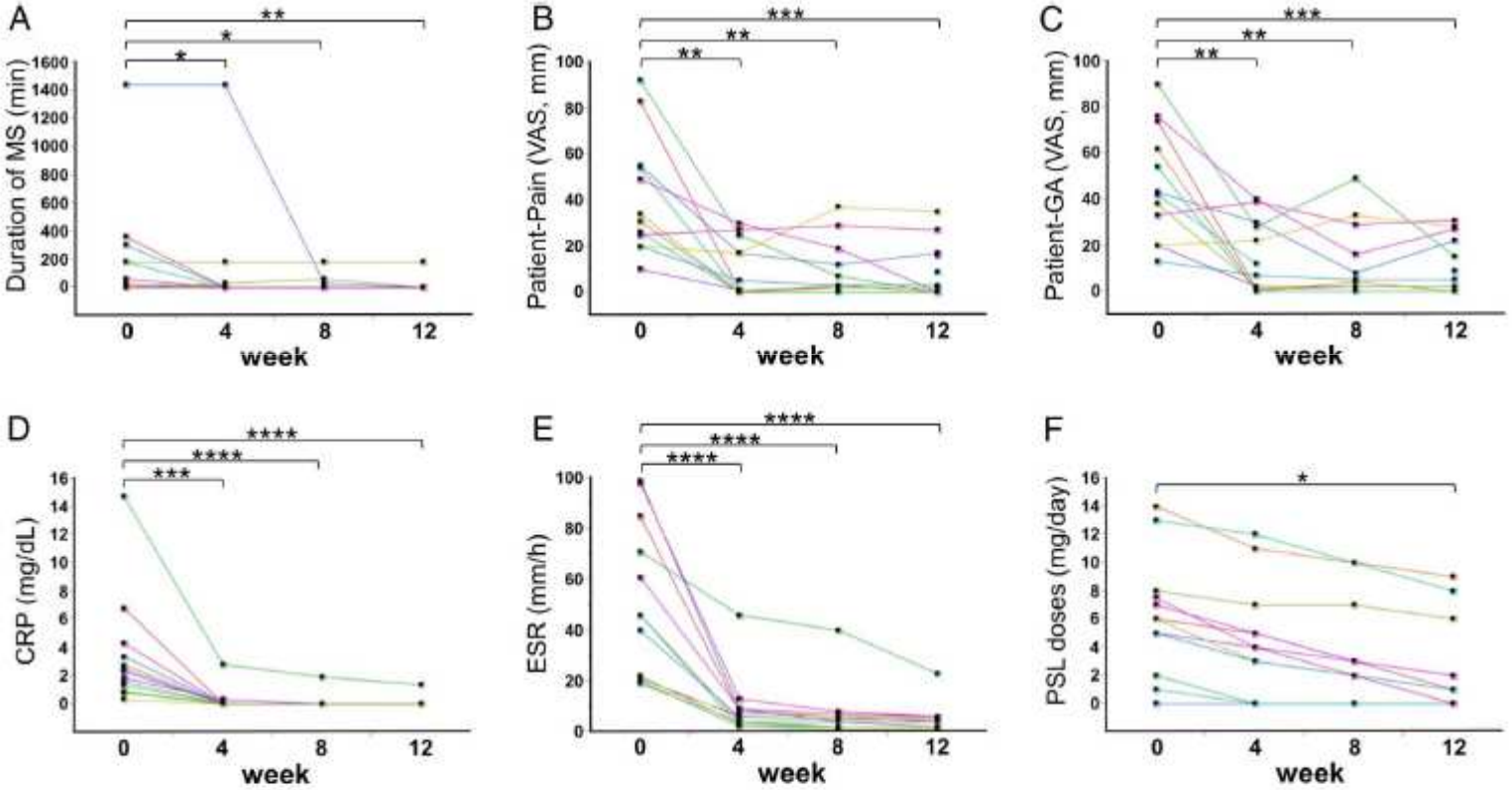

Figure 1 Changes in evaluation indicators from baseline to 12 weeks per visit. (A) Duration of morning stiffness (MS), (B) Patient-Pain, (C) Patient-Global Assessment (GA), (D) C-reactive protein (CRP), (E) erythrocyte sedimentation rate (ESR) and (F) prednisolone (PSL) doses (VAS, visual analogue scale). Asterisks indicate significant differences as compared with baseline analysed by Wilcoxon signed-rank test. *p<0.05, **p<0.01, ***p<0.001 and ****p<0.0001.

Table 4. **Medications Available for Treatment of Polymyalgia Rheumatica**

Drug	*Indication*	*Dosing/Tapering*	*Possible Adverse Events*	*Monitoring*
GCs (prednisone equivalent)				
Oral	First-line treatment for all patients with polymyalgia rheumatica	Initial daily dose: 12.5–25 mg; taper to 10 mg daily after 4–8 wk, then reduce daily dose by 1 mg every 4 wk until discontinuation. Relapse: Increase to prerelapse dose	Cushingoid appearance, weight gain, osteoporosis, hypertension, cardiovascular disease, hyperglycemia and diabetes mellitus, infections, skin atrophy, cataracts	Blood pressure at each visit, polyuria, polydipsia, edema, shortness of breath, vision changes, weight gain, urinalysis for glucose levels yearly, regular osteoporosis screening including dual-energy x-ray absorptiometry and bone density measurement
Intramuscular MP	Individualized alternative to oral GCs or when a low cumulative GC dose is desired	Initial dose 120 mg every 3 wk; taper from wk 12: 100 mg at wk 12, then injections at monthly intervals with dose reduced by 20 mg every 12 wk until wk 48; then, dose reduction by 20 mg every 16 wk until discontinuation	Same as for oral GCs	Same as for oral GCs

Immunosuppressive agents

MTX	Individualized first-choice immunosuppressive agent, concomitant with GCs: Early: Risk for relapse and/or GC-related adverse events Follow-up: Relapse, insufficient response to GCs, GC-related adverse events	7.5–10 mg/wk; taper after GC discontinuation	Dizziness, nausea, vomiting, diarrhea, loss of appetite, temporary hair loss, elevated liver enzymes, low leukocyte count, predisposition to infection, teratogenicity, mouth sores	Baseline: Complete blood count, measurement of aminotransferase and serum creatinine levels. Screening for hepatitis B/C in patients at higher risk for these infections Follow-up: Regular testing for complete blood count, measurement of amino-transferase and serum creatinine levels: 0–3 mo: Every 2–4 wk 3–6 mo: Every 8–12 wk >6 mo: Every 12 wk
Tocilizumab	For patients in whom MTX is unavailable or toxic, immuno-suppressive agent needed	8 mg/kg of body weight IV at 0, 2, and 4 wk, then every 4 wk, or 162 mg SQ weekly	Infections (particularly respiratory tract and urinary), local injection site reactions, increment of blood lipids, rarely diverticulitis	Baseline: Complete blood count, measurement of aminotransferase and serum creatinine levels, lipids. Exclusion of active or latent infection including screening for hepatitis B/C and tuberculosis (following national guidelines) Follow-up: Clinical exclusion of infections, regular testing for complete blood count, liver aminotransferase levels, serum creatinine: 0–3 mo: Every 4 wk; lipids 4 wk after treatment start >3 mo: Every 8–12 wk
Azathioprine	For patients in whom MTX is unavailable or toxic, immuno-suppressive agent needed	150 mg/d	Nausea, vomiting, diarrhea, low leukocyte count, anemia, predisposition to infection, rarely pancreatitis	Same as for MTX
Leflunomide	For patients in whom MTX is unavailable or toxic, immuno-suppressive agent needed	10–20 mg/d	Same as for MTX, hypertension	Same as for MTX

GC = glucocorticoid; IV = intravenous; MTX = methotrexate; MP = methylprednisolone; SQ = subcutaneous.

Quand demander un avis spécialisé (ACR/EULAR 2015)

Présentation atypique
- Arthrites périphériques
- Signes systémiques
- Inflammation faible
- Age<60 ans

Effets secondaire antérieurs sous corticoïdes

Risque prévisible des corticoïdes

Résistance à la corticothérapie

Récidive

Dejaco C et al. Ann Rheum Dis. 2015 Oct;74(10):1799-807

Conclusion

Des recommandations claires

Un suivi souvent simple

Eviter les excès de corticothérapie

- erreur de diagnostic
- excès de précaution

Une place pour le méthotrexate

Très probablement un grand avenir pour anti IL6

Inclusions dans Sémaphore