CCP
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Riesgo de enfermedad cardiovascular precoz

Se puede prevenir?

- IAM
- STROKE

Que datos tenemos de enfermedad precoz

RHEUMATOLOGY

Rheumatology 2013;52:1163–1171
doi:10.1093/rheumatology/ket106
Advance Access publication 15 March 2013

Review

Cardiovascular risk in juvenile idiopathic arthritis

Elizabeth J. Coulson[1], Wan-Fai Ng[1,2], Iain Goff[1] and Helen E. Foster[1,2]

El riesgo a largo plazo de enfermedad cardiovascular para las paciente con AIJ sigue siendo incierto.

Original Article www.jpgmonline.com

Assessment of left ventricular systolic and diastolic function in juvenile rheumatoid arthritis

Bharti BB, Kumar S, Kapoor A, Agarwal A*, Mishra R*, Sinha N*

Materials and Methods

Thirty-five children with JRA (American College of Rheumatology criteria) [5] seen in the department of Clinical Immunology outpatient clinic between January 2001 and January 2002 were included in the study after obtaining verbal informed consent from parents or eligible and competent adult patients. The control group consisted of children presenting to the paediatric outpatient department and included 35 age- and sex- matched healthy controls.

Mas de un tercio de los paciente mantienen la enfermedad activa persistente hasta la edad adulta

El mayor riesgo se atribuye a una mayor prevalencia de factores de riesgo cardiovascular tradicionales y al papel de inflamación sistémica en la aceleración de la aterosclerosis

Cuales son los factores de riesgo CV??

- Tabaquismo
- HTA
- DBT
- Obesidad
- Actividad física disminuida
- Tratamiento con corticoides y AINES

Tabaquismo

Arthritis Care Res. 1998 Oct;11(5):391-6.

Substance use among adolescents with juvenile rheumatoid arthritis.

Nash AA[1], Britto MT, Lovell DJ, Passo MH, Rosenthal SL.

Author information

1 Division of Adolescent Medicine, Children's Hospital Medical Center, Cincinnati, OH 45229-3039, USA.

- Se cree que los jóvenes con AIJ están menos expuestos que grupos de control sanos

Dislipidemia

Table 1 Abnormalities of the lipid profile in JIA

	JIA subtypes (*n*)	*N*	Lipid profile in JIA compared with controls	Drug therapy
Ilowite *et al.* [50]	Systemic [9] Pauciarticular [15] Polyarticular [11]	35	↓ Total cholesterol ↓ LDL ↓ HDL ↑ Triglycerides ↑ VLDL	Excluded if had received corticosteroid within 6 months
Tselepis *et al.* [51]	Polyarticular [15] Pauciarticular [8] Systemic [3]	26	↓ HDL ↑ Triglycerides[a]	NSAIDs [23] MTX [10] Methylprednisolone [6]
Gonçalves *et al.* [52]	Oligo [22] Polyarticular [17] Systemic [12]	51	↓ HDL ↑ Triglycerides ↑ VLDL	MTX NSAIDs Chloroquine Systemic steroids
Bakkaloglu *et al.* [53]	Oligo [19] Polyarticular [16] Systemic [2]	37	√ Total cholesterol √ Triglycerides √ HDL ↓ LDL	No patients receiving steroid therapy
Marangoni *et al.* [54]	Polyarticular only	28	↓ HDL ↑ LDL ↑ Triglycerides ↑ Total cholesterol	Steroids Chloroquine MTX/AZA [12] No biologic use
Breda *et al.* [41]	Oligo Polyarticular	38	↑ Total cholesterol ↑ LDL ↑ Triglycerides √ HDL	NSAIDs/DMARDs (predominantly MTX) alone [22] Etanercept [16]

Obesidad

Pelajo *et al. Pediatric Rheumatology* 2012, **10**:3
http://www.ped-rheum.com/content/10/1/3

PEDIATRIC
RHEUMATOLOGY

SHORT REPORT **Open Access**

Obesity and disease activity in juvenile idiopathic arthritis

Christina F Pelajo*, Jorge M Lopez-Benitez and Laurie C Miller

Obesidad

- Presentan disminución de la actividad física
- Tratamiento con CTC

DBT

- Los pacientes con AIJ tienen mayor prevalencia de DBT tipo I
- En AR hay mayor incidencia de insulino resistencia y DBT
- El tratamiento con CTC aumenta el riesgo de insulino resistencia

HTA

- La TA en niños con AIJ es mayor que en casos controles, pero dentro de rangos de normalidad

Actividad Física

- Se recomienda realización de actividad física regular de intensidad moderada
- El dolor es la principal limitación

Enfermedad inflamatoria activa

Disfunción endotelial → ↑↑ ateroesclerosis

Arthritis Care & Research
Vol. 63, No. 12, December 2011, pp 1736–1744
DOI 10.1002/acr.20613

ORIGINAL ARTICLE

Changes in Vascular Function and Structure in Juvenile Idiopathic Arthritis

ANTONIOS P. VLAHOS, PARASKEVI THEOCHARIS, ARIS BECHLIOULIS, KATERINA K. NAKA,

La función endotelial se ve afectada en pacientes con AIJ a una edad muy temprana. La disfunción vascular puede atribuirse en parte a los efectos de las características relacionadas con la enfermedad (inflamación, actividad de la enfermedad y medicamentos).

El aumento de los marcadores de actividad inflamatoria (PCR) y la actividad de la enfermedad son FR independientes de morbi-mortalidad CV en AR

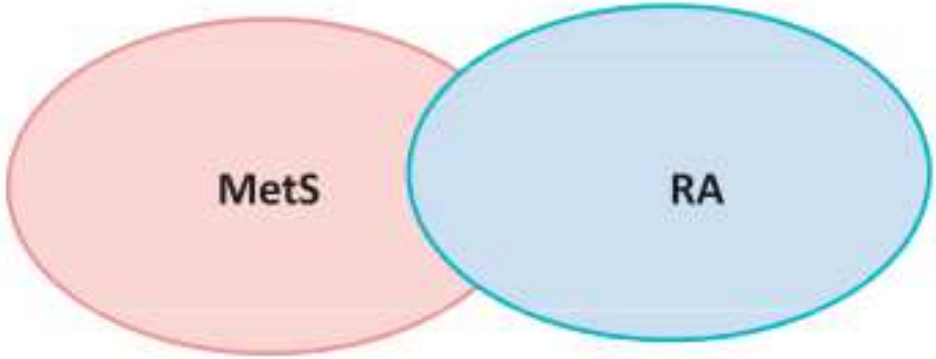
RHEUMATOLOGY

Rheumatology 2011;50:1944–1954
doi:10.1093/rheumatology/ker232
Advance Access publication 13 July 2011

Review

Cardiovascular risk and rheumatoid arthritis—the next step: differentiating true soluble biomarkers of cardiovascular risk from surrogate measures of inflammation

Lukasz Kozera[1], Jacqueline Andrews[1,*] and Ann W. Morgan[1,*]



↑TNF, ↑IL-6, ↑CRP,
↑leptin ,↑resistin, ↑/↓adiponectin,
↑insulin, ↑glucose

↑TNF, ↑IL-1, ↑IL-6, ↑CRP, ↑SAA,
↑leptin, ↑adiponectin , ↑visfatin
↑insulin, ↑glucose

↓

Endothelial dysfunction: ↑MCP-1, ↑sICAM-1, ↑sVCAM-1,
↑sE-selectin, ↓ sL-selectin, ↑VWF, ↑tPA, ↑PAI-1

↓

Plaque instability: ↑MMP9,↑myeloperoxidase, ↑sCD40L

↓

Cardiac overload/ Ventricular dysfunction: ↑NT-proBNP

Que rol juegan los fármacos en el riesgo CV??

Corticoides

- HTA
- Insulino-resistencia
- Aumento de peso

AINES

- HTA

Se asocian a mayor riesgo CV

LOS TRATAMIENTOS CON TNF Y METROTEXATE REDUCEN EL RIESGO CV, EL GROSOR DE LA INTIMA CAROTIDEA Y LA INCIDENCIA DE EVENTOS CV MAYORES

Recommendation

EULAR recommendations for cardiovascular disease risk management in patients with rheumatoid arthritis and other forms of inflammatory joint disorders: 2015/2016 update

R Agca,[1] S C Heslinga,[1] S Rollefstad,[2] M Heslinga,[1] I B McInnes,[3] M J L Peters,[4] T K Kvien,[5] M Dougados,[6] H Radner,[7] F Atzeni,[8] J Primdahl,[9,10,11] A Södergren,[12] S Wallberg Jonsson,[12] J van Rompay,[13] C Zabalan,[14] T R Pedersen,[15] L Jacobsson,[16,17] K de Vlam,[18] M A Gonzalez-Gay,[19] A G Semb,[20] G D Kitas,[21] Y M Smulders,[4] Z Szekanecz,[22] N Sattar,[23] D P M Symmons,[24] M T Nurmohamed[25]

	Level of evidence	Strength of recommendation	Level of agreement (SD)
Overarching principles A. Clinicians should be aware of the higher risk for CVD in patients with RA compared with the general population. This may also apply to AS and PsA. B. The rheumatologist is responsible for CVD risk management in patients with RA and other IJD. C. The use of NSAIDs and corticosteroids should be in accordance with treatment-specific recommendations from EULAR and ASAS			
Recommendations			
1. Disease activity should be controlled optimally in order to lower CVD risk in all patients with RA, AS or PsA	2b-3	B	9.1 (1.3)
2. CVD risk assessment is recommended for all patients with RA, AS or PsA at least once every 5 years and should be reconsidered following major changes in antirheumatic therapy	3–4	C	8.8 (1.1)
3. CVD risk estimation for patients with RA, AS or PsA should be performed according to national guidelines and the SCORE CVD risk prediction model should be used if no national guideline is available	3–4	C–D	8.7 (2.1)
4. TC and HDLc should be used in CVD risk assessment in RA, AS and PsA and lipids should ideally be measured when disease activity is stable or in remission. Non-fasting lipids measurements are also perfectly acceptable	3	C	8.8 (1.2)
5. CVD risk prediction models should be adapted for patients with RA by a 1.5 multiplication factor, if this is not already included in the model	3–4	C	7.5 (2.2)
6. Screening for asymptomatic atherosclerotic plaques by use of carotid ultrasound may be considered as part of the CVD risk evaluation in patients with RA	3–4	C–D	5.7 (3.9)
7. Lifestyle recommendations should emphasise the benefits of a healthy diet, regular exercise and smoking cessation for all patients	3	C	9.8 (0.3)
8. CVD risk management should be carried out according to national guidelines in RA, AS or PsA, antihypertensives and statins may be used as in the general population	3–4	C–D	9.2 (1.3)
9. Prescription of NSAIDs in RA and PsA should be with caution, especially for patients with documented CVD or in the presence of CVD risk factors	2a-3	C	8.9 (2.1)
10. Corticosteroids: for prolonged treatment, the glucocorticoid dosage should be kept to a minimum and a glucocorticoid taper should be attempted in case of remission or low disease activity; the reasons to continue glucocorticoid therapy should be regularly checked	3–4	C	9.5 (0.7)

CONCLUSIÓN

Incorporar el riesgo CV como parte de la atención clínica rutinaria de estos pacientes.

Muchas gracias!!!