Outreach

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Books can be searched for using SWIMS our online catalogue at www.swims.nhs.uk. Books and journals that are not available on site or electronically may be requested from other locations. Please email requests to: thomas.osborne@uhbristol.nhs.uk
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If you require full articles please email me @ Thomas.Osborne@UHBristol.nhs.uk

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Best Practice & Research Clinical Rheumatology –
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Differences in persistency with teriparatide in patients with osteoporosis according to gender and health care provider

Associations of polymorphisms in the SOST gene and bone mineral density in postmenopausal Chinese Women

Association of stressful life events with accelerated bone loss in older men: the osteoporotic fractures in men (MrOS) study

Cost-effectiveness of training rural providers to identify and treat patients at risk for fragility fractures

Post-fracture pharmacotherapy for women with osteoporotic fracture: analysis of a managed care population in the USA

Estrogen alone or in combination with parathyroid hormone can decrease vertebral MEF2 and sclerostin expression and increase vertebral bone mass in ovariectomized rats

A trabecular plate-like phenotype is overrepresented in Chinese-American versus Caucasian women

Vitamin D insufficiency over 5 years is associated with increased fracture risk—an observational cohort study of elderly women

Bone quality of the newest bone formed after two years of teriparatide therapy in patients who were previously treatment-naïve or on long-term alendronate therapy

Comparison of the effect of 18-month daily teriparatide administration on patients with rheumatoid arthritis and postmenopausal osteoporosis patients


Comparison of the effects of three oral bisphosphonate therapies on the peripheral skeleton in postmenopausal osteoporosis: the TRIO study

Osteocyte control of bone remodeling: is sclerostin a key molecular coordinator of the balanced bone resorption–formation cycles?

Vitamin D and skeletal health in infancy and childhood

Latest relevant Systematic Reviews from the Cochrane Library

If you require full articles, or a more enhanced search of any of the below topics please email me @ Thomas.Osborne@UHBristol.nhs.uk

Uricosuric medications for chronic gout

Alison SR Kydd, Rakhi Seth, Rachelle Buchbinder, Christopher J Edwards and Claire Bombardier

Non-pharmacological interventions for preventing job loss in workers with inflammatory arthritis

Jan L Hoving, Diane Lacaille, Donna M Urquhart, Timo J Hannu, Judith K Sluiter and Monique HW Frings-Dresen
Stem cells could repair Parkinson's damage

"Stem cells can be used to heal the damage in the brain caused by Parkinson's disease," BBC News reports following the results of new Swedish research in rats...

New activity in Uptodate/DynaMed

Hypogammaglobulinemia following rituximab therapy (November 2014)

Rituximab, a monoclonal antibody used in the treatment of hematologic malignancies and several autoimmune and rheumatologic disorders, depletes B cells and may cause hypogammaglobulinemia in some patients. Early clinical trials suggested that hypogammaglobulinemia following rituximab administration was transient and not associated with serious infections. However, subsequent reports have described persistent hypogammaglobulinemia associated with significant infections in a small subset of patients. A retrospective review of 19 patients with persistent, symptomatic hypogammaglobulinemia included patients who had received rituximab for periods ranging from one month to four years for hematologic malignancies or autoimmune or rheumatologic disorders [2]. Most patients experienced sinopulmonary infections, but three had enteroviral meningoencephalitis (with one fatality). All but one required immune globulin replacement to prevent infections. Clinicians should be aware of this complication, particularly in patients receiving multiple courses of rituximab, although risk factors for and incidence of hypogammaglobulinemia remain poorly defined. (See "Secondary immunodeficiency induced by drugs and biologics", section on 'Hypogammaglobulinemia'.)

Cytoplasmic 5'-nucleotidase 1A (cN1A) antibodies in inclusion body myositis (November 2014)

There are no definitive diagnostic laboratory tests for inclusion body myositis. However, testing for autoantibodies directed against cytoplasmic 5'-nucleotidase 1A (cN1A) may be helpful in establishing the diagnosis of inclusion body myositis (IBM). A study evaluated the diagnostic performance of IgM, IgA, and IgG anticN1A serum antibodies detected by enzyme linked immunosorbent assay (ELISA) in 205 patients, 50 of whom had IBM [4]. A combination assay of all three autoantibody levels resulted in a sensitivity and specificity of 76 and 91 percent, respectively. This assay is not yet commercially available and additional studies are needed to confirm the diagnostic utility of such testing. (See "Clinical manifestations and diagnosis of inclusion body myositis", section on 'Laboratory testing'.)

Statin-associated adverse muscle events (October 2014)
Terminology around statin-associated adverse muscle events is variable and has changed over time. The 2014 National Lipid Association Statin Muscle Safety Task Force has proposed new definitions for these adverse events [5], which are reflected in our discussion of statin myopathy. Additionally, we no longer suggest a trial of Coenzyme Q10 (CoQ10) for patients experiencing such statin-associated adverse muscle events. (See "Statin myopathy", section on ‘Coenzyme Q10’ and "Statin myopathy", section on ‘Definitions’.)

Individually tailored hand exercise program for rheumatoid arthritis (October 2014)

An individualized hand exercise program involving stretching and strengthening may provide additional benefit to patients with rheumatoid arthritis (RA), even those on a stable regimen of disease-modifying antirheumatic drugs. In a randomized trial involving nearly 500 patients with RA, the addition of an individually tailored strengthening and stretching hand exercise program to usual care from a therapist resulted in significantly greater improvement in overall hand function at one year of follow-up compared with usual care alone [13]. (See "Nonpharmacologic and preventive therapies of rheumatoid arthritis", section on ‘Occupational therapy’.)

Tofacitinib safety and risk of Herpes zoster in RA (October 2014)

The relative safety of tofacitinib, the orally administered Janus kinase inhibitor, was examined in an analysis of data from randomized trials and long-term extension studies involving more than 4700 patients with rheumatoid arthritis (RA) with more than 8000 patient-years of exposure to the drug [14]. The frequency of serious infections, which was stable over time, and the all cause mortality rate were comparable to those previously reported in patients with RA receiving biologic disease-modifying antirheumatic drugs (DMARDs). Factors associated with an increased risk of serious infection with tofacitinib use were age, glucocorticoid dose, diabetes, tofacitinib dose, and lymphopenia. (See "Treatment of rheumatoid arthritis resistant to initial DMARD therapy in adults", section on ‘Tofacitinib’.)

Abatacept in patients with proliferative lupus nephritis (November 2014)

CTLA4-Ig (abatacept) is a fusion protein that competitively inhibits CD28-B7 T cell costimulation. In the Abatacept and Cyclophosphamide Combination Efficacy and Safety Study (ACCESS), 134 patients with proliferative lupus nephritis (half also had membranous lupus) were treated with cyclophosphamide and glucocorticoids and were randomly assigned to also receive abatacept or placebo [21]. All patients received azathioprine after the conclusion of cyclophosphamide until week 24. The complete response rate at 24 weeks was 33 percent with abatacept and 31 percent with placebo. The total response rate at 24 weeks (complete or partial) was 59 percent in both groups. At one year, 64 percent of patients in the abatacept group and 68 percent in the placebo group had a complete or partial remission. Adverse events were similar between the two groups. Thus, these data do not support the use of abatacept in the initial treatment of proliferative lupus nephritis. (See “Therapy of diffuse or focal proliferative lupus nephritis”, section on ‘Costimulatory blockade with CTLA4-Ig’.)

Combination tacrolimus and mycophenolate mofetil in patients with lupus nephritis
Cyclophosphamide or mycophenolate mofetil (MMF), in combination with glucocorticoids, are the preferred agents for initial therapy in patients with focal or diffuse proliferative lupus nephritis (LN). A “multitarget” regimen that combined tacrolimus, low-dose MMF, and prednisone was compared with high-dose cyclophosphamide and prednisone in 368 Chinese patients with LN [22]. At 24 weeks, the rate of complete remission, defined as 24-hour urine protein excretion of 0.4 g or less, serum albumin of 3.5 g/dL or more, normal serum creatinine, and absence of an active urine sediment, was greater in the multitarget group (46 versus 26 percent) as was the overall response rate (complete or partial remission; 84 versus 63 percent). Serious adverse events, particularly infections, were more common with multitarget therapy (7 versus 3 percent), as was dropout due to adverse events (6 versus 2 percent). The study was limited by the lack of long-term follow-up of kidney function and by the fact that tacrolimus can reduce proteinuria through a hemodynamic mechanism (which may be unrelated to immunologic recovery). Since all of the patients in this trial had a normal serum creatinine at baseline, proteinuria reduction without immunological recovery could have been classified as a remission. Pending further data, we do not advise this multitarget regimen as induction therapy for most patients with proliferative lupus nephritis. (See “Therapy of diffuse or focal proliferative lupus nephritis”, section on ‘Tacrolimus’.)

CTLA-4 haploinsufficiency with autoimmune infiltration (CHAI) disease (October 2014)

Cytotoxic T lymphocyte antigen 4 (CTLA-4) is an inhibitory receptor expressed on regulatory T (Treg) cells. Based on studies of four unrelated families, haploinsufficiency of CTLA-4 has been shown to result in an autoimmune lymphoproliferative syndrome (ALPS)-like disorder with dysregulation of Treg cells and hyperactivation of effector T cells. Patients demonstrated lymphoproliferation, lymphocytic infiltration of nonlymphoid organs, autoimmune cytopenias, and B cell abnormalities with hypogammaglobulinemia [23]. A similar spectrum of clinical complications can result from CTLA-4-blocking agents (eg, ipilimumab, abatacept) that are used in patients with cancer and autoimmune disease. (See “Autoimmune lymphoproliferative syndrome (ALPS): Clinical features and diagnosis”, section on ‘CTLA-4 haploinsufficiency with autoimmune infiltration (CHAI) disease’.)

Degenerative joint disease of the knee

Closing-wedge high tibial osteotomy may increase conversion to total knee arthroplasty over 6 years compared to opening-wedge osteotomy in patients with medial compartment OA of knee (J Bone Joint Surg Am 2014 Sep 3)
Ankylosing spondylitis

nonpharmacologic interventions for preventing job loss in adults with inflammatory arthritis have limited evidence to evaluate efficacy and adverse effects (Cochrane Database Syst Rev 2014 Nov 6)

Rheumatoid arthritis (RA)

nonpharmacologic interventions for preventing job loss in adults with inflammatory arthritis have limited evidence to evaluate efficacy and adverse effects (Cochrane Database Syst Rev 2014 Nov 6)

Systemic lupus erythematosus (SLE)

case report of SLE (Lancet 2014 May 29 early online)

Degenerative joint disease of the low back

treatment with bone morphogenetic protein not associated with increased risk of invasive cancer in patients having spinal arthrodesis (J Bone Joint Surg Am 2014 Sep 3)

Ankylosing spondylitis

fat infiltration on sacroiliac joint MRI appears to have limited utility for diagnosis of nonradiographic axial spondyloarthritis (J Rheumatol 2014 Jan)

Fibromyalgia

aquatic exercise may increase muscle strength and reduce stiffness in adults with fibromyalgia, but may not have clinically important benefit in improving pain or function (Cochrane Database Syst Rev 2014 Oct 28)

Biologic disease- maintenance therapy with reduced
modifying antirheumatic drugs (DMARDs) for rheumatoid arthritis
dose etanercept (25 mg) plus methotrexate increases sustained remission rates compared to methotrexate alone following induction with etanercept 50 mg plus methotrexate for early moderate-to-severe active RA (N Engl J Med 2014 Nov 6)

Combination therapies for rheumatoid arthritis
maintenance therapy with reduced dose etanercept (25 mg) plus methotrexate increases sustained remission rates compared to methotrexate alone following induction with etanercept 50 mg plus methotrexate for early moderate-to-severe active RA (N Engl J Med 2014 Nov 6)

Etanercept
maintenance therapy with reduced dose etanercept (25 mg) plus methotrexate increases sustained remission rates compared to methotrexate alone following induction with etanercept 50 mg plus methotrexate for early moderate-to-severe active RA (N Engl J Med 2014 Nov 6)

Granulomatosis with polyangiitis
rituximab appears more effective than azathioprine for maintenance of remission in patients with ANCA-associated vasculitis (N Engl J Med 2014 Nov 6)

Adhesive capsulitis of shoulder
some electrotherapy modalities may improve pain and function in patients with adhesive capsulitis
Festive Reading

Were James Bond’s drinks shaken because of alcohol induced tremor?

BMJ 2013; 347 doi: http://dx.doi.org/10.1136/bmj.f7255 (Published 12 December 2013)

Abstract

Objective To quantify James Bond’s consumption of alcohol as detailed in the series of novels by Ian Fleming.

Design Retrospective literature review.

Setting The study authors’ homes, in a comfy chair.

Participants Commander James Bond, 007; Mr Ian Lancaster Fleming.

Main outcome measures Weekly alcohol consumption by Commander Bond.

Methods All 14 James Bond books were read by two of the authors. Contemporaneous notes were taken detailing every alcoholic drink taken. Predefined alcohol unit levels were used to calculate consumption. Days when Bond was unable to consume alcohol (such as through incarceration) were noted.

Results After exclusion of days when Bond was unable to drink, his weekly alcohol consumption was 92 units a week, over four times the recommended amount. His maximum
daily consumption was 49.8 units. He had only 12.5 alcohol free days out of 87.5 days on which he was able to drink.

**Conclusions** James Bond’s level of alcohol intake puts him at high risk of multiple alcohol related diseases and an early death. The level of functioning as displayed in the books is inconsistent with the physical, mental, and indeed sexual functioning expected from someone drinking this much alcohol. We advise an immediate referral for further assessment and treatment, a reduction in alcohol consumption to safe levels, and suspect that the famous catchphrase “shaken, not stirred” could be because of alcohol induced tremor affecting his hands.

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