



PIC QUESTION OF THE WEEK: 7/16/07

Q: What are the current recommendations for the treatment of pseudogout?

A. Calcium pyrophosphate dihydrate (CPPD) crystals frequently deposit in aging and osteoarthritic articular cartilage. Although typically found in joints of the knees, hands, and wrist, the crystals have been identified in many other sites including the temporomandibular joints. The term chondrocalcinosis is often used to describe the radiographic appearance of calcified cartilage. A number of clinical syndromes have been included under the heading calcium pyrophosphate deposition disease (CPDD). Presence of these crystals in the synovium occasionally stimulates an inflammatory response similar to acute gouty arthritis, thus the term *pseudogout*. Some patients suffer from only occasional attacks while others experience more chronic symptoms. The treatment of pseudogout is quite similar to that of acute gouty arthritis. Generally accepted treatment strategies include non-steroidal antiinflammatory drugs (NSAIDs) such as indomethacin, ketoprofen, naproxen, etc. Prednisone in doses of 40-50 mg per day tapered over 7-10 days is a suggested option. Intra-articular corticosteroids may also be of occasional benefit. Patients with pseudogout do respond to colchicine; however, frequent gastrointestinal complaints have now reduced its popularity. In some cases, standard treatment provides only temporary relief and patients suffer from repeated attacks. NSAIDs are commonly prescribed in patients with chronic pseudogout. Another interesting option for management of chronic attacks is methotrexate (MTX). This folate antagonist produces a variety of anti-inflammatory effects including down-regulation of polymorphonuclear (PMN) leukocyte recruitment and activation. MTX also increases the release of adenosine, a nucleoside that contributes to multiple antiinflammatory effects. A recent trial conducted in five patients with chronic pseudogout revealed an improvement in all clinical and laboratory parameters upon treatment with MTX. Patients received a median dose of 12.5 mg weekly along with supplemental folate. Reduction of symptoms was noted after a mean of 7.5 weeks (range 4-16 weeks) of therapy. Methotrexate is not intended for use in acute attacks of pseudogout. Patients who experience symptoms consistent with pseudogout should be referred to a rheumatologist for evaluation and treatment.

References:

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