Rheumatological emergencies in clinical practice

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Develop an attitude of gratitude, and give thanks for everything that happens to you, knowing that every step forward is a step toward achieving something bigger and better than your current situation.

—Brian Tracy
classification

- True rheumatological emergencies
- Medical emergencies in patients with systemic rheumatic diseases
True rheumatological emergencies

- Acute low back ache
- Acute gout
- Acute arthritis
  - Arthritis rising denovo
  - Acute exacerbation in a patient with chronic arthritis e.g. Rheumatoid flare
- Lupus flare
- Systemic necrotizing vasculitides
- Scleroderma renal crisis
- Catastrophic antiphospholipid syndrome
- Erythema nodosum
Medical emergencies in patients with systemic rheumatic diseases

- NSAID induced gastrointestinal bleeding
- Acute left ventricular failure in lupus nephritis with hypertension
- Intracranial bleed in lupus nephritis with HT
- Tuberculous meningitis in SLE
- Acute adrenal insufficiency due to sudden steroid withdrawal
- Seizures in SLE
- Cyclophosphamide induced haemorrhagic cystitis
- Drug induced bone marrow suppression
1. Acute Low back ache

- 40% cases recover within one week
- 80% cases recover within three weeks
- 90% cases recover within six weeks
- Only 7-10% experience symptoms for more than six months
- Only 1% require surgical intervention
Important causes of acute low back ache

- Reactive arthritis
- Epidural abscess
- Osteoporotic fracture
- Prolapsed intervertebral disc
- Rapture of abdominal aortic aneurysm
- Aortic dissection
Patients with low back ache who need laboratory testing/x-ray

- Trauma
- Neurologic dysfunction
- Sphincter involvement
- Constitutional/systemic features
- Previous malignancy
- Older age
- Drug/alcohol abuse
Indications for surgical intervention in low backache

- Fractures/dislocation
- Epidural abscess
- Pott’s spine
- Tumours
- Aortic dissection/aneurysm rapture
2. Acute Gout

- Clinical diagnosis
- Crystal identification
- Serum uric acid may be normal
- Medications
  - NSAIDs
  - Colchicine
  - Steroids
  - ACTH
- Allopurinol
  - Do not introduce till pain is controlled
3. Acute Arthritis

- Acute monoarthritis
  - Septic arthritis
  - Gout
  - Trauma

- Acute oligo/polyarthritis
  - Reactive arthritis
  - Viral arthritis
  - Rheumatic fever
  - HIV
  - Disseminated gonococcal infection
Acute monoarthritis

- Medical emergency
- Immediate joint aspiration and synovial fluid analysis
4. Lupus flare

- Precipitants
  - Stress
  - Exposure to sunlight
  - Steroid reduction/withdrawal
  - Pregnancy
  - Infection
  - etc

- Rule out infection if febrile
- Low TLC and normal CRP favour lupus activity
- Leucocytosis and raised CRP suggest infection
- Withdraw precipitating factor
- Increase corticosteroid dosage
5. Systemic vasculitides

- Escalation of immunosuppressive treatment
  - Corticosteroids
  - Azathioprine
  - Cyclophosphamide
- Intravenous methyl prednisolone pulses
6. Scleroderma renal crisis

- **Risk factors**
  - Diffuse skin disease
  - New unexplained anemia
  - New cardiac events
  - High dose steroids
  - Anti-RNA polymerase III antibodies

- **Features**
  - Accelerated hypertension
  - Rapidly progressive renal failure
  - Increased plasma renin activity
  - Thrombocytopenia
  - Microangiopathic hemolytic anemia

- **Treatment**
  - ACE inhibitors
  - Dialysis
7. Catastrophic Antiphospholipid syndrome (CAPS)

- Multi-organ failure in a patient with APS
  - Pulmonary
  - Gastrointestinal
  - Renal
  - Neurologic

- Precipitating factors
  - Surgery
  - Infections
  - Oral contraceptives
  - Anticoagulant withdrawal

- Treatment
  - Heparin
  - Aspirin
  - Steroids
  - Plasmapharesis
8. Erythema nodosum

- Painful erythematous nodules on shin and lower limbs
- Affected joints:
  - Ankles
  - Knees, hips, wrists, fingers, shoulders and elbows
- May be idiopathic

- Triggers
  - Infections (Streptococcal pharyngitis, TB)
  - Drugs (Sulphonamides, penicillins etc)
  - Sarcoidosis
  - Lymphoma
  - Inflammatory bowel disease
  - Behcet’s syndrome
Erythema nodosum: treatment

- A self limiting disease
- NSAIDS for pain relief
- Short course of steroids
- Recurrent attacks
  - Potassium iodide
  - Colchicine
  - dapsone
There are no secrets to success. It is the result of preparation, hard work, and learning from failure.

~Colin Powell
Conclusion

- Rheumatologic emergencies are common in clinical practice
- Can be handled by physicians
- Only a fraction require rheumatology referral or orthopedic intervention