Reumatol Clin. 2018;14(1):59–62

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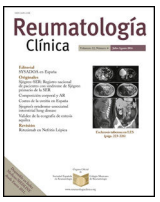

Letters to the Editor

Is gout an easy-to-treat disease? The importance of health determinants

¿Es la gota una enfermedad fácil de tratar? La importancia de los determinantes de salud

Dear Editor,

The patient is a 60-year old man we attended during a rheumatology campaign at his hometown, Etzatlan, Mexico. He has a 30-year history of gout and presented widespread tophus formation with extensive structural damage (Fig. 1). Based on the model of health determinants described by the WHO,[1] we depict the failures that explain why a supposedly easy-to-treat disease[2] progressed to polyarticular chronic tophaceous gout with multidimensional impact.

Genes predispose to the disease but do not determine outcomes. Regarding education and individual lifestyle, the patient had 2 years of schooling, frequently drank alcohol, and had a strong internal locus of control. Regarding healthcare services, the patient attended over 25 general practitioners (GPs), receiving different prescriptions and several contradictory indications, mainly on how to take allopurinol which varied from daily suboptimal doses to periodic use as "prophylaxis" when the patient planned to drink alcohol. The patient visited a rheumatologist once, who explained the disease in detail and how to treat it. But the patient did not understand and the rheumatologist did not make sure he understood. In fact, the patient perceived great disagreement among the visited physicians, so he decided what to do: take bethametasone, limit alcohol intake to weekends, and assigned allopurinol as the cause of worsening because every time he took it had an acute attack. Community and social networks also failed. He always attended medical appointments alone; his wife and children are resentful because he has not worked for the last 15 years and his children had to start working, which prevented them from attending high school. The socioeconomic and cultural conditions, such as myths surrounding the disease, the use of nonconventional therapies, and living in a small town without specialized medical services also had a negative impact.

Unfavorable health determinants may explain the reported increase in severity of gout in several countries[3–7]; there are several protagonists involved on these. In the sense of shared responsibility, the poor outcome of this patient, and of many others as reported in the literature, can be assigned not only to the patient's behavior, but also to GPs and their misconceptions; the inefficiency of social and community networks; the rheumatologist and his unadjusted communication skills towards his patient's culture; the health-care system and its inability to care for people beyond the activities of diagnosing and prescribing drugs to just the ones that attend to the clinics, etc. Perhaps if only one of the protagonists had done his job well, such multidimensional impact of an "easy-to-treat disease" would not have occurred.

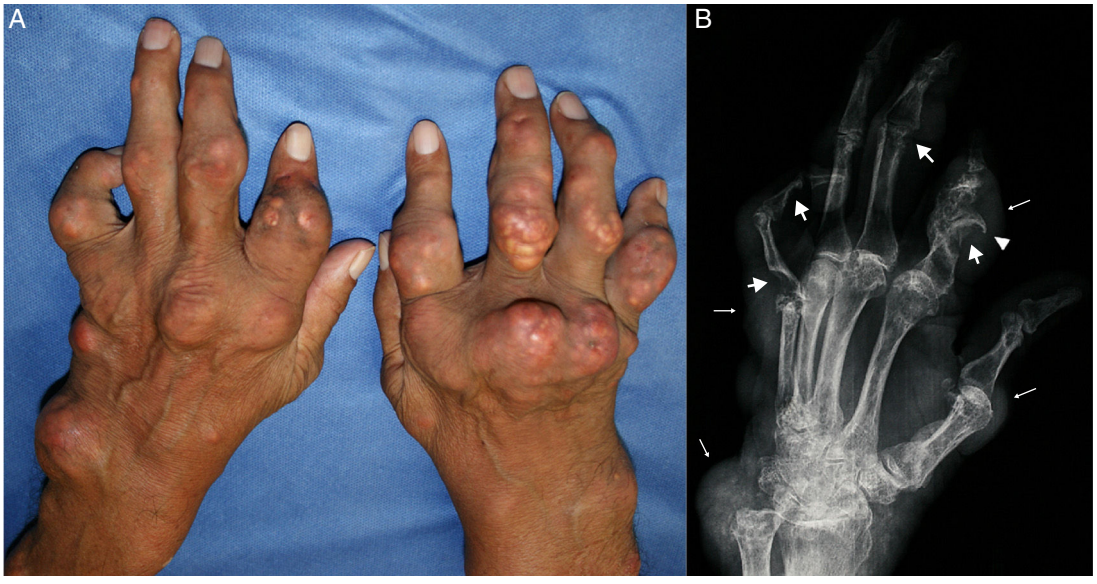

Fig. 1. (A) Tophaceous gout with multiple tophi on both hands. (B) The left hand X-ray shows punched-out erosions (thick arrows) with overhanging edges (arrowhead) and soft tissue nodules (thin arrows), findings suggestive of gout.

Funding

None.

Conflict of interest

The authors declare that they have no conflict of interest.

Acknowledgements

None.

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https://doi.org/10.1016/j.reuma.2017.03.008
1699-258X/

En respuesta a: Deformidad de Madelung

Response to: Madelung deformity

Sr. Editor:

Hemos leído atentamente la publicación de Ly-Pen y Andreu[1] en Reumatología Clínica, donde se presenta el caso de una mujer de 39 años, diagnosticada de síndrome del túnel carpiano bilateral secundario a deformidad de Madelung tratada mediante infiltración local con triamcinolona, con mejoría de la sintomatología. Nos gustaría exponer nuestra experiencia en nuestra unidad de reumatología pediátrica.

La deformidad de Madelung es una displasia de la fisis del radio distal. Su cierre prematuro conlleva a una deformidad progresiva con desplazamiento dorsal del cúbito y palmar del carpo, lo que conlleva una limitación de la supinación y la rotación. Afecta a mujeres entre los 8 y los 12 años, generalmente de manera bilateral. Se asocia a diversos síndromes como discondrosis de Leri-Weill, síndrome de Hurler, síndrome de Turner, condrodisplasia y enfermedad de Ollier.

Presentamos el caso de una niña de 14 años, diagnosticada en octubre de 2015 de síndrome de Leri-Weill de forma casual tras realización de radiografía por traumatismo. Presenta mutaciones en el gen SHOX Y en PAR1 en 5′. Acude a reumatología pediátrica derivada por endocrinología por dolor de ambos carpos de características mecánicas que ha aumentado progresivamente durante los últimos meses, con pobre respuesta a ibuprofeno. La exploración física era compatible con deformidad de Madelung bilateral, con dolor a la flexión dorsal de ambos carpos, sin limitación (figs. 1–3). No asociaba parestesias u otros síntomas neurológicos. Se realizó infiltración con 20 mg de triamcinolona en cada carpo, bajo sedación. En posterior revisión un mes después refiere clara mejoría, refiriendo casi total desaparición del dolor desde 24-48 h tras la infiltración con mejoría de la movilidad.

Consideramos, al igual que los autores cuya carta comentamos, que la infiltración local con corticoide es una opción válida en casos de dolor carpiano secundario a deformidad de Madelung en la edad pediátrica, incluso en ausencia de sintomatología

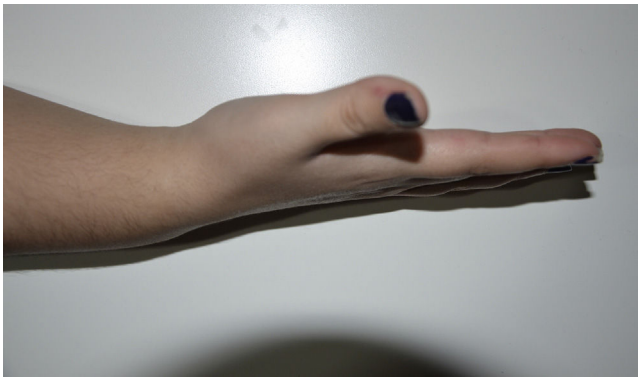

Figura 1.

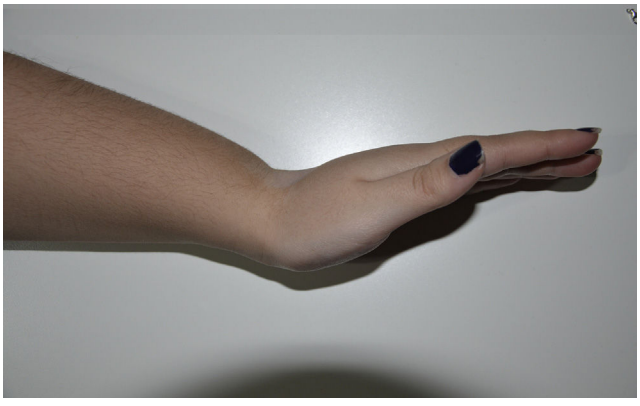

Figura 2.