CURRICULUM VITAE
INFORMAZIONI PERSONALI

COGNOME	Laselva
NOME	Gaetana
Luogo e data di nascita	Polignano a Mare (BA), 18/04/1971
Qualifica	Dirigente Medico
Amministrazione	IRCCS De Bellis "Castellana Grotte - Bari
Incarico attuale	Dirigente Medico – disciplina Medicina Interna, Ambulatorio di Reumatologia
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TITOLI DI STUDIO E PROFESSIONALI ED ESPERIENZE LAVORATIVE

Titoli di studio	Laurea in Medicina e Chirurgia (N.O.) il 18/04/1998 con voto 107/110
	Specializzazione in Reumatologia il 28/11/2002 con voto 50/50 e Lode
	Master di II livello in Reumatologia. "Clinical problem solving in reumatologia (1500 h – 60 cfu)" conseguito il 29/01/2016 con voto106/110, presso l'Università Nicolò Cusano (UNICUSANO) A.A. 2014/2015 – Roma

	I short Master teorico clinico di Reumatologia. Bari 21-26 Maggio 2018 – Università degli studi di Bari **Attestato di idoneità tecnica per l'espletamento dell'incarico di "ADDETTO ANTINCENDIO".** Registrato con verbale n°17804 del giorno 04/04/2019 è in possesso dei requisiti tecnici per l'espletamento dell'incarico di Addetto Antincendio ai sensi dell'art.37 co.9 del Dlvo 81/2008, in base al disposto dell'art. 17 co. 5 del Dlvo 139/2006 e del DM 10.3.98. Attestato rilasciato dal Comandante Provinciale (Dott. Ing. Vincenzo CIANI) del Dipartimento dei vigili del fuoco di Bari.
Altri titoli di studio e Professionali	• Diploma di maturità scientifica; • Idoneità all'esercizio dell'attività medica di emergenza Territoriale-118 conseguito in data 25/09/2003; • Vincitrice di una borsa di studio in favore di un Medico Specializzato in Reumatologia presso l'U.O. di Reumatologia Ospedaliera dell'Azienda Ospedaliera Ospedale Policlinico Consorziale di Bari, per il progetto di ricerca "Monitoraggio clinico di pazienti in trattamento con inibitori del TNF: valutazione degli eventi avversi e delle motivazioni cliniche di laboratorio di un possibile switch", della durata di un anno – inizio Agosto 2005; • Dal Marzo 2009 partecipe del progetto "ROBRI" (Registro Osteoporosi Brindisi)
Esperienze professionali (incarichi ricoperti)	• Dal 13/12/02 al 31/12/02 Medico sostituto di Medicina Generale c/o ASL ex BA /5; • Dal 01/01/2003 al 30/11/2003 Medico del Servizio di Emergenza territoriale 118 c/o ASL ex BA/ 1; • Dal 30/11/2003 allo 08/08/2004 Medico del Servizio di emergenza territoriale 118 c/o ASL ex BA/5; • Dal 09/08/2004 Avviso pubblico a tempo determinato in Medicina Interna fino al 07 Novembre 2004 c/o P.O Ruvo di Puglia la ASL ex Ba/1; • Dal 08 Novembre 2004 al 07 Novembre 2005 c/o la medicina Interna del P.O. di Fasano ASL BR; • Dal 02/01/2006 al 15/08/2007 avviso pubblico a tempo determinato c/o la Medicina Interna del P.O. di Gioia del Colle ASL ex Ba/05; • Dal 16/08/2007 assunzione in ruolo, presso la Divisione III di Pneumologia dell'Ospedale San Paolo di Bari fino al 31/10/2007; • Dal 01/11/2007 assunzione in ruolo c/o la Medicina Interna dello S.O. di Ostuni ASL BR fino al 15/08/2012 • Dal 16/08/2012 trasferimento in mobilità c/o Azienda Ospedaliero Universitaria "Consorziale Policlinico" - Bari fino al 30/04/2021. • Dal 01/05/2021 Dirigente Medico – disciplina Medicina Interna, Ambulatorio di Reumatologia presso IRCCS De Bellis – Castellana Grotte a tutt'oggi.
Capacità Linguistiche	Inglese Scientifico
Capacità nell'uso delle Tecnologie	Software per la gestione dei dati, piattaforme digitali, word, posta elettronica

Altro (partecipazione a **Convegni e seminari, pubblicazioni,collaborazione a riviste, ecc)**	**Pubblicazioni:** • D'Amore M, Marrone M, **Laselva G**, D'Amore S, Morrone LF: Tumor markers in some chronic inflammatory diseases in rheumatology, a statistical evaluation. **Minerva Med 2001 Oct; 92 (5):293-9 Italian PMID: 11675572 (PubMed-indexed for MEDLINE);** • Chiechi L, Secreto G, D'Amore M, Ganelli M, Venturelli E, Cantatore F, Valerio T, **Laselva G**, Loizzi P: Efficacy of a soy rich diet in preventing postmenopausal osteoporosis, the Menfis randomized trial. **Maturitas, 2002 Aug 3°, 42 /4):295. PMID: 12191852**; • P. Sfriso, R. Priori, G. Valesini, S. Rossi, C. M. Montecucco, A. D'Ascanio, L. Carli, S. Bombardieri, **G. Laselva**, F. Iannone, G. Lapadula, S. Alivernini, G. Ferraccioli, M Colaci, C. Ferri, D. Iacono, G. Valentini, L. Costa, R. Scarpa, A. LoMonaco, V. Bagnari, M. Govoni, I. Piazza, S. Adami, F. Ciccia, G. Triolo, E. Alessandri, M. Cutolo, L. Cantarini, M. Galeazzi, P. Ruscitti, R. Giacomelli, F. Caso, P. Galozzi, L. Punzi: Adult-onset Still's disease: an Italian multicentre retrospective observational study of manifestations and treatments in 245 patients. Clin Rheumatol. 2016 Jul;35(7):1683-9 **Comunicazioni:** 1. LoizziP.E., Di Coste D., De masi C., Cariello D., **Laselva G**.: Sindrome del tunnel carpale in una paziente con acromegalia; descrizione di un caso clinico. **Reumatismo 1998; 50N.2 (Suppl.3) 366**; 2. Di Coste D., De Masi C., **Laselva G**.,Cariello D., Scagliusi P.: Anticorpi anti SSA/RO, specificità e significato clinico nei pazienti con Lupus Eritematoso Sistemico. **Reumatismo 1998; 50 N. 2 (Suppl. 3) 419**; 3. P. Scagliusi, D. Di Coste, **G. Laselva**, G. Germinarlo, M. D'Amore: Connettiviti sommerse, il caso della sindrome di Sjogren. **Reumatismo 1999; 51 N2 (Suppl.2) 348**; 4. Di Coste D., **Laselva G**., De Masi C., Loizzi P.E., Scagliusi P. : Significato clinico degli anticorpi anti-SSA/RO nel Lupus Eritematoso Sistemico. **Reumatismo 1999; 51 N.2 (Suppl.2)353**; 5. P. Loizzi, A. Di Chio, D. Di Coste, **G. Laselva**, C. Bottalico, T. Chiarelli: Linfadenite tubercolare, raro caso di infezione specifica e di artrite reattiva. **Reumatismo 1999, 51 N.2 (Suppl.2) 365**; 6. C. Bottalico, A. Di Chio, **G. Laselva**, P. Scagliusi, M. D'Amore: Importanza del dosaggio degli ormoni sessuali nell' osteoporosi maschile. **Reumatismo 1999; 51 N.2 (Suppl.2) 374**; 7. T. Chiarelli, **G. Laselva**, C. Bottalico, A. Di Chio, P. Loizzi : Problemi clinici e terapeutici per un caso clinico di artrite sieronegativa in un paziente affetto da favismo. **Reumatismo 1999; 51 N2 (Suppl.2)381**; 8. **G. Laselva**, L.M. Chiechi, A. Lobascio, F. P. Cantatore, D. Di Coste, M. D'Amore: Utilità di alcuni parametri strumentali e bioumorali nella diagnosi precoce delle osteopatie demineralizzanti. **Reumatismo 1999; 51 N.2 (Suppl. 2) 237**; 9. M. D' Amore, **G. Laselva**, A. Di Chio, T. Valero, A. Grillo, L.F. Morrone, P. Scagliusi: Limiti e vantaggi dei parametri strumentali e di laboratorio nella

	diagnosi delle osteopatie rarefacenti. **100° Congresso Nazionale della Società Italiana di Medicina Interna, 1999-N.158**; 10. M. D' Amore, **G. Laselva**, L.F. Morrone, P. Scagliusi: I markers neoplastici e le malattie infiammatorie croniche in reumatologia, una nuova chiave di lettura? **XIV Seminario Nazionale di Studi Reumatologici, 1999-N.228**; 11. M. D'Amore, **G. Laselva**, S. D'Amore: Utilità di una dieta ricca di fitoestrogeni in donne in postmenopausa nella prevenzione dell'osteoporosi. Dati preliminari. **101° Congresso Nazionale della Società Italiana di Medicina Interna, 2000-N.211**; 12. M. D'Amore, L.M. Chiechi, **G. Laselva**, T. Valerio, A. Grillo, P. Scagliusi: Food prevention with phytoestrogen in postmenopausal osteoporosis, preliminary data. **Annual European Congress of Rheumatology, EULAR 2000, Vol. 59 (Suppl. I) 90 (POS-101)**; 13. A. Trotta, **G. Laselva**, P. Loizzi: I fattori prognostici del danno radiologico nell'Artrite Reumatoide in fase iniziale. **Reumatismo 2000; 52 N.3 (Suppl.2) 537**; 14. **G. Laselva**, A. Trotta, M.P. marrone, P. Loizzi: Incidenza delle malattie cardiovascolari in pazienti affetti da Artrite Reumatoide. **Reumatismo 2000; 52 N.3 (Suppl.2) 539**; 15. P. Loizzi, **G. Laselva**, A. Trotta: Artrite Psoriasica e Amiloidosi. **Reumatismo 2000; 52 N. 3 (Suppl. 2) 606**; 16. M. D'Amore, **G. Laselva**, L.F. Morrone, P. Scagliusi: Studio della correlazione statistica tra markers neoplastici ed indici di flogosi nelle malattie infiammatorie croniche. **Reumatismo 2000; 52 N.3 (Suppl.2) 622**; **17. G. Laselva**, I. Favia, M. Marrone, G. Minenna, A. Trotta, P. Loizzi: La gotta femminile tofacea legata all'assunzione di farmaci diuretici a proposito di tre casi. **Reumatismo 2001; 53 N.3 (Suppl.4)434;** **18.** A. Trotta, M. Marrone, I. Favia, G. Minenna, **G. Laselva**, P. Loizzi: Associazione tra artrite psoriasica e colite ulcerosa. Descrizione di un caso clinico. **Reumatismo 2001; 53 N.3 (Suppl. 4) 434;** 19. P. Scagliusi, G. Minenna, **G. Laselva**, M. D'Amore: La polimialgia reumatica è una potenziale sindrome paraneoplastica (ovvero una "sindrome paraneoplastica ad espressione reumatologica può simulare una polimialgia reumatica"). **Reumatismo 2001; 53 N.3 (Suppl.4) 388**; 20. G. Minenna, M. Marrone, I. Favia, **G. Laselva**, A. Trotta, P. Loizzi: La poliartrite reumatoide ad esordio tardivo. **Reumatismo 2001; 53 N.3 (Suppl.4) 420**; 21. P. Loizzi, I. Favia, M. Marrone, **G. Laselva**, G. Minenna, A. Trotta: La sclerodermia sistemica (SS) quale espressione di una sindrome paraneoplastica. **Reumatismo 2001; 53 N.3 (Suppl.4) 365**; 22. M. D'Amore, P. Scagliusi, A. Trotta, M. Marrone, G. Minenna, **G. Laselva**: Sono i fitoestrogeni un'alternativa valida alle terapie convenzionali nella

	prevenzione dell'osteoporosi postmenopausale. **Reumatismo 2001,53 N.3 (Suppl.4) 272;** 23. M. D'Amore, M.L. Chiechi, **G. Laselva**, A. Grillo, S. D'Amore: Effect of phitoestrogen rich diet on bone mineral density in postmenopausal women. **4th International Symposium, women's health and menopause, new strategies improved quality of life, 2001**; 24. A. Trotta, G. Minenna, F. Papacicco, **G. Laselva**, I. Favia, P. Loizzi: Gli anticorpi contro il citoplasma dei neutrofili con pattern perinucleare (p-ANCA) in pazienti con sclerosi sistemica. **Reumatismo 2002, 54 N.3 (Suppl.2) 254**; 25. **G. Laselva**, M. Tampona, G. Minenna, A. Trotta, I. Favia, F. Papappicco, P. Loizzi: Nuova metodica per la determinazione degli anticorpi dei granulociti neutrofili (ANCA) nelle vasculiti sistemiche (dati preliminari). **Reumatismo 2002, 54 N.3 (Suppl.2) 389**; 26. Pubblicazione su **Case Reports vol III di immune Mediated Inflammatory Diseases** " Efficacia dell'Infliximab in una paziente con iridociclite resistente, sacroileite B27+ e psoriasi cutanea", **2006**; 27. Relatrice al Corso su " Il dolore articolare e periaricolare, uso appropriato dei FANS selettivi e non selettivi in medicina Generale". Gioia del Colle (BA) ,Hotel Svevo,19/05/2007. **28.** P.Piscitelli, V. Rigliano, C.Neglia, G. Chitano, A.Argentiero, D.Paladini, S. mundi, L. paladini, M. Greco, C. Girasoli, M.E.Gianicolo, V. Pantile, D. Argentiero, G.de Padova, L. Nibio, L. Pansa, E.A. Sbenaglia, L.Dipaola, P.Di Giuseppe, A. Minosi, L. Cirasino, **G. Laselva**, M. Scialpi, D. D'Angela, M. Benvenuto, M.L. Brandi, A. Distante- "Early menopause influences osteopenic or osteoporotic status in postmenopausal women: preliminary results from prof project". **Osteoporos Int (2010)21:(Suppl 1)S25-S388;** **29.** P. Piscitelli, V. Rigliano, C. Neglia, G. Chitano, A. Argentiero, D. Paladini,S. Mundi, L. Paladini, M. Greco, C. Girasoli, M. E. Granicolo, V. Pantile, D. argentiero, G. De Padova, L. Nibio, L. Pansa, E. A. Sbenaglia, L. Dipaola, P. Di Giuseppe, A. Minosi, L. Cirasino, **G. Laselva,** M. Scialpi, M. Benvenuto, D. D'Angela, M. L. Brandi, A. Distante -"Low body mass index correlates with osteopenic and/or osteoporotic status in postmenopausal women:The results obtained by bone ultrasonic testing within the prof study. **Osteoporos Int (2010)21:(Suppl 1)S25-S388;** **30.** P. Piscitelli, G. Colì C. Neglia, G. Chitano, A. Argentiero, D. Paladini, S. Mundi, L. Paladini, M. Greco, C. Girasoli, M. E. Granicolo, V. Pantile, D. Argentiero, G. De Padova,L. Pansa, L. Nibio, P.Di Giuseppe, A. Minosi, L. Cirasino, **G. Laselva,** M. scialpi, V. Rigliano, E. A. Sbenaglia, L.Dipaola, M. Benvenuto, D. D'Angela, M. L. Brandi, A. Distante. –"Parental fragility fractures correlate with osteopenic and/or osteoporotic status in postmenopausal women: preliminary results of prof stud with bone ultrasonic testing. **Osteoporos Int (2010)21:(Suppl 1)S25-S388;** 31. P. Piscitelli, G. Colì C. Neglia, G. Chitano, A. Argentiero, D. Paladini, S. Mundi, L. Paladini, M. Greco, C. Girasoli, M. E. Granicolo, V. Pantile, D. Argentiero, G. De Padova, L. Nibio, L. Pansa, P. Di Giuseppe, A. Minosi, L.

	Cirasino, **G. Laselva,** M. scialpi, V. Rigliano, E. A. Sbenaglia, L.Dipaola, M. Benvenuto, D. D'Angela, M. L. Brandi, A. Distante.-"Bone quantitative ultrasound does help to detect patients with fragility fractures: Preliminary results of prof project in salento area. **Osteoporos Int (2010)21:(Suppl 1)S25-S388;** **32.** P. Piscitelli, G. Colì C. Neglia, G. Chitano, A. Argentiero, D. Paladini, S. Mundi, L. Paladini, M. Greco, C. Girasoli, M. E. Granicolo, V. Pantile, D. Argentiero, G. De Padova, L. Pansa, L. Nibio, P. Di Giuseppe, A. Minosi, L. Cirasino, **G. Laselva,** M. scialpi, V. Rigliano, E. A. Sbenaglia, L.Dipaola, M. Benvenuto, D. D'Angela, M. L. Brandi, A. Distante.-"Reduced physical activity correlates with osteopenic or osteoporotic status in postmenopausal women: Preliminary results from the prof project. **Osteoporos Int (2010)21:(Suppl 1)S25-S388;** 33. M.G. Anelli, C. Scioscia, C. Rotondo, A. Notarnicola, G. Lopalco, E. Praino, L. Coladonato, S. Lopriore, N. Lascaro, A. Rinaldi, L. Dinoia, A. Zaza, **G. Laselva**, L. Serafino, M. Covelli, F. Iannone, G. Lapadula. Incremento del numero di nuove diagnosi e miglioramento nella precocità della diagnosi in una coorte di pazienti con "early inflammatory arthritis" (eia): esperienza di sei anni di follow-up. **Reumatismo 2013, Vol.65 (Num. Spec. 2) 72**; 34. M.G. Anelli, C. Scioscia, C. Rotondo, A. Notarnicola, G. Lopalco, E. Praino, L. Coladonato, S. Lopriore, N. Lascaro, A. Rinaldi, L. Dinoia, **G. Laselva**, L. Serafino, M. Covelli, F. Iannone, G. Lapadula. Sei anni di follow-up in una coorte di pazienti con "early inflammatory polyarthritis": l'esperienza di Bari. **Reumatismo 2013, Vol.65 (Num. Spec. 2) 320**; 35. L. Dinoia, A. Notarnicola, S. Lopriore, N. Lascaro, **G. Laselva**, F. Iannone, G. Lapadula. Valutazione della leucopenia in una coorte di pazienti in terapia con farmaci biotecnologici. **Reumatismo 2013, Vol.65 (Num. Spec. 2) 322**; 36. E. Praino, E. Lanciano, G. Lopalco, L. Coladonato, C. Rotondo, C. Scioscia, M.G. Anelli, A. Notarnicola, **G. Laselva**, M. Covelli, F. Iannone, G. Lapadula. Un raro caso di morphea generalizzata e sclerosi sistemica: esordio atipico o evoluzione atipica? **Reumatismo 2013, Vol.65 (Num. Spec. 2) 338**; 37. S. Lopriore, L. Coladonato, N. Lascaro, G. Lopalco, A. Rinaldi, **G. Laselva**, G. Lapadula. Pericardite refrattaria come manifestazione d'esordio della arterite di takayasu. **Reumatismo 2013, Vol.65 (Num. Spec. 2) 338**; 37. C. Rotondo, M.G. Anelli, C. Scioscia, A. Sergio, A. Caputo, R. Lavermicocca, R. Vendola, S. Lopriore, N. Lascaro, A. Rinaldi, E. Praino, **G. Laselva**, L. Serafino, M. Covelli, F. Iannone, G. Lapadula Efficacia del trattamento riabilitativo domiciliare e servizio innovativo di telemedicina nei pazienti con spondilite anchilosante: uno studio pilota. **Reumatismo 2013, Vol.65 (Num. Spec. 2) 345**; 38. Fornaro M, Cacciapaglia F, Lopalco G, Venerito V, Schiraldi S, Renna D, Laselva G, Scioscia C, Lapadula G, Iannone F. (2019). AB0245 PREDICTORS OF BIOLOGIC THERAPY DISCONTINUATION IN RHEUMATOID ARTHRITIS PATIENTS AFTER REMISSION ACHIEVEMENT: A MONOCENTRIC

	OBSERVATIONAL STUDY FROM BIOLOGIC APULIAN REGISTRY (BIOPURE). **DOI: 10.1136/annrheumdis-2019-eular.2890** **39.** F Iannone, M Nivuori, G Lopalco, M G Anelli, L Coladonato, G Laselva, C Scioscia. FIBROMYALGIA IS THE STRONGEST NEGATIVE PREDICTOR FOR THE ACHIEVEMENT OF EITHER REMISSION AND MINIMAL DISEASE ACTIVITY IN NAÏVE PSORIATIC ARTHRITIS PATIENTS STARTING BIOLOGIC DRUGS. **DOI: 10.1136/annrheumdis-2019-eular.2220** **40.** S. Perniola, F. Cacciapaglia, M. Nivuori, M. Giannini, M. Giannotta, G. Laselva, C. Fiorentini, G. Lapadula, F. Iannone. Impact of biological therapies for rheumatoid arthritis on lipid profile. P59. Presentazione poster. **Reumatismo, vol. 68 (numero speciale3). 2016** **Poster 06:70- SIR 2014:** M.G. Anelli, C. Scioscia, C.Rotondo, N. Lascaro, S. Perniola, E. Praino, L. Coladonato, M. Nivuori, **G. Laselva**, L. Serafino, F. Iannone, M. Covelli, G. Lapadula Incremento del numero di nuove diagnosi in una coorte di pazienti con "Early inflammatory Arthritis (EIA): esperienza di sette anni di follow-up **Poster 12:140 – SIR 2014:** S. Lopriore, N. Lascaro, **G. Laselva**, S. Perniola, M. Covelli, G. Lapadula, F. Iannone Un caso di vasculite intestinale in una paziente con Sindrome Rhupus. **Poster 2:22-**Trattamento con Abatacept in paziente affetta da artrite psoriasica associata ad uveiti recidivanti. N. Lascaro, A. Rinalsdi, R. Fanizzi, M.G. Anelli,**G. Laselva**, G. Lapadula, F. Iannone- Reumatismo 2015 vol. 67 8 numero speciale 2); **Poster: 11:141-**Sindrome di Gullain Barrè in artrite psoriasica in trattamento con Tocilizumab. A. Rinaldi, **G. Laselva,** A. Chialà, N. Lascaro, S. Lopriore, P. Mancino, G. Lapadula, F. Iannone- Reumatismo 2015 vol. 67 (numero speciale 2); **Poster 13:184**- Toxic epidermal necrolysis (TEN) – like disease in paziente affetta da lupus eritematoso sistemico. L. Coladonato, M. Nivuori, G. Righetti, B. Didonna, C. Fiorentini, **G. Laselva,** G.Lapadula, F. Iannone – Reumatismo 2015 col. 67 (numero speciale 2); **Poster 19:268 –** Valutazione del tessuto adiposo sottocutaneo e viscerale e della circonferenza peritoneale, mediante ecografia trans-addominale, e loro correlazione con gli indici di flogosi nella sclerosi sistemica. C. Rotondo, A. Chialà, M.Nivuori, E. praino, L. Coladonato, M.G. Anelli, G. Lopalco, M. Covelli, **G. Laselva,** C. Fiorentini, G. Lapadula, F. Iannone. Reumatismo 2015 volume 67 (numero speciale 2); **(ABO714)** Improvement of refractory dysphagia in patients with idiopathic inflammatory myopathies receveing immunoglobulin intravenous therapy. Autthors: M. Giannini, M.L. Fiorella, L. Coladonato, D. D'abbicco, A. Amati, G. Lopalco, **G. Laselva,** G. Lapadula, F. Iannone. Ann Rheum Dis 2015; 74 (Suppl 2): 1137.n

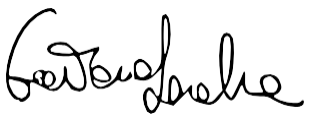
Convegni ECM:

- 39° Congresso Nazionale della Società Italiana di Reumatologia, Bari, 6-9/11/2002;
- Convegno "Il rachide nell'adolescente e nell'adulto. Clinica e riabilitazione", Cassano Murge (BA), Oasi S. Maria, 18-19/10/2002;
- Corso di Rianimazione Cardiopolmonare e defibrillazione precoce per operatori sanitari ("BLS-D-B"), Andria, 22/01/2003;
- Corso di formazione in Reumatologia, Lecce, 10-12/09/2003;
- 40° Congresso Nazionale della società italiana di Reumatologia, Udine, 20-23 Novembre 2003;
- IV Congresso Nazionale GIBIS-Corso multidisciplinare interattivo sulle osteopatie metaboliche, Montecatini Terme, (PT), 03-05/12/2003;
- Un approccio "umano" al paziente reumatico, Bari, 31/01/2004;
- "Focus 2004 sulla Artrite Reumatoide", Giardini Naxos (ME), 27-28/02/2004;
- "Postgraduate course on metabolic bone diseases", Ostuni (Br), 11-13/03/2004;
- Abbott meeting on ReAct: Treating RA in real-life clinical practice, Atene, Grecia,14-15/05/2004;
- M02-497 ReAct Study/M03-634 ReAlise Study- Italian Investigators Meeting, Venezia, 13-14/09/2004;
- XLI Congresso Nazionale della Società Italiana di Reumatologia, Stresa, 22-25/09/2004;
- "Focus sulla terapia con farmaci biologici: Artriti…e non solo artriti", Bari, 20/11/2004;
- Investigators' Meeting sullo Studio "Heal-RA", Roma, 23/11/2004;
- Progress & Promise 2005: Meeting Today's Challenges in Rheumatology, Atene, Grecia, 11-13/03/2005;
- 2ND Conference on Heart Rheumatism and Autoimmunity, Silvi Marina (TE), 19-20/05/2005;
- VIII Congresso Nazionale del Collegio di Reumatologi Ospedalieri Italiani "Nuove Acquisizioni in Tema di Infiammazione, Dolore e Autoimmunità nelle Malattie Reumatiche", Silvi Marina (TE), 20-22/05/2005;
- "Corso Teorico Pratico per la diagnosi e la terapia dell' Artrite Reumatide", Pavia, 23-24/06/2005;
- La ipertensione polmonare: una entità clinica emergente, Bari, 18/02/2006;
- La terapia nelle malattie reumatiche: un update, Bari, 10-11/03/2006;
- Progetto Experience In Bone Strength Management, Stresa, 18-19/10/2006;
- Il trattamento delle patologie reumatologiche: ruolo dei DMARDS tradizionali, Origgio, 9/06/2007;
- REFRESH-Frequent Knowledge Refreshment, Roma, 26-27/10/2007;
- VII Congresso Nazionale della Società Italiana dell'Osteoporosi, del Metabolismo Minerale e delle Malattie dello Scheletro, Firenze, 14-17/11/2007;
- "Corso di Ecocardiografia-Corso teorico-pratico", Napoli, 12-14/02/2008;
- XI Congresso Nazionale CROI, Situazioni difficili in reumatologia clinica, Bologna, 2-5/4/2008;

	• Master Class in Pneumologia, Roma, 18-19/04/2008; • Allergie respiratorie e rinite allergica, nuove prospettive, Bari, 17/05/2008; • Giornate Pneumologiche Garganiche, Vieste (FG), 30-31/05/2008; • "Early Rheumatoid Arthritis", Pavia, 20-21 Giugno 2008; • Approccio interdisciplinare al trattamento con Farmaci Biologici nelle patologie con interessamento reumatologico, Lecce, 4/10/2008; • "XLV Congresso Nazionale della Società Italiana di Reumatologia", Venezia, 15-18/10/2008; • Focus su contraccezione e gravidanza nelle più frequenti situazioni di patologia, Bari, 7-8/11/2008; • 5 anni di Elettrostimolazione ad Ostuni, Ostuni (BR), 11/10/2008; • XV Riunione Annuale S.I.R. sezione Puglia, "Le malattie reumatiche autoimmuni: aspetti sistemici", Mesagne,15/11/2008; • VIII Congresso Nazionale SIOMMMS.Società Italiana dell'Osteoporosi, del Metabolismo Minerale e delle Malattie dello scheletro, Perugia 19-22/11/2008; • Corso teorico pratico di formazione e aggiornamento multidisciplinare in OSTEOPOROSI, Gallipoli (LE), 6-7/03/2009; • VI° Congresso Nazionale Cardiopneumo AIMEF 2009; Bari,19-20-21/02/2009; • La Sclerosi Sistemica e le sue Complicanze," La gestione pratica del paziente sclerodermico", Abano Terme (PD), 13/03/2009; • XII Congresso Nazionale CROI, "Le rachialgie in Reumatologia", Napoli, 2-4 Aprile 2009; • VII Congresso Nazionale GIBIS, Bologna, 18-19/05/2009; • Il Governo Clinico in Reumatologia, Lecce, 17-2-2010; • XI Congresso Nazionale Aspam "Incontro tra specialista e generalista", Siracusa 8-10 Ottobre 2010; • Il dolore cronico in Ortopedia tra specialista e medico di medicina generale, Ostini (BR) 13-11-2010; • L-acetilcarnitina nel sistema nervoso, Napoli, 20-11-2010; • XVIII RIUNIONE ANNUALE SIR Sezione Puglia, Martina Franca, 7-8 Ottobre 2011; • Diagnosi e trattamento della insufficienza respiratoria, Acquaviva delle Fonti (BA) 28 ottobre 2011; • Progetto G&G - I farmaci equivalenti nella pratica clinica, Torino, 06 aprile 2012; • SPA.C.E. Day 2012 update teorico-pratico su Artrite psoriasica e spondilite anchilosante. Dalla clinica all'imaging, Roma 20-21 aprile 2012; • Apollo. Approccio multidisciplinare per la definizione di fattori predittivi al paziente reumatologico, Matera, 2-3 maggio 2012; • Rheuma TwoDay - Noicattaro (BA) 25-26 ottobre 2012; • 49° Congresso della SIR - Milano 21 - 24 novembre 2012 • II Seminario Monopolitano di Reumatologia Low pain: kei messages per MMG e Specialisti, Monopoli(Ba) 13-4-2013; • Incontri OEG-GISEA-I Evento multiregionale, Noicattaro (BA), 15-16 Febbraio 2013; • Progetto i-Orchestra "Consensus meeting sulla gestione "real-life" del paziente con AR e SA" c/o Sheraton Nicolaus Hotel, Bari 22 marzo 2013;

	• Implicazioni cli8niche e terapeutiche dell'inibizione del RANK Ligando con denosumab, Bari 35 Maggio 2013: • Corso teorico-pratico sulle spondiloartriti, BARI, 28-29 Giugno e 14 Settembre 2013; • 14° Corso Nazionale di Capillaroscopia, Jesi 11-12-13 Settembre 2013; • Interactive SPA Academy focus on PSA, c/o Hotel Donna Camilla Sacelli, Roma 3-4 Ottobre 2013; • Corso di Ecografia Muscoloscheletrica e Articolare in Reumatologia c/o Sheraton Nicolaus Hotel, Bari 19 Giugno-15 Novembre 2013; • 50° Congresso Nazionale della Società Italiana di Reumatologia, c/o Mostra d'Oltremare a Napoli, 27-30 Novembre 2013; • Congresso "Il Management delle SpA, Roma 12-13 Maggio 2014; • Congresso EULAR 11-14 Giugno 2014, Parigi; • 51° Congresso Nazionale SIR e 17° Congresso Nazionale CROI, Rimini 26-29 Novembre 2014; • Lupus Expert Awareness Driving Education and Research, Università di Padova 5-6 Dicembre 2014; • IV Giornata Reumatologica Salentina (Red Flags Reumatologici), Gallipoli (LE), il 20-21 febbraio 2015; • Allargare gli orizzonti, tracciare nuove rotte, Napoli 6-7 Febbraio 2015; • IV Giornata Reumatologica Salentina, Gallipoli (LE) 20-21 febbraio 2015; • Update sulle caratteristiche della Artrite Psoriasica, Bari 8-9 maggio 2015; • First on Target, Torino 22 Maggio 2015; • La corretta gestione del paziente con LES, Bologna 3-4 Giugno 2015; • EULAR 2015, Roma 10-13 Giugno 2015; • Corso Educazionale SIOMMMS " Aggiornamenti in tema di Malattie Metaboliche dello Scheletro", Bari 14-15 Settembre 2015; • XXII Riunione Annuale SIR Sezione Puglia, Ceglie Messapica (BR), 9-1\0 Ottobre 2015; • presente e futuro nel trattamento delle malattie reumatiche, Bari 17 Ottobre 2015; • XV Congresso Nazionale SIOMMMS, Bologna 12-14 novembre 2015; • Corso Hands on Radiologia Convenzionale, Rimini 25 novembre 2015; • 52 Congresso Nazionale della Società Italiana di Reumatologia, Rimini 25-28 novembre 2015 • Algo Management- Dolore Muscoloscheletrico, conoscerlo per saperlo gestire tenutosi dal 01/10/2015 al 30/09/2016; • Il trattamento attuale della artrite psoriasica, Bari 22-23 Gennaio 2016; • Rhewind Arms 2016, Bologna 11-12 Febbraio 2016 • Update in reumatologia il bambino e l'adulto con febbre e artrite, Bari 26 Febbraio 2016. • Convegno GISEA OEG INTERNATIONAL SYMPOSIUM 2016, Torino, 10-11 Marzo 2016. • Convegno "La gravidanza nelle malattie reumatiche autoimmuni", Trani, Palazzo San Giorgio 16-17 Settembre 2016. • XXIII Riunione Annuale SIR Sezione Puglia "Alla ricerca di una terapia personalizzatain Reumatologia", 7-8 Ottobre 2016, Taranto. • 53 Congresso Nazionale della Società Italiana di Reumatologia, Rimini 23-26 Novembre 2016.

	• "Portrait. Rheumatoid arthritis: the importance of identifying patient types. The italian experience" Bologna 3-4 febbraio 2017, • "Il percorso clinico integrato del paziente con malattia cronica infiammatoria", Trani 19-20 Maggio 2017; • "Measure the Future", Bari 22/09/2017, • "Portrait. Rheumatoid arthritis: the importance of identifyng patirnts types. The italian experience." Roma 24/06/2017 • SIOMMMS, Bologna 19-20-21 Ottobre 2017, • "SPARKLING Il valore della persistenza in pazienti SpA e AR" , Brindisi 28/10/2017 • "Approcci interdisciplinari nelle malattie interleuchina-1 mediate", Bari 17/11/2017, • 54° Congresso Nazionale della Società Italiana di Reumatologia, Rimini 22-25 Novembre 2017, • "PUGLIA NET" Documentazione clinica, percorsi clinico-assistenziali diagnostici e riabilitativi, profili di assistenza-profili di cura, Bari 2/12/2017; • "Terapia nel paziente con dolore articolare: dalla terapia alla real life", corso completato il 12 Febbraio 2018; • "Efficacia della inibizione della IL-6: non solo Artrite Reumatoide", Noicattaro (BA), 13-14 Aprile 2018; • "Osteoporosi inquadramento diagnostico e terapeutico partendo dalla presentazione e discussione di casi clinici", in qualità di Relatrice, Bari, 20/04/2018, aula "Giannelli" Istituto di Anatomia Umana ed Istologia-"R. Amprino"- Università degli studi di Bari "A. Moro"; • Reumaimaging 2018 "Reumatologi e Radiologi a confronto: l'importanza del decision making dalla diagnosi al follow up"in qualità di membro della Faculty, tenutosi a Lecce 11-12 Maggio 2018. • Crossteam, approccio multidisciplinare ai pazienticon malattia psoriasica, Bari 15 Maggio 2018. • XXV RIUNINONE ANNUALE SIR Sezione Puglia- IL PAZIENTE COMPLESSO", Trani 05-06 Ottobre 2018; • Progetto TaIL6ring (Advisory Board), 16-17 Novembre 2018, Trani (BT); • 55° congresso nazionale della Società di Reumatologia, 21-24 Novembre 2018, Rimini; • Rhewind Arms 2019, Bologna 7-8 Febbraio 2019; • "Il percorso clinico integrato del paziente con malattia cronica infiammatoria-IV edizione", Torre a Mare (BA) 1-2 Marzo 2019- UNA Hotel Regina, ha partecipato all'evento in qualità di RELATORE; • "Artriti coast to coast 1 anno dopo: dalla teoria alla pratica" tenutosi presso UNA HOTEL REGINA Noicattaro (BA), 9 Marzo 2019; • Un "Genere" di desiderio: percorsi assistenziali per la donna in età fertile con malattia reumatica cronica, tenutosi presso Sala Convegni Regione puglia-Bari, 10 Aprile 2019. • Meeting del Gruppo Italiano di Studio sulla Sindrome di Sjogren,Udine, 03 luglio 2019; • La gestione della donna in età fertile affetta da artrite infiammatoria: il ruolo centrale del Reumatologo, Bari, 05 luglio 2019; • "Le malattie reumatiche nel futuro", Bari, 19 luglio 2019; • XXVI Riunione Annuale SIR Sezione Puglia (Rheumatologisists look at the future) , Bari, 4-5 ottobre 2019;



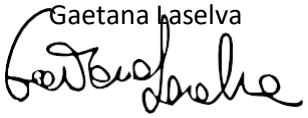
	• 56° Congresso Nazionale della Società Italiana di Reumatologia, tenutosi a Rimini dal 27 al 30 Novembre 2019; • Sanità Lean. Salute du valore – (Lean Lab), Warm-up e refresh in Lean Methodology, Bari 11/12/2019. • AR E MEDICINA DI PRECISIONE MOMAR INTERACT_LECCE, Lecce 26/05/2021.

Dichiaro sotto la mia responsabilità quanto di su scritto, ai sensi del D.P.R. del 28/12/2000, N°445 art. 46 e 47. Consapevole delle sanzioni penali in caso di dichiarazioni non veritiere, di formazione o uso di atti falsi, richiamate dall'art. 76 del D.P.R. 445/2000, dichiaro che quanto di seguito riportato corrisponde a verità. Ai sensi del D. lgs. 196 del 30/06/2003 dichiaro, altresì, di essere informata che i dati personali raccolti saranno trattati, anche con strumenti informatici, esclusivamente nell'ambito del procedimento per il quale la presente dichiarazione viene resa e che al riguardo competono alla sottoscritta tutti i diritti previsti dall'articolo 7 del medesimo decreto.
Ai sensi e per gli effetti delle vigenti disposizioni in materia, la presente dichiarazione curriculare, di cui mi assumo tutte le responsabilità per la veridicità, è sostitutiva di ogni certificazione.

Polignano a Mare, il 07/06/2021

In fede

Gaetana Laselva

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POLIGNANO A MARE (BA) 18.04.1971
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ORIGINAL ARTICLE

Adult-onset Still's disease: an Italian multicentre retrospective observational study of manifestations and treatments in 245 patients

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Abstract Adult-onset Still's disease (AOSD) is a systemic inflammatory condition of unknown aetiology characterized by typical episodes of spiking fever, evanescent rash, arthralgia, leukocytosis and hyperferritinemia. Given the lack of data in Italian series, we promote a multicentric data collection to characterize the clinical phenotype of Italian patients with AOSD. Data from 245 subjects diagnosed with AOSD were collected by 15 centres between March and May 2013. The diagnosis was made following Yamaguchi's criteria. Data regarding clinical manifestations, laboratory features, disease course and treatments were reported and compared with those presented in other published series of different ethnicity. The most frequent features were the following: arthritis (93 %), pyrexia (92.6 %), leukocytosis (89 %), negative ANA (90.4 %) and neutrophilia (82 %). As compared to other North American, North European, Middle Eastern and Far Eastern cohorts, Italian data show differences in clinical and laboratory findings. Regarding the treatments, in 21.9 % of

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cases, corticosteroids and traditional DMARDs have not been able to control the disease while biologics have been shown to be effective in 48 to 58 patients. This retrospective work summarizes the largest Italian multicentre series of AOSD patients and presents clinical and laboratory features that appear to be influenced by the ethnicity of the affected subjects.

Keywords Adult-onset Still's disease · Biologic drugs · Clinical presentation · Laboratory findings · Retrospective study

Introduction

Adult-onset Still's disease (AOSD) is a rare complex autoinflammatory disorder of unknown aetiology. First described in children by George Still in 1896 [1], same symptoms were reported in 1971 by Eric Bywaters in adult patients who did not fulfil criteria for classic rheumatoid arthritis [2]. Its incidence is approximately 0.16 per 100,000 persons in France [3], and it affects usually young adults (median age 36 years).

The pathogenesis of AOSD is unknown, but genetic factors and various infectious agents have been considered as predisposing factors [4]. Genetically predisposed individuals would develop autoinflammatory reactions to environmental triggers, leading to neutrophil and macrophage activation, a hallmark of AOSD.

Main features of AOSD include high spiking fever, arthralgia or arthritis, evanescent skin rash, sore throat, hepatosplenomegaly, leukocytosis with neutrophilia, elevated liver enzymes and ESR, and hyperferritinemia with decreased glycosylated ferritin (<20 %). According to the clinical course of the disease, AOSD may be conventionally divided into three main patterns [5]: monocyclic pattern, characterized by systemic single episode completely resolving within months; intermittent or polycyclic pattern, associated with one or more disease flares and characterized by complete remissions lasting to a couple of years; and chronic pattern, usually associated with polyarthritis.

Diagnosis is difficult, delayed and usually based on classification criteria set, such as Yamaguchi and Fautrel's criteria [5, 6]. Due to the heightened clinical heterogeneity in AOSD, exclusion of other entities including infectious, neoplastic and autoimmune disorders should be ruled out before any diagnosis.

The treatment of AOSD remains largely empirical, relying only on small retrospective case series [7]. Patients usually respond to nonsteroidal anti-inflammatory drugs (NSAIDs), glucocorticoids, disease-modifying anti-rheumatic drugs (DMARDs) such as methotrexate, and polyvalent intravenous immunoglobulins (IVIg). Biologic agents are considered for treatment of corticosteroids- and DMARDs-refractory cases and represent major therapeutic advances. IL-1 inhibition with Anakinra (IL-1 receptor antagonist), Canakinumab (anti-IL-1 monoclonal antibody) or Rilonacept (anti-IL-1 fusion protein) seem to be effective, well tolerated and steroid-sparing in systemic AOSD patients, whereas TNF-α blockers could be interesting in chronic polyarticular AOSD. Inhibition of IL-6 with tocilizumab is documented and seems effective in patients with active arthritis [8].

Most of the data on AOSD come from monocentric studies with limited number of cases.

The Italian Society of Rheumatology study group on autoinflammatory diseases promoted a multicentric data collection of Italian AOSD cases aiming to develop a national registry. In this work, we report the clinical manifestations, laboratory profile, patterns of disease course and therapy, collected by the different centres.

Patients and methods

Fifteen Italian University Hospital centres participated in this retrospective study and collected clinical and laboratory data together with disease and therapy information from AOSD patients. Data is referred to a cohort of patients recorded between March and May 2013. Diagnosis of AOSD was based on Yamaguchi's diagnostic criteria [6] and required the presence of 5 major, minor or exclusion findings, of whom 2 or more must be major. Major Yamaguchi criteria include the presence of intermittent high spiking fever (≥39 °C) lasting 1 week or longer, arthralgia lasting more than 2 weeks, characteristic rash and leukocytosis (white blood cell count ≥10, 000/μL per mm^3) with >80 % granulocytes, whereas minor criteria are sore throat, lymphadenopathy and/or splenomegaly, abnormal liver function tests and negative rheumatoid factor and anti-nuclear autoantibody (ANA) titre. The presence of infections, malignancies and other rheumatic diseases are exclusion conditions.

Each centre has recorded patients' data by using a standardized form, created specifically for collecting AOSD cases. Together with clinical characteristics, laboratory features are reported including blood cell count, coagulation parameters, serum ferritin (SF), ESR, C-reactive protein (CRP), liver enzymes, rheumatoid factor (RF) and ANA.

All treatments were listed with information about doses, durations and adverse events, along with the follow-up of different biologic treatments.

Concerning the disease course, the patients were stratified into four classes: polycyclic systemic, chronic articular polycyclic, monocyclic systemic and chronic articular monocyclic.

The collected data were compared with those reported in five published series of different ethnic origin and with sample size more than 50 subjects [4, 5, 8–10]. Descriptive statistics are represented as mean ± standard deviation (SD).

This retrospective study was approved by Padua Hospital Ethics Committee.

Results

Clinical features

Two hundred and forty-five patients (116 females and 129 males) with AOSD diagnosis and Caucasian origin were collected. The median age at the onset of disease manifestations was 38.8 years (range, 16–78.6), and the median delay of diagnosis was 1.5 months (range, 0–232). The disease manifestations were reported and compared with other series [4, 5, 8–10] in Table 1. At the time of onset, principal manifestations consisted of arthralgia (93 %), arthritis (75.8 %), pyrexia (92.6 %) and leukocytosis (89 %). Patients experiencing fever report high temperature (39.1 ±0.7 °C) and one or two spikes per day in 27.3 and 51.9 % of cases, respectively. The pattern of fever was intermittent, with an average duration of 10.3 days and an intercritical phase of 3.2 days. Other symptoms observed in AOSD patients were the following: typical rash (67.7 %), sore throat or pharyngitis (61.8 %) and lymphadenopathy (60.4 %). Among patients with arthritis, 23.7 % had monoarthritis, 44.3 % had oligoarthritis and 32.0 % had polyarthritis.

Reactive hemophagocytic syndrome (RHS) was reported in seven patients (2.85 %).

The clinical course in our patients were polycyclic systemic in 40.8 % of cases, chronic articularpolycyclic in 30.7 %, monocyclic systemic in 23.9 % and chronic articular monocyclic in 4.6 %.

Laboratory features

As presented in Table 2, leukocytosis (white blood cell count ≥10,000/mm^3) occurs in 81 % of patients (mean ± SD, 16,200 ± 7850/mm^3) and was composed of ≥80 % PMN in 70.3 % (mean ± SD, 13,483 ± 7341/mm^3). CRP was increased in 93 % of patients (mean ± SD, 101.9 ± 88.6 mg/L) in a range 1–355 mg/L. Platelet count was 378 ± 176 × 10^9/L (range, 20–922), and thrombocytosis (>400 × 10^9/L) occurred in 46 % of patients.

Elevation of hepatic enzymes was observed in 53.5 % of patients, and rheumatoid factor was positive only in 3.8 %. Patients were tested for autoantibodies: 0.5 % of patients was positive for anti-CCP, 9.6 % for ANA and 3.7 % for anti-ENA. Serum ferritin above the normal levels was observed in 56.4 % of patients (mean ± SD, 5743 ± 9723) within a range of 156–52,395.

Comorbidities

At the time of the last follow-up, almost 70 % of patients presented comorbidities: cardiovascular diseases in 61 patients, pneumopathies in 17, nephritis in 12, hepatitis in 11, bowel diseases in 8, thyroiditis in 26, autoimmune diseases in 8, diabetes in 19, neoplasia in 6, and other diseases in 4 patients (Table 3).

Treatment

84.5 % of patients received steroids and 3 % steroids in bolus. Fifty-one percent of those patients took DMARDs and about

Table 1 Clinical manifestations of 245 Italian AOSD patients compared to 5 previously published series

	Our data	Fautrel 2002	Cagatay 2009	Kong 2010	Gerfaud-Valentin 2014	Asanuma 2014	Average (731 patients)
Country	Italy	France	Turkey	China	Spain	Japan	
No.	245	72	84	104	57	169	
Female	47.3 %	NR	70.2 %	75 %	53 %	72 %	61.4 %
Male	52.7 %	NR	29.8 %	25 %	47 %	28 %	38.6 %
Age at onset[a]	38.8	NR	NR	NR	NR	46	42.4
Delay of diagnosis[b]	1.5	NR	NR	NR	4	1.5	2.33
Arthralgia	93 %	88.8 %	96.4 %	90 %	95 %	83.1 %	90 %
Fever	92.6 %	85 %	95.2 %	100 %	95 %	91.6 %	93 %
Sore throat	62 %	NR	65.5 %	78 %	53 %	59.3 %	63.5 %
Maculo-papular rash	67.7 %	71 %	59.5 %	95 %	77 %	62.2 %	70 %
Hepatomegaly	41.7 %	NR	38.1 %	44 %	21 %	NR	39.2 %
Lymphadenopathy/splenomegaly	60.4 %	44.4 %	33.3 %	66 %	60 %	44.7 %	53 %
Pericarditis	17.3 %	20.8 %	11.9 %	NR	19 %	3.10 %	13.3 %

The final column lists the average percentages of all patient series

NR not reported

[a] Years (median)

[b] Months (median)

Table 2 Laboratory features of 245 Italian AOSD patients compared to 5 previously published series

	Our data	Fautrel 2002	Cagatay 2009	Kong 2010	Gerfaud-Valentin 2014	Asanuma 2014	Average (731 patients)
CRP (mg/L)	101.9 ± 88.6	NR	115.9 ± 68.1	NR	183.4 ± 108.5	Positive in 91.5 %	134
Elevated ESR (>20 mm/h)	87 %	NR	94 %	96 %	96 %	68.90 %	85.4 %
Leucocyte count (No./mm^3)	16,200 ± 7854	NR	16,234 ± 7785	NR	13,930 ± 7050	NR	15,455
>10,000/mm3	81 %	88.80 %	84.15 %	99 %	72 %	79.40 %	84 %
Neutrophil count (No./mm^3)	13,483 ± 7341	NR	NR	>8000 in 98 %	11,980 ± 6140	NR	12,732
PMN >80 %	70.30 %	69.80 %	55.56 %	NR	77 %	71.50 %	69.2 %
Platelet count (10^9/L)	378 ± 176	NR	378 ± 158	>300 in 77 %	NR	<15 in 13.6 %	
>40,000/mm^3	46 %	NR	23.80 %	26 %	26 %	NR	35.6 %
Serum ferritin (ng/mL)	5743 ± 9723	NR	1126 ± 1474	NR	8745 (84–130,000)	NR	5204
>N	56.40 %	69.40 %	NR	99 %	NR	88.50 %	74.7 %
>3N	80.10 %	38.9 %[a]	38 %[a]	83 %	NR	60 %	65.9 %
Elevated liver enzymes	53.50 %	73.60 %	NR	62 %	54 %	73.90 %	62.5 %
Negative ANA	90.40 %	91.70 %	NR	100 %	92 %	74.20 %	88 %
Negative RF	96.20 %	98.60 %	NR	95 %	100 %	79.90 %	92.4 %

The final column lists the average values of all patient series

NR not reported

[a] Serum ferritin >5N

35 % concomitant drugs (FANS), such as indomethacin, ibuprofen and diclofenac. Among patients treated with DMARDs, 60 % used methotrexate, 18.5 % cyclosporin, 13.2 % hydroxychloroquine, 3.4 % salazopyrin, 2.4 % azathiopyrin and 2.4 % leflunomide.

As reported in Table 4, treatment with first-line biologic agents was prescribed on 58 occasions (23.7 %), 3.5 ± 4.3 years after the disease diagnosis and at 40.6 ± 15.3 years of age. Within them, 46.6 % received TNF-blockers and 53.4 % anakinra. Second-line biologic drugs were used 19 times (7.7 %), of which TNF-blockers in 10 patients, anakinra in 4 patients and others in 5 patients. Moreover, third-line biologic agents were used as treatment on 7 occasions (2.8 %): 4 times TNF-blockers and 3 times others.

Forty-two patients are reported to continue with biologic treatments; in details, 30 patients use first-line biologic agents (13 TNF-blockers and 17 anakinra), 9 patients take second-line agents (3 TNF-blockers, 4 anakinra and 2 others) and 3 patients receive third-line biologics (2 TNF-blockers and 1 others). Sixteen up to 58 patients treated with biologic agents have definitively withdrawn this treatment, due to adverse events (8 times), loss or lack of efficacy (2 times) and remission (6 times).

Given the absence of consensus regarding a disease activity measures in AOSD, the therapeutic efficacy of the biologic agents was evaluated based on disappearance of all clinical symptoms and biological manifestations (complete response, partial response, no response). The therapeutic efficacy of anakinra and TNF-blockers is reported in Table 5.

Table 3 Comorbidities in 245 Italian AOSD patients at the time of last follow-up

Comorbidities	No.
Autoimmune diseases	
Anti-CCP positivity	1
Urticarial vasculitis	1
Behçet's disease	1
Raynaud's syndrome	2
Systemic lupus erithematosus	1
Psoriasis	1
IBD	1
Neoplasia	
Prostatic carcinoma	2
Frontal meningioma	2
Chronic myeloproliferative disease	1
Astrocytome	1

Discussion

AOSD is a heterogeneous complex disorder with unknown pathogenesis and difficult diagnosis [7]. Due to the limited number of clinical cases, often referring to individual centres, the Italian Society of Rheumatology study group on autoinflammatory diseases promoted a multicentric collection of Italian AOSD patients' data. The main aims of this registry are to define the clinical and laboratory pattern of AOSD and the therapeutic attitude towards the disease in Italy.

Table 4 The first, second, and third line of biologic treatments followed by Italian AOSD cohort

Biologic agents	No. beginners (%)	No. in progress (%)
1st-line biologics		
Anakinra	31 (53.4 %)	17 (56.7 %)
TNF-blockers	27 (46.6 %)	13 (43.3 %)
-Adalimumab	4 (6.9 %)	
-Etanercept	12 (20.7 %)	
-Infliximab	5 (8.6 %)	
Total	58 (23.7 %)	30 (12.2 %)
2nd-line biologics		
Anakinra	4 (21.1 %)	4 (44.4 %)
TNF-blockers	10 (52.6 %)	3 (33.3 %)
-Adalimumab	5 (26.3 %)	
-Etanercept	3 (15.8 %)	
-Infliximab	2 (10.5 %)	
Others	5 (26.3 %)	2 (22.2 %)
-Abatacept	1 (5.3 %)	
-Rituximab	2 (10.5 %)	
-Tocilizumab	2 (10.5 %)	
Total	19 (7.7 %)	9 (3.7 %)
3rd-line biologics		
Anakinra	0 (0 %)	
TNF-blockers	4 (57.1 %)	2 (66.7 %)
-Etanercept	2 (28.6 %)	
-Golimumab	1 (14.3 %)	
-Infliximab	1 (14.3 %)	
Others	3 (42.9 %)	1 (33.3 %)
-Abatacept	1 (14.3 %)	
-Rituximab	1 (14.3 %)	
-Tocilizumab	1 (14.3 %)	
Total	7 (2.8 %)	3 (1.2 %)

Furthermore, as long-term purpose, the registry aims to identify prognostic factors of the disease. Up to date, AOSD data on the Italian population derive only from monocentric studies and are not a complete representation of the nation [11–14].

In this retrospective study, we reported 245 patients with AOSD diagnosis referring to 15 Italian Rheumatologic Centres, 6 from northern Italy, 5 from central Italy and 4 from the southern Italy. To the best of our knowledge, this registry collects the largest number of AOSD patient data in Italy.

Table 5 Therapeutic response to anakinra and TNF-blockers in 76 treatment courses

	Anakinra	TNF-blockers
Complete response	26	9
Partial response	7	10
No response	1	22
Total treated	35[a]	41

[a] A patient cannot be evaluated, due to the short period of treatment

Tables 1 and 2 present a wide variability in the frequencies of clinical and laboratory features in our Italian AOSD patients compared with data from different ethnicity. Italian and Japanese patients were generally older at disease onset than subjects from the other series. In our study, the mean age of the patients at the time of diagnosis was 40.5 ±16.5 years, whereas in other European countries, Turkey and China, the mean age is around 34 years. The delay to final diagnosis was highly variable from 0 to 232 months (median 1.5 months), which indicates possible diagnostic difficulties.

The tendency for AOSD to show female predominance has been already noticed [4, 5, 9, 10], but the reason is not clear. Curiously, in our population, males and females are equally affected; this may be due to an unexpected selection bias or may reflect a peculiar characteristic of the Italian population.

In the present study, arthralgia (93 %) and fever (92.6 %) were the most common clinical findings, the frequency of which was similar to the other reported cases. Symptoms such as pharyngitis and maculopapular rash appear to be less frequent in Italian and Turkish subjects, whereas lymphadenopathy is most experienced by Italian, Spanish and Chinese patients than other series. Spanish patients showed the lowest frequency of hepatomegaly and sore throat, while the French subjects had the highest frequency of pericarditis. Recently, in a single-centre retrospective study on 39 AOSD patients, F. Dall'Ara et al. looked for predictors of the use of biologic agents. They suggested that pericarditis may be a possible marker of severe AOSD associated with higher probability of a disease refractory to conventional DMARDs. They found pericarditis in 7 patients (38 %) receiving biologic agents and in 1 patient (5 %) of those receiving traditional DMARDs. Our data show a similar tendency since we found pericarditis in 20 % of patients receiving biologic agents and in 12 % of patients receiving traditional DMARDs, thus supporting the suggestion that pericarditis in AOSD patients should be considered a red flag for clinicians [15].

In the Chinese cohort, a higher prevalence of lymphadenopathy, hepatomegaly, maculopapular rash and pharyngitis was noted. In our series, rash, lymphadenopathy and sore throat were sensitive (>60 %) and specific (>60 %), suggesting that these 3 features are useful for establishing a diagnosis of AOSD in the Italian cohort.

Hemophagocytic syndrome is a rare life-threatening syndrome that can complicate the course of AOSD. It is suggested that prevalence of RHS in AOSD is underestimated due to underdiagnosis in several cases. In our cohort, we observed RHS only in 2.8 % of patients. This number is low in comparison to other AOSD series, however is consistent with the recently reported results of Zhang Y. et al. who retrospectively identified 10 cases of RHS among 315 AOSD patients (3.2 %) [16].

With regard to clinical course, monocyclic subset was reported most commonly [14, 17], whereas in our cohort, most

frequent subsets were polycyclic systemic pattern (40.8 %) and chronic articular polyciclic (30.7 %).

Particular attention should be paid to the laboratory values, since it may be a very helpful diagnostic hint for AOSD. Among other laboratory features, the white blood cell count seems to be an interesting predictor of patient outcome. Increased white blood cell counts were associated with AOSD relapses, whereas other studies showed a significant association between elevated serum ESR or CRP and a poor prognoses or higher relapse rates [9, 18].

Notably, the Italian cases experienced hyperferritinemia and showed a remarkably higher level of serum ferritin with respect to Turkey and Chinese series. Besides total ferritin level, the diagnostic interest of the glycosylated ferritin (GF) has been suggested [19]. Unfortunately, GF determination was not available in Italian routine clinical practice at the time of the study enrollment.

The determination of RF and ANA is also recommended, since it can be effective in narrowing the differential diagnosis. The frequency of RF and ANA positivity, always at low titre in our patients, is comparable to other studies.

The treatment of AOSD remains largely empirical, based on few case studies but not on randomized trials. NSAIDs are traditionally recommended as initial treatment of AOSD, although they are rarely effective in controlling the disease with a response rate of 20–25 % [20]. Corticosteroids are usually required to induce symptom remission and are indicated in case of life-threatening complications in AOSD [21, 22]. To reduce the effects of the steroids, immunomodulatory agents as methotrexate (MTX) can be used as second-line treatment [23]. However, if conventional immunosuppressive therapy is not effective, biological agents targeting IL-1, IL-6 and TNF-α represent major therapeutic advances. In our cases, corticosteroids and traditional DMARDs have not been able to control the disease in 21.9 % of patients while biologics have been shown positive effects. The efficacy of infliximab (anti-TNF-α) in corticosteroid- and MTX-resistant AOSD patients was demonstrated in several case series and case reports [24, 25]. Infliximab is generally well tolerated; however, it has been associated with side effects including infusion reactions, skin rash, infections, fulminant hepatitis and exacerbation of heart failure. Switching from one TNF-α inhibitor to another may be useful. In fact, etanercept (anti-TNF-α) was used successfully for the treatment of AOSD patients with complications, whereas adalimumab was effective as second-line biologic drug in etanercept or infliximab not responders [26]. Treatment with IL-1 inhibitor (anakinra) resulted in rapid and complete resolution of both systemic and articular manifestations as well as normalization of inflammatory marker levels [27]. Three of our cases received anti-IL-6 receptor, which has been considered for treating AOSD. A recent review of 35 patients reported that 86 % of tocilizumab-treated patients experienced prompt articular improvement, and 96 % experienced a disappearance of systemic symptoms [28].

We conducted a nationwide survey of AOSD, which provides important information on the clinical, laboratory and therapeutic features in the greatest cohort of Italian patients. Nevertheless, the present study has few limitations. First, the study was retrospective and had to contend with some degree of missing clinical and laboratory investigation data. Therefore, we await additional studies from other institutions in different countries to enrich and confirm the present results.

Compliance with ethical standards This retrospective study was approved by Padua Hospital Ethics Committee.

Disclosures None.

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Efficacy of a soy rich diet in preventing postmenopausal osteoporosis: the Menfis randomized trial

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Abstract

Objectives: To compare the effect of a soy rich diet and hormone replacement therapy (HRT) on the main biomarkers of bone turnover and bone mineral density (BMD) at postmenopausal age. *Methods:* 187 healthy asymptomatic postmenopausal women, aged 39–60, were recruited and randomized into a soy rich diet group, a HRT group, and a control group. Bone biomarkers and BMD were evaluated at baseline and after 6 months at the end of the study. *Results:* Diet is not as effective as HRT in reducing the postmenopausal turnover; however diet stimulates bone osteoblastic activity, as evidenced by significant increase in osteocalcin concentrations. BMD decreases significantly only in the control group, but not in the intervention groups. *Conclusions:* Our data suggest that soy products could be effective in reducing the risk of osteoporosis in asymptomatic postmenopausal women, but our findings should be confirmed before recommending the diet as a valid alternative to HRT. © 2002 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Menopause; Osteoporosis; Isoflavones; Soy; Prevention

1. Introduction

Failure of ovarian estrogen production at menopause is the main factor in the genesis of osteoporosis and subsequent fractures in elderly women [1,2]; it is known that estrogen replacement therapy (ERT) is highly effective in preventing early postmenopausal bone loss [3] and subsequent hip fractures [4]. To obtain significant skeletal benefit however, ERT should be given continuously for many years; Lindsay et al [5] estimated at least a 10 year period of active estrogen treatment necessary for appreciable delaying in the onset of bone fractures in oophorectomized women. It should be noted, moreover, that bone loss starts promptly again following ERT interruption; a consequence, at old age, when the risk of bone

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fracture is high, the bone mass of ERT treated patients is the same as untreated controls [6,7]. A number of relevant side effects are attributed to ERT, in particular cardiovascular illness, gallbladder disease and cancer [8–10]. In addition, many postmenopausal women are reluctant to try hormones; up to 50% of women discontinue hormone replacement therapy (HRT) within 6–9 months, and an estimated 30% of women never fill prescribed therapy [11].

For these reasons physicians and women are searching for alternatives to HRT.

Accumulating evidence indicates that consumption of phytoestrogen-rich diet alleviates menopausal symptoms, exerts favourable effects on postmenopausal osteoporosis and cardiovascular diseases, and is associated with a lower incidence of hormone-depending tumours, including breast cancer. Studies investigating the effects of dietary phytoestrogens on bone in postmenopausal women are however extremely limited. Some authors [12–14] showed as a treatment with isoflavone-rich soy is important in maintaining bone integrity in postmenopausal women, but other [15,16] did not confirm these results, so the matter is still controversial.

The Menfis trial was set up to assess the effect of a phytoestrogen rich diet on the risk of postmenopausal cardiovascular disease and osteoporosis, compared with the outcome of the HRT [17]. Data on the changes of lipidic profile induced by diet and HRT have already been published [17], while the effect on biomarkers of bone turnover and bone mineral density (BMD) are reported in the present paper.

2. Subjects and methods

The study was conducted at the University of Bari, following approval of the institutional review board and the ethic committee. Participants gave written informed consent. From January to May 1999, we enrolled in the study 187 healthy postmenopausal asymptomatic volunteers aged 39–60, living in the Bari area, Southern Italy.

The design and methods of the present study was described previously [17].

In brief, the 187 recruited women were randomized in a diet intervention group, a HRT group, and a control group, including all women both in spontaneous menopause and with bilateral ovariectomy. Exclusion criteria were designed to exclude women aged more than 60, drinkers, and those assuming anti-osteoporotic, HRT or other interfering drugs in the previous 6 months, with cancer or chronic diseases such as osteoporosis, thyroid, liver, cardiovascular disease, diabetes, in vegetarian or macrobiotic diet, or with menopausal symptoms requiring therapy. Women in the diet group were invited to continue their usual diet, only adding a soy food serving every day (e.g. soymilk, miso soup, tofu, tempeh, or soybeans) and changing two meals twice a week with two meals of the menu of the study based on phytoestrogen rich foods. The compliance to treatment in the diet group was assessed by measuring urinary daidzein levels (17).

Biomarkers of bone turnover (osteocalcin, *N*-telopeptide-C, hydroxyproline) and bone mineral density (BMD cortical and trabecular) were evaluated at baseline and after 6 months, at the end of the study. Urinary *N*-telopeptide-C was analyzed using the Osteomark test (OSTEX International Inc, Seattle, WA). For the analysis of the osteocalcin the h-Osteocalcin test (Chemiluminescence Immunoassay Kits, Institute Diagnostics, USA) has been used. Urinary hydroxyproline has been determined using the Hypronosticon test (Organon Teknika B.V., Holland). Bone densitometry was measured only at the dominant forearm level by a single photonic densitometer (densitometer with a single pic source) (NORLAND mod.).

Mean differences in each group were evaluated by a Student's *t*-test for paired samples. Differences in the percentages were evaluated by the χ-test. The analysis of variance was used to detect the differences in the changes recorded in the different groups for each variable.

3. Results

Baseline characteristics of women in the study are reported in Table 1. About 80% of women in the control group and HRT group completed the

Table 1
Mean values of bone biomarkers, BMD, lifestyle, anthropometric and hormonal variables in the study subjects after randomization

	Control group No. 58		Diet group No. 53		HRT group No. 55		*F*	*P*
	Mean	±S.D.	Mean	±S.D.	Mean	±S.D.		
Age (years)	52.7	3.4	54.2	4.04	53.4	4.4	1.86	0.16
Months since menopause	54.3	52.02	66	60.5	70.7	51.9	1.31	0.27
Menopause:							$\chi^2 = 6.67$	0.03
Spontaneous	47		49		42			
Surgical	11		3		13			
Education in years	9.4	4.5	11.1	4.9	10	4.5	1.72	0.18
Smoking							$\chi^2 = 0.19$	0.9
Yes	8		6		6			
No	49		45		46			
Sedentariness							$\chi^2 = 2$	0.45
Yes	39		30		32			
No	19		23		23			
Height (cms)	156.4	6.2	158.3	5.6	156.9	6.6	1.3	0.28
Weight (Kg)	70.8	13.9	68.5	14.06	66.9	11.8	1.24	0.29
BMI	28.9	5.7	27.06	4.9	27.2	4.5	2.44	0.09
WHR	0.86	0.05	0.86	0.06	0.88	0.05	1.31	0.27
FSH (UI/l)	59.1	27.6	60.9	21.6	59.06	25.2	0.1	0.91
E2 (pg/ml)	13.6	16.3	10.1	18.8	6.7	6.01	3.14	0.05
Osteocalcin	15.5	10.5	21.9	44.3	14.5	11.3	1.2	0.3
N-telopeptyde-C	29.9	40.7	29.5	31.3	40.6	64.4	0.96	0.38
Hydroxyproline/creatinine	50.7	25.7	55.3	32.1	55.9	46.4	0.36	0.7
BMD cortical	0.769	0.112	0.755	0.118	0.707	0.100	4.78	0.009
BMD trabecular	0.741	0.119	0.723	0.149	0.674	0.111	4.13	0.01
Daidzein (ηg/ml) after 5 months	91.4		3214.6		124.07			

study, but more than half of participants in the intervention group discontinued the study, mainly for the dislike of soy and for difficulties in finding and cooking foods. According to the food frequency diaries, women in the intervention group consumed approximately 47 mg/die of isoflavones, largely from soy milk.

Differences between baseline and 6 months values of bone biomarkers and BMD are reported in 2. A significant decrease of bone turnover was observed only in HRT group.

Findings in the diet group are rather contradictory and not easy to explain; however osteocalcin concentrations increased significantly in the diet group compared with the other two groups. We did not observe significant improvements in BMD, either in the diet group or in the HRT group (Fig. 1) perhaps because of the short duration of the study. However, both groups showed a slightly lower decrease of bone trabecular density compared with the control group Fig. 1.

4. Discussion

HRT is increasingly recommended for prevention and treatment of the long-term effects of menopause, mainly cardiovascular disease and osteoporosis. Wide evidence suggests that long-term hormonal treatments are necessary to obtain a substantial decrease of risk for these diseases, but serious side effects discourage long-term HRT use. Alternative treatments retaining beneficial health effects without hazardous consequences of HRT would be highly desirable. We pointed our attention on natural occurring estrogens, and, in the present study, we investigated the suitability of a

Table 2
Mean differences of the values of bone biomarkers and BMD in the diet, replacement and control group after 6 months

	Control group		Diet group		HRT group		F	P
	No. 43	C.I.	No. 24	C.I.	No. 41	C.I.		
Osteocalcin	1.7	−1.34/4.8	**5.45**	0.36/10.5	−1.10	−5.94/3.73	2.05	0.13
N-telopeptyde-C	1.34	−17.6/20.3	4.92	−20.1/29.9	−10.1	−23/2.7	0.76	0.47
Hydroxyproline/creatinine	−4.6	−13.9/4.6	−6.12	−25.9/13.7	**−16.2**	−26/−6.4	1.26	0.29
BMD cortical	−0.10	−0.04/0.01	0.01	−0.02/0.05	−0.001	−0.03/0.02	0.86	0.43
BMD trabecular	**−0.03**	−0.06/0.001	−0.02	−0.06/0.01	−0.01	−0.05/0.01	0.24	0.79

N.B. The bold types show a $P < 0.05$ for the mean differences at baseline and after 6 months. F and P express the significativity by analyses of variance in the different groups.

soy-rich diet, containing high levels of active phytoestrogens, in providing some protection against postmenopausal osteoporosis. A preventive effect of phytoestrogens on bone loss is biologically plausible, given their structural similarity to estradiol and the presence of high levels of ER-β in the bone [18,19]. Many of the phytoestrogens are ER-β selective and bind to ER-β with

Table 3
Composition of the diet regimen at baseline in the three groups

	Control group No. 58		Diet group No. 53		HRT group No. 55	
Variable	Mean	S.D.	Mean	S.D.	Mean	S.D.
H_2O	1049.2	265.3	1071.6	300.7	1133.02	265.5
PR	90.3	18.7	90.5	23.2	94.9	27.8
L	93.1	20.7	94.4	25.5	98.4	29.3
GD	242.6	53.2	263.9	70.9	253.07	72.2
GA	141.7	41.9	152.8	55.3	143.2	60.1
GS	88.5	23.8	97.8	30.01	97.3	23.5
Fibre	20.55	5.7	23.09	6.08	22.4	5.7
Kcal	2080.2	374.01	2149.1	452.2	2152.08	513.3
KJ	8716.6	1565.1	9005.7	1896.3	9015.6	2148.5
Na	2382.9	782.8	2702.09	1038.4	2431.4	943.8
K	3356.7	663.8	3498.02	779.2	3597.2	787.4
Fe	18.2	6.7	18.8	7.8	20.5	8.8
Ca	984.1	269.04	953.3	299.4	1036.7	370.5
P	1457.1	319.7	1468.3	373.6	1560.3	446.2
B1	1.01	0.25	1.1	0.3	1.09	0.3
B2	1.59	0.42	1.5	0.4	1.6	0.5
PP	16.7	3.8	16.8	4.09	17.5	4.9
VA	1411	897.3	1613.08	1060.9	1599.1	974.6
VC	151.6	50.6	164.3	61.2	176.2	56.7
AGS	327.3	268.1	351.3	324.1	411.5	370.5
AGM	36.6	6.5	35.8	6.7	36.6	7.8
AGP	9.1	2.09	9.2	2.4	9.3	2.8
Col	286.9	89.4	284.8	87.5	306.6	101.05
FS	4.9	1.2	5.5	1.5	5.3	1.6
FI	11.04	3.4	12.8	3.9	12.5	3.6
Cell	0	0	0	0	0	0
PC	0	0	0	0	0	0
Alcohol	8.5	9.4	6.06	9.8	7.1	9.07

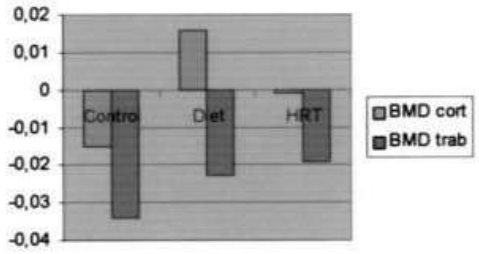

Fig. 1. Variation of the BDM in the three groups after 6 months.

greater affinity than estradiol; for instance, genistein has a sixfold greater affinity for ER-β than ER-α [20]. The different tissue distribution of α and β receptors brings to light the possibility of tissue-selective effects of the isoflavones. ER-α predominates in the uterus whereas ER-β predominates in bone [21]. Anyway, limited evidence supports this action. Studies conducted so far are of short duration and involve a small number of subjects. More convincing are studies with ipriflavone, a synthetic isoflavone derivative [22,23] and experiments in animals [24,25].

Data of the present report show that diet is not as effective as HRT in reducing the increased postmenopausal bone turnover, assessed in our study by levels of bone markers of resorption (*N*-telopeptide-C and hydroxyproline) and formation (osteocalcin). However, the significant increase of osteocalcin concentrations in the diet group, indicates stimulation of osteoblastic activity and suggests a beneficial effect of diet through this mechanism.

This action of natural or derivative isoflavones seem to be only of stimulus on osteoblastic activity; in fact their action is masked by the inhibitory action on the bone turnover of the estrogens when taken together [26]. Enhanced bone formation rather than slower bone resorption is a known outcome of soy rich diets [27,28] and could explain the effect of the dietary phytoestrogens on bone density, where phytoestrogens increase bone mineral cortical density. It is also possible that other factors can act together with phytoestrogens to increase bone density, as the high intake of calcium of soy products, or the accelerated intestinal absorption of Ca [29]; but other unknown factors of soy foods could also work in this sense; for example, in addition to the direct effect of isoflavones on bone tissue, several studies have found that in comparison with animal protein, soy protein decreases calcium excretion, a result of the lower sulfur amino acid content of soy protein, thus indirectly enhancing bone strength [30].

The most disturbing outcome of the study is the low compliance to diet in the intervention group because the soy and soy products are not usual foods in the diet regimen of our population. We cannot exclude that the high drop out in this group introduced some bias, making some results not easy to explain. Nevertheless, we think that soy foods could be an interesting and valid alternative to HRT in the prevention of postmenopausal osteoporosis in asymptomatic postmenopausal women. However, findings in the present report should be confirmed before recommending the natural approach of diet.

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[Tumor markers in some chronic inflammatory diseases in rheumatology: a statistical evaluation]

[Article in Italian]

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Abstract

Background: Since tumor markers can be high in the course of many inflammatory diseases, the aim of this study is to verify if it also occurs in the course of rheumathologic chronic inflammatory diseases, and if there is any statistical correlation between tumor markers and inflammatory indices.

Methods: Seventy-nine patients (51 females and 28 males) with rheumatologic chronic inflammatory diseases, aged 17-92 years, were studied, all of them took 4 mg of prednisone. alphaFP, CEA, TPA, CA19.9, CA15.3, CA72.4, CA125, ferritina, beta2 microglobuling, betaHCG, and free and total PSA in males, were evaluated as tumor markers; and VES, PCR and Fibrinogen, as inflammatory indices.

Results: The results obtained showed that there is a significative correlation between ferritin, beta2 microglobulin, TPA and PCR, and between free and total PSA and Fibrinogen.

Conclusions: PCR is a very good index of an active disease and it can be helpful, along with tumor markers, in the monitoring of chronic inflammatory diseases.