A different sort of arthritis

Spondyloarthropathies

For years, your husband has had to work at maintaining flexibility in his lower back due to an arthritis-like spine condition. So far, it’s worked out pretty well, despite the occasional pain flare-ups. The condition is one of a group of disorders called spondyloarthropathies (spon-duh-lo-ahr-THROP-uh-thees).

Spondyloarthropathies are among more than 100 forms of arthritis. These chronic inflammatory back disorders often can be managed with exercise and drug therapy as necessary.

Distinguishing marks

Spondyloarthropathies are a group of inflammatory disorders, meaning the immune system acts against the body by targeting specific tissues. Although these disorders can cause inflammation in different areas of the body, they often affect the spine — in particular, where the spine attaches to the pelvis (sacroiliac joints). The inflammation also affects sites where tendons and ligaments attach to bones in the spine and other joints, such as where the Achilles tendon attaches to the heel bone. Joints affected by this chronic inflammation

Ankylosing spondylitis is the most common of inflammatory disorders called spondyloarthropathies. Ankylosing spondylitis may lead to fusion between the spinal vertebrae and the sacroiliac joints connecting the spine and pelvis. Left untreated or in advanced stages, the result can be a hunched-forward posture and restricted chest expansion.
Ankylosing spondylitis (ang-kuh-LOE-sing spon-duh-LIE-tis) — This is the most common of these inflammatory disorders. Ankylosis is the process in which a joint becomes stiff or fixed. Ankylosing spondylitis typically begins in young adulthood and is more likely to affect men. Eventually, it may lead to fusion between the spinal vertebrae and the sacroiliac joints connecting the spine and pelvis. Left untreated or in advanced stages, the result can be a hunched-forward posture and restricted chest expansion.

Early signs and symptoms may include intermittent low back pain and

Drug treatment options

A range of medications may be used to treat spondyloarthropathies, some of which include:

- **Nonsteroidal anti-inflammatory drugs (NSAIDs)** — These are commonly used medications that help to relieve pain, inflammation and stiffness. Examples include naproxen (Aleve, others), indomethacin (Indocin) and others. When effective, NSAIDs make activity and exercise possible, which helps maintain posture and improve quality of life. There’s evidence that continuous use of NSAIDs in ankylosing spondylitis may reduce the amount of bone growth and spine fusion.

- **Disease-modifying antirheumatic drugs (DMARDs)** — Examples include methotrexate (Rheumatrex) and sulfasalazine (Azulfidine). These DMARDs may be especially useful in managing disease that affects peripheral joints in the arms and legs. They generally aren’t effective for the spine inflammation, although sulfasalazine may be tried for early spondylitis.

- **Corticosteroids** — In some situations, injected corticosteroids may be of temporary help for sacroiliac pain that hasn’t responded to other treatments.

- **Tumor necrosis factor (TNF) blockers** — TNF is a cell signaling protein that acts to increase inflammation. TNF blockers target this protein to help reduce pain, stiffness, and tender or swollen joints. TNF blockers — which include adalimumab (Humira), etanercept (Enbrel), infliximab (Remicade), golimumab (Simponi) and certolizumab (Cimzia) — are relative newcomers, having been used to treat spondyloarthropathies over the past decade. Their value is seen in suppressing inflammation and joint destruction and reducing pain. However, they don’t slow formation of new bone in the spine.

Although TNF blockers generally aren’t the first line of therapy, they’re a good option when other therapies fail to control high levels of disease affecting the large joints in the legs and arms or if disease is confined to the spine. However, these are expensive drugs and they pose a risk of infection.

Specific disorders

Among the various spondyloarthropathies are:

- **Ankylosing spondylitis**
stiffness in the lower back and hips that’s worse upon awakening and after periods of inactivity.

Ankylosing spondylitis doesn’t follow a set course. The severity of symptoms and development of complications vary widely from person to person. Among complications that may occur are inflammation of part of the eye (uveitis) and joint pain, especially in the lower extremities.

- Reactive arthritis — This type of arthritis may develop within several weeks after a bacterial infection has occurred in the intestines, genitals or urinary tract. Joint pain and swelling come on suddenly, usually in the knee, ankle or foot joints. Some experience tendon inflammation affecting the Achilles tendon or the sole of the foot (plantar fasciitis). The course of reactive arthritis is variable. For most, the joint pain is mild and lasts several months, but inflammation may persist for a year or more.

- Psoriatic arthritis — Up to 7 percent of people with the chronic skin condition psoriasis also have psoriatic arthritis. This chronic form of arthritis is highly variable, as it may affect only a few joints, or multiple joints and the spine, including the neck. Small and large joints can be affected. Along with the joint pain, there may be nail changes, such as pitting and staining.

- Inflammatory bowel disease (IBD)-associated arthritis — Up to 20 percent of people who have Crohn’s disease and 7 percent of those who have ulcerative colitis may develop inflammatory arthritis in the large joints of the legs and arms. Arthritis flare-ups tend to occur during periods of gut inflammation. Controlling the IBD disorder usually helps control the arthritis. However, up to 7 percent of those with IBD have inflammation in their vertebrae or sacroiliac joints that comes and goes independent of bowel inflammation.

- Undifferentiated spondyloarthritis — This newly defined diagnostic category includes people who have some evidence of inflammation that occurs in these other disorders. However, the inflammation is incomplete and so defies true definition as one of the above.

Management varies

The goal of treatment for these disorders is to relieve pain and stiffness and prevent or delay complications and spinal deformity. A key component is physical therapy and exercise. Learning range-of-motion and stretching exercises and practicing them as directed can help maintain joint flexibility and preserve good posture. Abdominal and back exercises can help maintain upright posture. Sleep posture also is important — rather than sleeping curled on your side, adapt to a straight back position. Dedication to this aspect of treatment can help preserve good posture so that even if portions of your spine do fuse, the fusing will be upright, allowing for more ease in getting around doing regular day-to-day life activity.

In addition, various drug therapies are used to treat spondyloarthropathies depending on their severity and type.

With proper treatment, most people with spondyloarthropathies have minimal or no disability and can have a productive life despite back stiffness. Although there are likely to be inflammation flares, alternating periods of little or no inflammation also are fairly typical with these conditions.

Ankylosing spondylitis may lead to fusion between the sacroiliac joints connecting the spine and pelvis.

Health tips

Stopping postnasal drip

Your nose and throat continually produce mucus. For many people, this isn’t noticeable. But for some, it causes the sensation of postnasal drip and may lead to irritation or coughing. Steps to reduce postnasal drip include:

- Drinking more water — This can help thin mucus secretions, making it less noticeable.
- Limiting caffeine consumption — Caffeine has a diuretic effect that can make mucus thicker.
- Using saline nasal sprays or irrigation — Try using purified saline water in a squirt bottle or neti pot. Humidifying a dry environment also may help.
- Reducing exposure to allergens or irritants — Pet dander, tobacco smoke, dust and certain foods such as dairy products may cause mucous thickening.
- Trying prescription nasal sprays — These include intranasal steroid spray (Flonase, Nasonex), the intranasal antihistamine spray azelastine (Astepro) and intranasal ipratropium (Atrovent). These may help reduce mucous thickening and production. Use of decongestants may be tempting, but they can actually thicken mucus.
- Controlling gastroesophageal reflux disease (GERD) — When stomach acid backs up into the throat, it can irritate the throat and make it hard to swallow mucus.
- Addressing underlying problems — Your doctor may be able to diagnose an underlying cause of postnasal drip, such as diseases that affect your ability to swallow, sinus infections, sinus polyps and drug side effects.
Muscle weakness

When it’s not just lack of fitness

You’re well aware that you aren’t as strong as you once were. But lately, it seems as though it’s been getting harder to just do the basics, like getting out of a chair. You wonder if a medical problem may be making you weak.

Don’t ignore muscle weakness. Rapid or sudden muscle weakness can signal a stroke or other serious problem requiring immediate attention. More gradual loss of strength can contribute to many health problems, including increased risk of falls, decreased bone strength and weight gain.

Distinctions

Diagnosing the cause of muscle weakness that develops over time can be challenging. There are many potential causes and multiple causes may be at play.

An important distinction is whether your feeling of weakness is actually the result of loss of muscle power caused by either central nervous system disease or by muscles or nerves that aren’t functioning properly. Alternatively, you may feel weak and limited due to factors such as fatigue, sleepiness, lightheadedness or chronic pain.

Sleep problems, depression, chronic heart, lung or kidney problems, or poor nutrition and being sick are among many causes of generalized fatigue that can make you feel unenergetic and weak. Your muscle use may be limited by having chest pain or shortness of breath related to a heart condition or a sickness such as pneumonia or other lung disease. Arthritis in one or more joints or pain-causing conditions such as fibromyalgia can make you feel weak because it’s painful to move.

These problems aren’t “true” muscle diseases in the sense that muscles still function normally, even though activity

More evidence regarding vitamin C and kidney stone risk

Findings from a large Swedish study suggest that men who take vitamin C supplements may be at added risk of developing kidney stones. Vitamin C is a commonly taken supplement and is also found in multivitamins.

Data for the study — published March 11, 2013, in the Journal of the American Medical Association Internal Medicine — was from a large population of middle-aged and elderly men who had not had kidney stones. Of them, 907 took daily vitamin C supplements, which in Sweden are typically high dose at 1,000 milligrams (mg). More than 22,000 didn’t take any nutritional supplements.

Researchers found that the men who took vitamin C supplements were twice as likely to develop kidney stones than were men who didn’t take any vitamin supplements. They also found that men who took only multivitamins, and not high-dose vitamin C supplements, were at no increased risk of stones when compared with men who used no supplements. To be clear, the findings relate only to vitamin C supplements, not vitamin C from food. Although the findings need to be confirmed by other studies, researchers say they may be relevant in advising men who’ve had previous kidney stones to avoid high-dose vitamin C supplements. While Mayo Clinic kidney specialists agree, they note a level of uncertainty due to conflicting studies. Even so, given the lack of sound data that shows any benefit from high-dose vitamin C supplementation, they say it’s reasonable for men prone to kidney stone formation not to take more than 500 mg a day of vitamin C supplements.

Aspirin’s role in preventing recurring deep vein blood clots

If you develop a blood clot in a leg vein (deep vein thrombosis, or DVT) or if a blood clot travels to the lung, chances are you’ll be prescribed a powerful clot-preventing medication. These drugs may be taken for three months for the initial treatment and possibly longer to help prevent recurrence.

However, because these drugs cause diminished ability to stop internal or external bleeding, many people opt to stop taking them after the highest risk phase of blood clot recurrence. This is where aspirin enters the picture.

Aspirin isn’t as powerful when it comes to preventing blood clots in the veins. However, according to two articles in the May 24, 2012, and Nov. 22, 2012, issues of the New England Journal of Medicine, it does have some preventive effect. When results of these two studies are combined, they show that people who took 100 milligrams (mg) of aspirin daily after stopping a stronger anti-clotting drug reduced the risk of a recurrent blood clot by 32 percent compared with people who took an inactive substance (placebo). In the U.S., aspirin is available in 81 mg and 325 mg tablets.

Those taking aspirin also reduced their risk of any problem caused by a vessel-clogging blood clot — whether a heart attack, stroke or vein clot — by 34 percent compared with those who took a placebo.

This new data suggests that aspirin may be effective, though to a lesser degree than certain anti-clotting drugs. The risk of major bleeding is much lower with aspirin. Mayo Clinic doctors say that for people who don’t wish to continue taking clot-preventing drugs after the initial treatment of venous clots, aspirin appears to provide some protection against clot recurrence.

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News and our views

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Brain or spinal cord disease — Stroke or brain disorders such as Parkinson’s disease can cause weakness, or difficulty coordinating with or initiating muscle movement. Cognitive decline, tremors, rigidity, muscle spasm or overly active reflexes are signs and symptoms suggestive of brain or spinal cord disease. A magnetic resonance imaging (MRI) test of the affected area can show stroke damage, the presence of a tumor, an area of brain atrophy and some types of inflammatory conditions such as multiple sclerosis. When looking specifically at the spinal cord, MRI can help identify spinal cord compression, which may be caused by structural degenerative changes in the spine, and can also be helpful for diagnosing inflammatory disease. Another possibility to consider is amyotrophic lateral sclerosis (ALS), which can cause weakness, abnormal reflexes and muscle twitches.

Peripheral nerve damage — This can interrupt signals that the brain sends and can occur in many areas of the body, including nerve roots exiting the spinal cord and nerves supplying the tips of your fingers and toes. In addition to weakness, nerve damage can cause loss of feeling and decreased reflexes and muscle tone. An initial evaluation usually includes nerve conduction tests — where a small shock is passed through the nerve to measure the strength and speed of nerve signals — and an electromyogram, where electrical signals in affected muscles are measured. Damage to nerve roots can result in weakness and pain in the distribution of a specific nerve root. Many types of peripheral neuropathy manifest as damage to nerves around the hands and feet. When peripheral neuropathy is suspected, extensive blood testing may be needed to identify a possible underlying condition, such as diabetes, inflammatory or genetic diseases, or nutritional deficiencies.

Problems where nerves meet muscles — Your brain transmits nerve impulses at the neuromuscular junctions. Here, nerve endings release the transmitter acetylcholine that travels through the junction to muscles and signals them to contract. Neuromuscular junction diseases occur when there’s a loss of normal connection between nerves and muscles. These diseases — such as myasthenia gravis or Lambert-Eaton syndrome — often cause weakness that increases with activity of the particular muscle group, but don’t cause loss of sensation. Characteristics may include eyelid droop, double vision, slurred speech, and difficulty swallowing and breathing. Nerve conduction tests and electromyogram are important in obtaining a diagnosis, as are certain blood tests for specific antibodies.

Muscle disease — Weakness can be caused by muscle disease, without involvement of the nerves. Muscle pain can occur, but loss of sensation doesn’t. Causes among many can include inflammatory diseases such as polymyositis, dermatomyositis and inclusion body myositis, genetic disorders, or endocrine abnormalities such as thyroid disease. Muscle weakness can also be a side effect of various medications such as cholesterol-lowering statin drugs and corticosteroids.

Nerve conduction and electromyogram tests are important for diagnosis. Blood tests also are important, in particular a test called creatine kinase, which can identify abnormally high levels of muscle breakdown. Heart or breathing tests and muscle biopsy may sometimes be necessary.

Undiagnosed diseases — Weakness is sometimes a sign of something that you don’t realize you have. Examples include rheumatoid arthritis, lupus or polymyalgia rheumatica, infections such as Lyme disease or diabetes, vitamin D deficiency, or electrolyte imbalances.

Exercise for all

Of all the causes of weakness, being unfit is one of the most common. Loss of muscle mass can occur over time or even with short periods of inactivity such as a hospital stay. Fortunately, nearly everyone can do some sort of exercise. ❒

Disruption in function occurring anywhere between the brain and muscle can result in muscle weakness.
Preventing golf injuries

How to stay in the game

With the return of warmer weather, golf courses are once again drawing players of all ages back to the links. Golf may appear to be a relatively undemanding sport without much risk of injury, but in fact, golf-related injuries are common.

Among recreational golfers, the most common injuries tend to involve the low back, shoulders and forearms. The majority of injuries are typically related to repetitive motion or overuse.

Ideally, proper conditioning is done throughout the year. Core strengthening as well as stretching and strengthening your major muscle groups year-round provide more stability and flexibility when you get back on the golf course. The stretches shown on this page can be incorporated into your regular workout and are especially helpful before and after a round of golf.

Another important step that can reduce the risk of injury is warming up properly before you play. One study found that golfers who stretched and warmed up for at least 10 minutes before play had a 60 percent decrease in injury compared with golfers who didn’t warm up. You might start with five minutes of brisk walking, and then do some simple stretches that focus on your shoulders, back and legs. Follow this with some gentle swings of one or two clubs, gradually increasing your arc of motion.

In addition to proper conditioning and warming up, a critical part to avoiding injury is having good swing mechanics. The basic golf swing relies upon conditioned muscles moving in a coordinated fashion through a large range of motion. It also involves most of your major muscles and joints.

Consider taking lessons from a certified golf instructor to improve your swing technique. Improving your swing may even improve your score.

Golf stretches

Stretching can help promote a more fluid swing. Ideally, these stretches should be done every day as well as before and after each round of golf. Hold each stretch for five to 10 seconds prior to golfing and 30 seconds afterward. Perform three to five repetitions during each session. Remember to keep stretching gentle, and don’t bounce. If you feel pain, you’ve stretched too far.

Shoulder and chest stretch

Stand in a walking position. Bend your elbow and support your forearm against a door frame or corner. Gently rotate your upper trunk away from the arm until you feel the stretching in your chest muscles and hold. Repeat the stretch on the opposite side.

Front hip muscle stretch

Use a stable chair to assume a large step position. Place your hands on your knee. While keeping your back leg straight, tighten your stomach muscles to avoid a low back arch and push your hips forward until you feel a stretch in the front of your thighs. Hold. Repeat on the opposite side.

Hip stretch

In a seated position, raise your right knee up and grasp it with your left hand (illustration above, left). Pull your right knee up toward your left shoulder — you’ll feel a stretch in your right buttock — sit up tall and turn your shoulders to the right (illustration above, right). Hold. Repeat the stretch on the opposite side.
High blood glucose

Regaining diabetes control

Anyone with diabetes is going to have a bad day now and again with blood glucose control. Often, this corresponds with a known slip-up, such as eating too much at a party or forgetting to exercise. It isn’t considered losing control if getting back to your usual routine gets things back on track.

However, blood glucose levels can rise above your target range in a more persistent way. You may not understand why your blood glucose levels are high, or how to get them back within your goal range. You may not even know your blood glucose levels are higher than desired, since you may not feel any different.

If you lose control of your blood glucose levels, it needs to be addressed, often with the help of your doctor.

How do you know?

If blood glucose levels rise high enough, you may experience symptoms such as a dry mouth, thirst, frequent urination, blurred vision and fatigue. Call your doctor promptly if your blood glucose level is above 240 milligrams per deciliter (mg/dL) and have tested and found ketones in your urine. Ketones are a toxic byproduct created when your body can’t get energy from glucose.

However, it’s common for blood glucose values to be elevated, yet not high enough to cause symptoms that you can feel. Even though you feel fine, excess blood glucose is slowly eroding the health of your nerves, blood vessels, organs and other tissues. Over time, this leads to complications such as kidney disease, loss of vision, nerve damage, heart attack and stroke.

In the absence of symptoms, you may notice consistently elevated blood glucose levels with day-to-day glucose testing. But this only captures a snapshot of your blood glucose at a particular instant. It’s possible for blood glucose levels to rise unnoticed above your desired range between the times that you test.

This is why it’s recommended that all people with diabetes also have a glycated hemoglobin (A1C) blood test at their doctor’s office at least two times a year. The test measures your average blood glucose level over the past three months. An A1C measurement of 7 percent or lower is a common treatment target for people with diabetes. The target may be slightly higher for some.

Factors to consider

Elevated blood glucose can be caused by many factors, including:

- **Changes in what you eat** — There may be times when you eat more food without realizing it — such as around the holidays — or begin consuming extra calories from a hidden source, such as a sugary beverage.
- **Changes in exercise habits** — Exercise helps lower blood glucose levels. If the amount of exercise you get declines from your usual routine, your body may not use as much glucose, leaving more in your bloodstream.
- **Medications** — The time of day you take diabetes medication and the dose needed to keep your blood glucose within the desired range may vary and require adjustment from time to time to keep your diabetes in good control. In addition, medications stored improperly or used after their expiration date lose their potency.

Medications taken for other conditions can also affect blood glucose. Any time you start to take a new drug — or discontinue taking a drug — ask your doctor if it will affect your blood glucose control.

- **Infections** — Colds, the flu or bacterial infections cause your body to produce hormones that increase blood glucose. If you’re sick, you may need to monitor your blood glucose more carefully and make adjustments.

High glucose levels also may be caused by an infection that you don’t know you have or a festering infection that isn’t being adequately treated.

- **Medical care or major medical problem** — Surgery, a heart attack, major emotional stress, an injury from an accident or a hospital stay can affect glucose-altering hormones and may involve medications or treatments that affect blood glucose. Tell your medical caregivers about your diabetes, and consider wearing a medical identification bracelet in case you can’t communicate.

Treatments involving steroids — including a steroid injection for back or joint pain, chemotherapy for cancer or treatment for autoimmune diseases such as rheumatoid arthritis — often affect glucose levels.

- **The “dawn effect”** — This is an abnormal early-morning increase in blood glucose thought to be related to the release of hormones while you sleep. Monitoring of your blood glucose through the night may be necessary to determine if you experience the dawn effect, or if elevated morning blood glucose is due to another cause.

Steps to take

For recurring episodes of higher than desired blood glucose, you may be able to make adjustments to get yourself back on track. With the help of your doctor, develop a plan to make sure you stay in control as much as possible. Anticipate potential problems — such as might be caused by travel, starting a new medication or simply getting sick — so that you can respond promptly and according to your plan.

If your fasting blood glucose levels are persistently above your goals — even though you’ve been following your diet and taking your medications as directed — an A1C test can alert you and your doctor to problems. Then, you can work with your doctor to determine why your blood glucose is high and identify changes in your lifestyle or medication that can help you get it back under control.
Second opinion

Q  As my eyesight has gotten worse from macular degeneration, I've started to see hallucinations of people. I know they're not real, but I'm worried this may be the start of Alzheimer's. Are there other explanations?

A  Although Alzheimer’s disease or other forms of dementia can cause hallucinations, there are many other causes. These include Parkinson's disease, sleep disturbances, alcohol abuse or withdrawal, migraine, seizure disorders, and psychiatric problems.

However, for older adults with vision loss, one fairly common cause of visual hallucinations is macular degeneration. This relationship has become known as the Charles Bonnet (bo-NAY) syndrome, named after the Swiss scientist who first described the condition.

It’s estimated that 11 to 15 percent of older adults with moderate to advanced vision loss — due to diseases such as macular degeneration, cataracts, glaucoma, diabetic retinopathy or stroke — experience Charles Bonnet syndrome. But the true incidence is difficult to gauge because many people are reluctant to confide in their doctor due to fears of being diagnosed with dementia or a psychiatric illness. Many people are afraid to tell friends or even close relatives because of concerns others might say they’re “crazy.”

Visual hallucinations from Charles Bonnet syndrome commonly involve vivid images of people, animals or scenes. Less frequently, they involve simple lines, flashes or geometric shapes. These can last from less than a minute to being almost continuous, and may occur several times a day or as just a few isolated episodes. These hallucinations are almost always recognized as unreal, but may be so disturbing and frightening that they interfere with daily tasks. They’re thought to be caused by spontaneous firings of vision-related brain cells due to diminished stimulation from visual information.

If you have visual loss from macular degeneration, the macular degeneration can be presumed to be the cause and other tests aren’t necessary. Treatment of an eye disease — such as removing a cataract — may improve vision, possibly ending the hallucinations.

If not, reassurance that the disease doesn’t pose a threat to overall health is often sufficient to ease worries and manage the condition. Visual hallucinations sometimes go away over time, and they may be manageable with steps such as improving lighting, blinking the eyes and turning the head away. In addition, certain medications — such as those used to treat depression or other psychiatric problems — may be helpful in reducing visual hallucinations or the resulting emotional distress.

Q  What is lichen sclerosus?

A  Lichen sclerosus is a chronic skin disorder that causes patches of skin to become shiny, smooth and white. Over time, these patches can appear thin, crinkled and even scarred. Areas of affected skin can become very itchy, even painful. Although it’s more typically seen in women, lichen sclerosus can also occur in men and children. For women, the peak age is during postmenopausal years. The cause is uncertain.

Lichen sclerosus may develop on any skin surface, but it most typically is found on skin in the genital and anal areas. In women, it tends to occur on the inner and outer folds of skin (labia) surrounding the clitoris and on the skin leading back to and encircling the anus.

Although there’s no cure for lichen sclerosus, twice daily applications of a corticosteroid ointment — clobetasol (Cormax, Temovate) — to the affected area is generally prescribed to control symptoms. Once symptoms are controlled, applications can be cut to twice a week for the long term. Along with ongoing treatment, personal hygiene that minimizes irritation of the skin — such as gentle cleansing with mild unscented soaps and using soft unscented toilet paper — can help.

Have a question or comment?
We appreciate every letter sent to Second Opinion but cannot publish an answer to each question or respond to requests for consultation on individual medical conditions. Editorial comments can be directed to:

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