THE ORIGIN OF RHEUMATOID ARTHRITIS IN ELDERLY PATIENTS

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Abstract: Currently, the genetic mechanisms of rheumatoid arthritis (RA) have been studied more widely; other mechanisms, for example, pathological changes in the elderly that occur in the pathogenesis and progression of the disease remain out of sight. Timely diagnosis of rheumatoid arthritis in older adults allows timely adjustments to be made in treatment.

Key words: rheumatoid arthritis, elderly age, treatment

RA – a systemic disease of connective tissue with predominant damage to small joints, such as erosive-destructive polyarthritis of unknown etiology with complex autoimmune pathogenesis. The onset of the disease can be acute, subacute and chronic. The acute onset is more often observed in young people and is characterized by the rapid (within several days and sometimes hours) development of severe arthritis with the addition of fever, myalgia, the development of severe general stiffness and a serious condition. With the subacute onset of the disease, signs of inflammation increase over 1-2 weeks. Arthralgia can be moderate, without affecting joint function. Possible low-grade fever. This variant of the onset of the disease more often occurs in middle-aged people, especially women [1,2].

RA affects about 1% of the adult population, mainly of older age, and has clinical features when it debuts in old and senile age. According to the age classification presented by WHO, the elderly group includes people 60–74 years old, the senile group 75–89 years old, and those over 90 years old are considered centenarians. In Uzbekistan, the latter age categories are rarely encountered in rheumatologist practice, given the average life expectancy of the population and the impact of rheumatic diseases themselves on demographic indicators.

Determining predictors of severe RA is an urgent task, since in these cases it is necessary to carry out aggressive therapy for the possible transformation of such a course into a more benign one. Predictors of functional failure, structural changes and increased mortality are identified. Predictors of increased mortality include middle and old age, a sedentary lifestyle, high values of rheumatoid factor, the presence of extra-articular manifestations of RA and comorbid diseases, pronounced structural changes.

According to A.M. Satybaldeva et al. the onset of RA in old age is often characterized by a low degree of activity of the inflammatory process, which in a retrospective assessment is classified as a "chronic" course of the disease. In such patients, signs of articular syndrome develop gradually, over several months, and extra-

articular manifestations are observed no more than in 20% of cases. S.C. Mastbergen et al. It is believed that RA in the elderly has a more acute onset, with virtually no prodromal period. The ratio of men and women who developed RA in old age is the same - 1:1, while at a younger age, females predominate among those affected: the male:female ratio is 1:3–1:4. In approximately 2/3 of elderly patients, RA begins with symmetrical oligoarthritis, in 1/3 – with symmetrical polyarthritis, and there is a predominant involvement of large joints rather than small joints of the hands and feet [3, 4, 5].

Damage to large joints at the onset of the disease occurs in 30% of cases. Articular syndrome is often accompanied by an increase in body temperature to febrile levels with the addition of extra-articular signs: lymphadenopathy, rheumatoid nodules, polyneuropathy (in 1/3 of patients), ulceration of the skin [6].

RA in the elderly is characterized by a rapid destructive process in the joints combined with proliferative changes and the formation of ankylosis. X-ray examination has low sensitivity in detecting erosive lesions typical of RA in the early stages of the disease, and therefore there may be a discrepancy between the X-ray picture and the functional state of the patient. The formation of erosions is observed in 30% of patients in the first six months after the onset of RA. In such cases, MRI and ultrasound of the joints are recommended [7, 8].

According to the literature, organ damage in RA in the elderly occurs with a slightly different frequency than in younger people. In old age, it initially proceeds slowly, with a gradual development of clinical symptoms over several months or years, much less often - subacute or acute. About 2/3 of cases manifest as polyarthritis, the rest - mono- or oligoarthritis, and the articular syndrome often has no clinical specificity, which greatly complicates differential diagnosis. The onset of rheumatoid arthritis in old age requires a differential diagnosis with osteoarthritis, in which secondary synovitis and limitation of joint mobility may develop, with crystalline arthropathy, including gout, exclusion of polymyalgia rheumatic, as well as an oncological search [9].

Seronegative variants of rheumatoid arthritis must be differentiated from remitting gray-negative symmetrical synovitis with severe edema. The onset of clinical manifestations characteristic of RA suggests the presence of one of two situations in an elderly person: the first is a combination of a tumor process and RA, one of which precedes the appearance of the other. In this situation, we are talking about the combination and mutual influence of pathologies without a cause-and-effect relationship between them. The second is the appearance of RA as a pair of neoplastic syndromes that developed as a result of autoimmune reactions caused by the emergence and progression of the tumor process. According to the literature, the most common osteoarticular lesions associated with neoplasia are rheumatoid arthritis.

Manifestations of RA, according to various oncologists, occur in 13% of cancer patients and are more often observed in tumors of the lung and gastrointestinal tract. Articular syndrome in this case is more often manifested by symmetrical polyarthritis involving the small joints of the hands and feet. Some patients have subcutaneous rheumatoid nodules, radiological signs of a long-term rheumatic process - erosive changes in the articular surfaces of the epiphyses. These changes can occur already in the early stages of malignant growth; they are resistant to glucocorticosteroids and cytostatics used to treat these diseases, and most often disappear after radical removal of the tumor. The effect of therapy in this case can be one of the reliable criteria for making a diagnosis [7,8].

Polymorbidity is the most pressing problem of modern clinical geriatric practice. On average, during a clinical examination of elderly and senile patients, at least 4-5 diseases and manifestations of pathological processes are diagnosed. The interaction of diseases changes their classic clinical picture, the nature of their course, increases the number of complications and their severity, worsens the quality of life and prognosis. In elderly patients, comorbid conditions were more often diagnosed: coronary artery disease, myocardial infarction, arterial hypertension, stroke, etc. The age of patients plays a large and sometimes decisive role in the choice of basic therapy for RA [9].

Conclusion: Aminoquinoline drugs in the elderly increase the risk of developing retinopathy and degenerative changes in the macular area, but it is worth remembering that these phenomena stop after discontinuation of the drug. D-penicillamine causes a more frequent occurrence of dermatoses and taste disorders. When prescribing cytostatics, more frequent monitoring of hematological parameters and the state of liver function is required. When taking azathioprine, a more frequent development of opportunistic infections was noted in elderly patients than in young patients. There are data on the treatment of elderly patients with RA with leflunomide, which indicate a pronounced effect of the drug on joint syndrome with a slowdown of destructive changes in the joints after a year of regular use of the drug and a relatively low risk of serious adverse reactions.

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