Methods: 150 doctors in GP health institutions were collecting data in 2005, and 2006 about risk factors for gastro-intestinal (GI) bleeding in their patients using NSAID’s. Following risk factors were included: smoking, corticosteroid therapy, regular aspirin therapy, anticoagulant therapy, history of GI problems and excess alcohol consumption. Research technique: Face-to-face interview, in health institution. Over the period of one week, GPs kept records of treating patients using NSAID’s. Duration of questionnaire: 8-10 minutes. Descriptive statistic methods were used for data analyzes.

Results: Age distribution of patients was: under 30y 373 (3.8%) patients, 30-45y 1521 (15.7%) patients, 46-60y 3655 (37.6%) patients, over 60y 3926 (40.4%) patients out of total 9704 patients - 4209 (43.4%) men, and 5495 (56.6%) women. The reason for use of NSAID’s was: osteoarthritis in 5301 (54.6%) patients, arthritis in 2032 (20.9%) patients, other in 2371 (24.4 %) patients. Total number of patients with risk factors for GI bleeding was 7809 (80.5%). The frequency of particular risk factor was as follows: smoking in 2594 (33.2%) patients, history of GI problems in 1812 (23.2%) patients, regular aspirin therapy in 1329 (17%) patients, anticoagulant therapy in 662 (8.5%) patients and excess alcohol consumption in 587 (7.5%) patients. 

Conclusions: Total number of patients with risk factors for GI bleeding was extremely high - 7809 (80.5%), smoking being the most widespread risk factor (33.2%) followed by history of gastro-intestinal problems. Most of the patients were over age of 60 (40.4%), which is the independent risk factor for GI bleeding. High frequency of GI risk factors in population of patients treated in general practice emphasize the need for possible protective measures (use of COX-2 selective drugs, concomitant use of NSAID’s and inhibitors of proton pump-PPI) to reduce the risk for GI bleeding.

AB18
Our experiences with diagnosis of latent tuberculosis in patients before the initiation of anti-TNF treatment with QuantiFERON-TB Gold test

E. Zanova a, M. Jesenak b, I. Solovic c, V. Polanova c, I. Rybar a, J. Rovensky a

a National Institute for Rheumatologic Diseases, Piešťany, Slovakia, b Department of Pediatrics, Jessenius School of Medicine, Martin, Slovakia, c National Institute for Tuberculosis, Pulmonary Diseases and Thoracic Surgery, Vysne Hagy, Slovakia

Objective: Recently, the possibility of anti-TNF treatment was introduced into clinical praxis in Slovakia (2001 — Infliximab, 2003 — Etanercept and 2005 — Adalimumab). One of the most serious and redoubtable side effects of anti-TNF treatment is the development of latent tuberculosis (TBC). Subjects with latent TBC have positive skin tuberculin test and in their organisms, there are vital TBC bacteria which are inactive (“hibernating status”). After immunosuppression of various origins, it comes to the activation of these bacteria and these persons become contagious. Latent form of tuberculosis is curable. QuantiFERON-TB Gold Test presents the break in the diagnosis of latent tuberculosis on the basis of quantification of interferon-gamma produced by T-lymphocytes after stimulation with mycobacterial proteins. Since 1st April 2007, this test was according to the Methodic Letter of Main expert for Pneumology and Phthiseology in Slovakia incorporated into the standard algorithms for screening of latent TBC before the initiation of anti-TNF treatment.

Aim: Examination of the patients with QuantiFERON-TB Gold Test before the initiation or in continuance of anti-TNF treatment.

Methods: We enrolled all the 106 patients before the initiation of anti-TNF treatment (indicated after 1st April 2007) and 73 other patients with already initiated anti-TNF treatment. Nowadays there are approximately 500 patients with rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis treated with anti-TNF medication.

Results: In patients with planned anti-TNF treatment (all from 1st April 2007) we observed in 70% negative, 9% positive and 6% questionable results. In 15% we are still waiting for the final result of the test. In the group of patients with already initiated anti-TNF treatment we noted in 93% negative, 4% positive (3 subjects) and 3% questionable results. In the patients we verified reactivation of the latent tuberculosis during anti-TNF treatment.

Conclusion: All the patients with negative test results initiated anti-TNF therapy. Those with positive results were firstly treated according to the protocol for the prophylactic anti-tuberculosis therapy during 6 months and after 2 months of therapy after consensus with pneumologist-phthiseologist we could start anti-TNF therapy. Patients with questionable test results (immunosuppressed) underwent after one month re-testing. Surprisingly, we found the lower frequency of questionable results in the group of already treated patients (3%) in comparison with those with planned anti-TNF treatment (6%). Test is suitable for the identification of highly risk persons, for the detection of hidden form of tuberculosis, decreased the risk of false negative results and prevents the development of active diseases. It allows to eliminate the mistakes in the interpretation of skin tuberculin test, economically execute desired number of the samples, accelerate the establishment of the diagnosis and consecutively specifically initiate adequate therapy. It is necessary to consider also the risk of false positive results of this test.