Pseudogout

(From various sources)

Pseudogout and the associated calcium pyrophosphate dihydrate (CPPD)- crystal-related arthropathies are common conditions that present particular management problems in clinical practice as they often affect older patients with multiple medical comorbidities. The epidemiology, metabolic and endocrine disease associations, and routine investigations used in the diagnostic workup are briefly reviewed. Current treatment approaches that are mainly directed at relieving the symptoms of joint inflammation are outlined. Unlike gout, there are no agents available that have been shown to decrease crystal load in CPPD-related joint disease.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3383522/

Joint trauma — People who have previously experienced a significant injury to or surgery on a joint have an increased risk of developing CPP crystal deposits.

PSEUDOGOUT DIAGNOSIS

A healthcare provider can confirm or rule out a diagnosis of pseudogout by performing an examination and tests. In many patients, a sample of joint fluid is obtained in order to determine whether calcium pyrophosphate dihydrate (CPP) crystals are present and to exclude arthritis due to other causes, such as gout or joint infection.

PSEUDOGOUT TREATMENT

There is no treatment that can completely remove or prevent the formation of calcium pyrophosphate dihydrate (CPP) crystals. However, the joint pain and swelling generally resolve with treatment, including the following:

Joint aspiration and/or injection — A clinician may insert a needle into the affected joint to remove the fluid and crystals that have accumulated. This can help to relieve pressure and pain. An injection of glucocorticoids (steroids) into the joint may relieve the associated joint inflammation.

Oral medications — Joint aspiration or injection is usually preferred when one or two joints are affected but may not be recommended if more than two joints are affected. In this case, an oral medication, such as a nonsteroidal antiinflammatory drug (NSAID), oral glucocorticoids, or colchicine, may be preferred.

Taking an NSAID such as ibuprofen (Advil, Motrin), indomethacin (Indocin), or naproxen (Aleve, Naprosyn) can help to relieve symptoms of pain and inflammation. Prescription-strength tablets (as opposed to over-the-counter tablets) may make it more convenient to take the relatively high doses of NSAIDs that are needed to control an attack. (See "Patient information: Nonsteroidal antiinflammatory drugs (NSAIDs) (Beyond the Basics)".)

Joint immobilization — Patients may be advised to avoid weight bearing (walking or running if the legs or feet are involved), to avoid excessive movement, and to limit activity for a period of time to minimize pain and swelling. In some cases, a temporary splint will be recommended to limit joint movement.

http://www.uptodate.com/contents/pseudogout-beyond-the-basics

Prevention

Long-term prevention of recurrent pseudogout is often best achieved with small daily doses of colchicine and optimal hydration.

Dr. McGrath points out that unlike with gout, you cannot reduce your risk of pseudogout by losing weight or changing your diet and alcohol habits.

http://www.everydayhealth.com/arthritis/inflammatory-arthritis/ankylosing-spondylitis-explained.aspx