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G．知的財産権の出願、登録状況

特になし

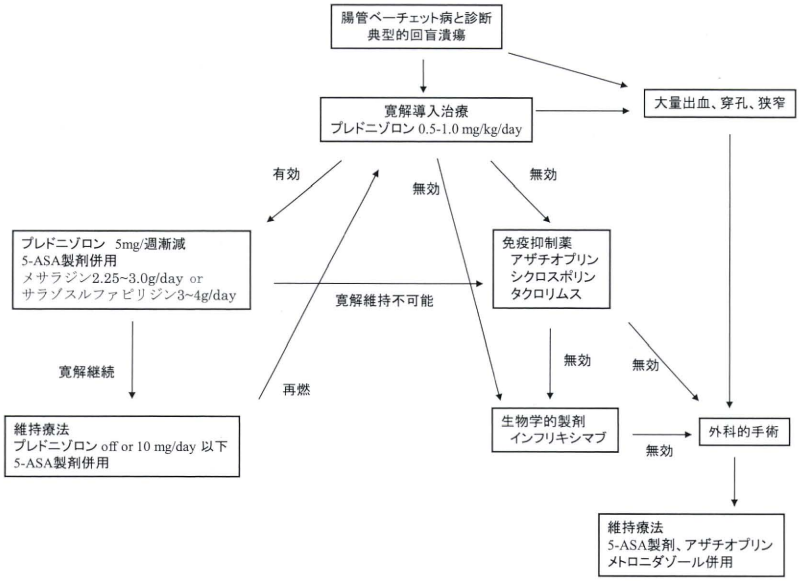

図1．腸管ベーチェット病治療のフローチャート（腸管ベーチェット病診療ガイドライン平成21年度案―コンセンサス・ステートメントに基づく―　付図3より抜粋）

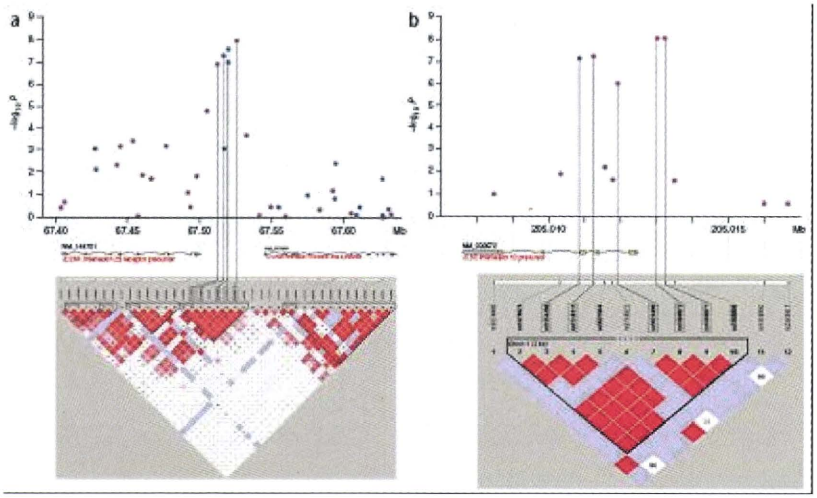

図2．IL23R-IL12RB2およびIL10領域における詳細なSNP解析

II 分担研究報告

厚生労働科学研究費補助金（難治性疾患克服研究事業）
分担研究報告書

臨床調査個人票の改定案

研究代表者　石ヶ坪良明　横浜市立大学大学院学研究科病態免疫制御内科学
研究分担者　岳野　光洋　横浜市立大学大学院学研究科病態免疫制御内科学
黒沢美智子　順天堂大学医学部衛生学
大野　重昭　北海道大学大学院医学研究科眼科学
蕪城　俊克　東京大学医学部付属病院眼科学
水木　信久　横浜市立大学大学院学研究科視覚病態学
後藤　　浩　東京医科大学眼科学
金子　史男　南東北病院皮膚科
中村晃一郎　埼玉医科大学皮膚科学

研究要旨
現行のベーチェット病の臨床調査個人票の情報、特に「更新」に関しては疫学調査を行う上で不十分であるという指摘があり、研究分担者および協力者の意見を反映して、臨床調査個人票改定案を作成した。さらに、この改定案を各施設で施行し、実用性をチェックし、さらなる修正点を検討し、最終的な改定案を作成した。
最大の変更点は、「更新」の個人票からも十分な情報が得られるように、症状、治療について「ここ１年間」と「全経過を通じて」を加えたことである。そのほか、「新規」・「更新」の各症状の表記、「新規」個人票の「参考となる所見」および「鑑別診断」についても全面的に見直した。この変更に伴い、厚生労働省ベーチェット病診断基準についても見直しを行い、特殊型の定義、参考となる所見、参考事項など診断における補助項目について改定を行い、臨床調査個人票改定案との整合性を確認した。

A．研究目的

特定疾患における臨床調査個人票は重要な疫学調査の情報源であるが、現在のベーチェット病の「更新」個人票では十分な調査ができないとの指摘があった。また、一方では、「新規」個人票の参考となる所見にある「レンサ球菌ワクチンプリックテスト」の項目について、事務局に数件の問い合わせがあったが、その抗原の供給体制などの問題から、十分な対応ができなかった。こうした反省から、個々の項目を見直し、日常臨床業務に支障をきたさず、かつ、疫学調査の情報源としても十分に対応できる個人票の改定案を作成することを目的とする。

B．研究方法

1．現在の臨床調査個人票の記載上の問題点を班会議およびメールにて意見交換し、改定案をまとめた。
2．改定案を以下の施設の協力を得て、試行した。
帝京大内科、慶応大リウマチ内科、東京医

大リウマチ・膠原病内科、東京医科歯科大学消化器内科、北里大学膠原病・感染内科、東大眼科、横浜市立大学眼科およびリウマチ・血液・感染症内科、横浜市立大学附属センター病院リウマチ・膠原病センター 藤沢市民病院血液・膠原病科、国立横浜医療センターリウマチ科、横浜南共済病院リウマチ科 。

3．実施上の問題点を解析し、さらに新しい改定案を作成した。

4．臨床調査個人票改定に対応して、診断基準についても見直しを行い、両者の整合性を確認した。

C．研究結果

1．臨床調査個人票の主な変更点は以下の通りである。

1）「新規」・「更新」共通の変更点

a．副症状③内視鏡で確認できる消化器病変を「あり」「なし」に変更し、具体的な病変部位を記載する。

b．副症状④血管病変の分類を動脈瘤、動脈閉塞、深部静脈血栓症（皮下の血栓性静脈炎は含まない)、肺塞栓に変更する。

c．副症状⑤神経病変の分類を急性型（髄膜炎・脳幹脳炎など)、慢性進行型（体幹失調・精神症状など）に変更する。

d．薬物療法の記載を、(1.ステロイド（プレドニゾロン換算　mg/日）　2シクロスポリン　3.コルヒチン　4．インフリキシマブ　5.その他（　　)) に変更する。

e．「主な治療法」を「その他の治療法（手術など)」に変更する。

f．「本例の特徴」を除く。

2）「新規」のみの変更点

a．参考となる所見のHLA-B51（B5）をHLA-B51とし、HLA-A26およびその他のクラスⅠについての記載項目を加える。

b．参考となる所見「レンサ球菌ワクチンプリックテスト」を除く。

c．結節性紅斑の生検組織像は「脂肪織炎および血管病変」のあり・なしに変更する。

d．視力は非発作時の視力であることを明記する。

e．眼症状をもつ疾患の鑑別診断を以下に変更する。サルコイドーシス、細菌性および真菌性眼内炎、急性網膜壊死、サイトメガロウイルス網膜炎、HTLV-I関連ぶどう膜炎、トキソプラズマ網膜炎、結核性ぶどう膜炎、梅毒性ぶどう膜炎、ヘルペス性虹彩炎、糖尿病性虹彩炎、HLA-B27関連ぶどう膜炎、仮面症候群」。

f．消化器症状をもつ疾患鑑別診断を以下に変更する。急性虫垂炎、感染性腸炎、クローン病、薬剤性腸炎、腸結核。

g．血管系症状をもつ疾患の鑑別診断より深部静脈血栓症を除く。

3）「更新」のみの変更

症状、治療状況について、「ここ1年間」と「全経過を通じて」を別々に記載する。

2．診断基準改定

厚生労働省診断基準は1987年を基に、2003年に改定されており、臨床調査個人票の各項目の根拠となっている。今年度，臨床調査個人票改定案を作成し、病診断基準についても見直しを行い、特殊型の定義、参考となる所見、参考事項など診断における補助項目について改定を行い、臨床調査個人票改定案との整合性を確認した（表3、表4)。

D．考察

従来の「更新」の臨床調査個人票には症状の記載項目がなく、個々の症例解析が困難であった。そこで、「更新」の調査票の症状に関しては、本疾患における症状の経年的変化を考慮し、症状の有無の項目を単に加えるだけでなく、「ここ1年間」と「全経過を通じて」

を別々の記載することとし、治療状況に関しても同様の変更を行った。他の膠原病など慢性炎症性疾患の特定疾患の調査個人票はほとんど「ここ1年間」と「全経過を通じて」を個別に記載する様式になっており、改定案試行時にも「分量は多いが、許容範囲」との意見がほとんどで、日常臨床業務、特に外来においても対応可能と考えられる。

改定項目が特殊病型を中心とした内科的領域に集中し、眼科医から内科的項目に関しては「不明」が増えるとの懸念もあった。また、「新規」の「視力」が「非発作時の視力」であることは、眼科医にとっては常識的であっても、内科医、皮膚科医は判断に迷うとの意見もあり、「非発作時の視力」であることを明記した。記載診療医の専門領域の問題は、ベーチェット病が多臓器疾患であるがゆえに避けて通れないものであり、根本的には各施設で診療科間連携で対処していただくほかないと思われる。

活動状態の「非活動期」についても問題点が指摘された。「非活動期」にある患者は「軽快者」と認識されがちであるが、実際には、インフリキシマブ治療により「非活動期」に至っている重症ぶどう膜炎患者も存在する。このような患者をとらえ、医療費の受給が中止されてしまうと、薬剤費が高額であるだけに、治療を断念せざるを得ない患者も出てくる可能性もある。それは再び失明の危機にさらされる危険性を意味しており、社会的問題にもなりかねない。この点に関しては、「治療状況」の区分を改定し、新たにシクロスポリン、インフリキシマブなどを選択肢に加え、明確にした。

今回の改定により、臨床調査個人票の情報は個々の患者を把握するのにより有用性の高いものとなった。

また、上述したように厚労省の診断基準の小改定も併せて行い、さらに現在作成中の眼病変および腸管ベーチェ病の診療ガイドラインとの整合性についても考慮している。

E．結論

ベーチェット病の臨床調査個人票を、疫学的にも十分活用でき、かつ臨床的に実用性の高いものとする改定案を示した。この改定とともに、関連する厚労省の診断基準の小改定を行うとともに、現在作成中の眼病変および腸管ベーチェ病の診療ガイドラインとの整合性についても考慮していく。

F．健康危険情報

特記事項なし。

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