SOCIETÀ MEDICA
LAZZARO SPALLANZANI

PATOLOGIE DELLE GHIANDOLE SALIVARI: RICONOSCERE, TRATTARE, INVIARE

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REGGIO EMILIA, 10 OTTOBRE 2026

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. Patologie autoimmuni e sistemiche (30 min) 10.50

Relatore: Manfredi - Setti

- Sindrome di Sjögren: sintomi chiave, approccio diagnostico precoce.
- Diagnosi Differenziale con altre patologie autoimmuni
- Xerostomia da farmaci (antidepressivi, antipertensivi, anticolinergici).
- Ruolo del MMG: sospetto clinico, primo inquadramento, corretta richiesta di esami.
- Interazione con odontoiatra e specialista per la gestione integrata.
- Strumenti semplici in studio (stimolazione salivare, valutazione del flusso).

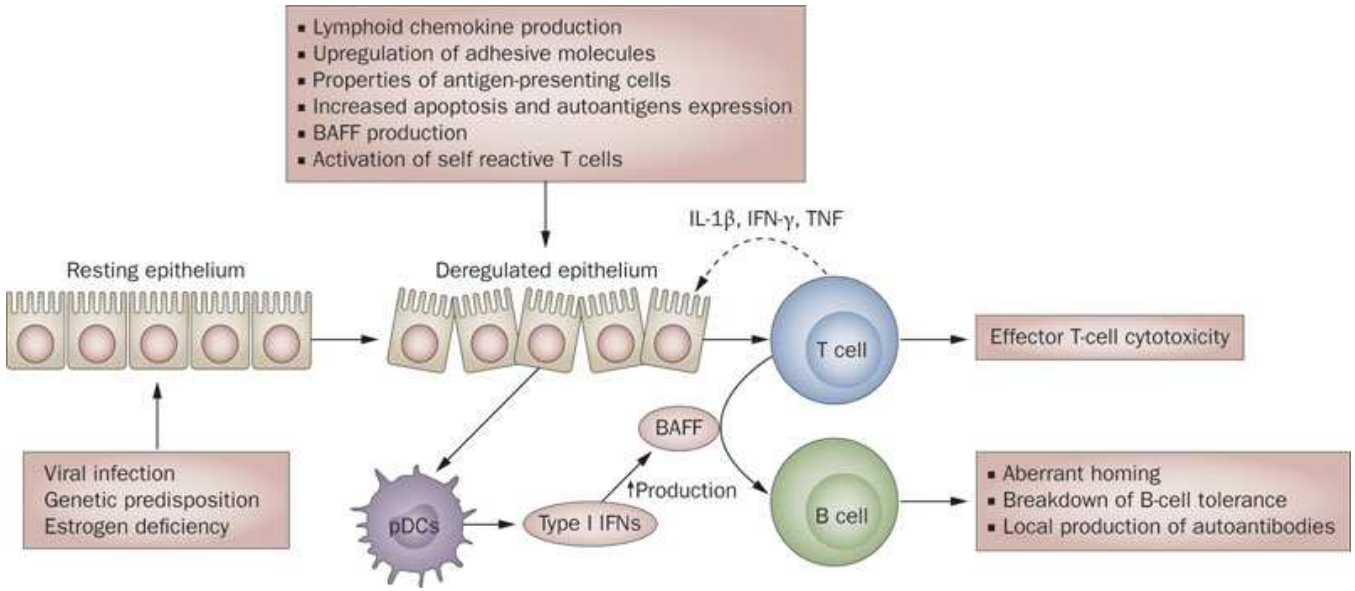
Criteria

2016 American College of Rheumatology/European League Against Rheumatism classification criteria for primary Sjögren's syndrome

A consensus and data-driven methodology involving three international patient cohorts

Caroline H Shiboski,[1] Stephen C Shiboski,[1] Raphaèle Seror,[2] Lindsey A Criswell,[1] Marc Labetoulle,[2] Thomas M Lietman,[1] Astrid Rasmussen,[3] Hal Scofield,[4] Claudio Vitali,[5,6] Simon J Bowman,[7] Xavier Mariette,[2] the International Sjögren's Syndrome Criteria Working Group

La sindrome di Sjögren (SS) è una malattia autoimmune sistemica caratterizzata da ipofunzione delle ghiandole salivari e lacrimali, con possibile interessamento di più organi. La gestione è affidata principalmente ai reumatologi, in collaborazione con oftalmologi e specialisti in medicina e patologia orale



Infiltrazione linfocitaria delle ghiandole esocrine con formazione di scialoadenite linfoepiteliale.
Popolazione linfoide che circonda e infiltra i dotti salivari e disorganizzazione e proliferazione delle cellule epiteliali duttali

Table 3 American College of Rheumatology/European League Against Rheumatism classification criteria for primary Sjögren's syndrome: The classification of primary Sjögren's syndrome (SS) applies to any individual who meets the inclusion criteria,* does not have any of the conditions listed as exclusion criteria,† and has a score of ≥4 when the weights from the five criteria items below are summed

Item	Weight/score
Labial salivary gland with focal lymphocytic sialadenitis and focus score of ≥1 foci/4 mm^2‡	3
Anti-SSA/Ro-positive	3
Ocular Staining Score ≥5 (or van Bijsterveld score ≥4) in at least one eye§¶	1
Schirmer's test ≤5 mm/5 min in at least one eye§	1
Unstimulated whole saliva flow rate ≤0.1 mL/min§**	1

SCORE DI 4

*These inclusion criteria are applicable to any patient with at least one symptom of ocular or oral dryness, defined as a positive response to at least one of the following questions:

(1) Have you had daily, persistent, troublesome dry eyes for more than 3 months?
(2) Do you have a recurrent sensation of sand or gravel in the eyes?
(3) Do you use tear substitutes more than three times a day?
(4) Have you had a daily feeling of dry mouth for more than 3 months?
(5) Do you frequently drink liquids to aid in swallowing dry food? or in whom there is suspicion of Sjögren's syndrome (SS) from the European League Against Rheumatism SS Disease Activity Index questionnaire (at least one domain with a positive item).

†Exclusion criteria include prior diagnosis of any of the following conditions, which would exclude diagnosis of SS and participation in SS studies or therapeutic trials because of overlapping clinical features or interference with criteria tests: (1) history of head and neck radiation treatment, (2) active hepatitis C infection (with confirmation by PCR), (3) AIDS, (4) sarcoidosis, (5) amyloidosis, (6) graft-versus-host disease, (7) IgG4-related disease.

Manifestazioni orali

Candidiasi orale riportata in oltre l'80% dei pazienti. Di solito si presenta come cheilite angolare o candidiasi acuta eritematosa

Tumefazione delle ghiandole salivari maggiori: 25-66% nella SS primaria, molto rara nello Sjogren secondario

Carie

Disgeusia

Tumefazione delle ghiandole salivari maggiori



cheilite angolare

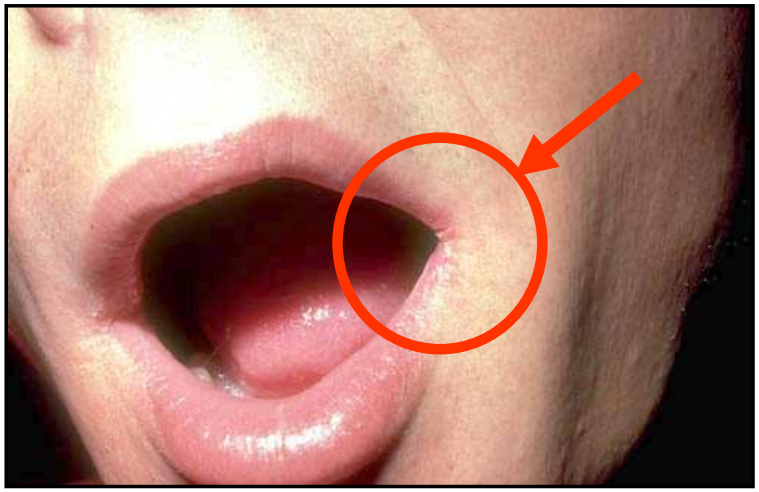










Fig. 2. Biopsy of the lesser salivary glands of the lips.



Si osservano tipicamente **aggregati focali di almeno 50 linfociti** e, in minor misura plasmacellule e macrofagi.
Almeno un aggregato focale deve essere presente in 4 mm^2. Aggregati focali si osservano in tutte le ghiandole.
Focus score: numero di foci in 4 mm^2 (da 1 a 4)

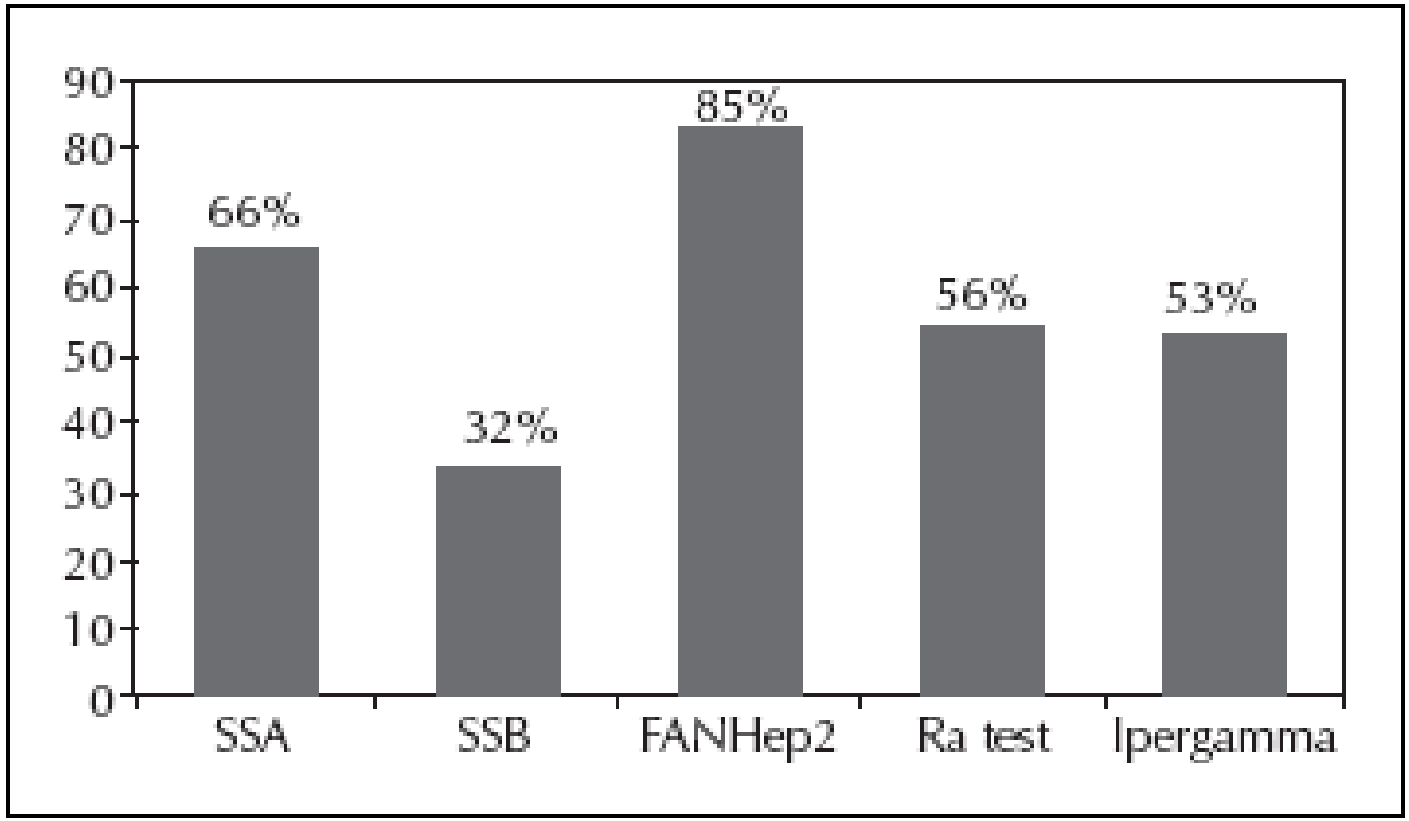
Infiltrati linfocitari possono essere osservati anche in altri organi:
Mucosa gastrica: infiltrati linfocitari con atrofia gastrica
Rene: infiltrati interstiziali
Polmone: polmonite interstiziale linfocitaria

GRADING STANDARD FOR LABIAL SALIVARY GLAND BIOPSY

Grade	*Lymphocytes per 4 sq mm of Salivary Tissue*
0	Absent
1	Slight infiltrate
2	Moderate infiltrate or less than one focus[1]
3	One focus
4	More than one focus

[1]Focus = an aggregate of 50 or more lymphocytes and histiocytes.

La biopsia delle ghiandole salivari permette di evidenziare un linfoma o una necrosi granulomatosa non caseosa di una sarcoidosi.

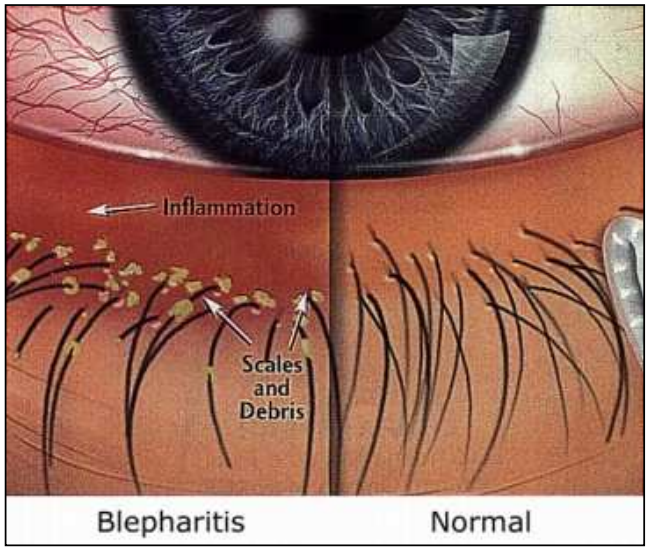

90
80
70
60
50
40
30
20
10
0
66%
32%
85%
56%
53%
SSA
SSB
FANHep2
Ra test
Ipergamma

Manifestazioni oculari

La xeroftalmia è la principale manifestazione della SS.
La diminuita secrezione di lacrime conduce ad un danno dell'epitelio corneale e bulbare (**cheratocongiuntivite secca**)
Sintomi sono la sensazione di sabbia o corpo estraneo, il prurito, l'impossibilità a rimanere in ambienti con molta luce e fumo

All'osservazione si apprezzano dilatazione e tortuosità dei vasi della congiuntiva bulbare, lesioni corneali, abrasioni

Una blefarite si può presentare in alternativa o in associazione alle altre manifestazioni



1

Predisposizione

Genetica + stimoli ambientali

2

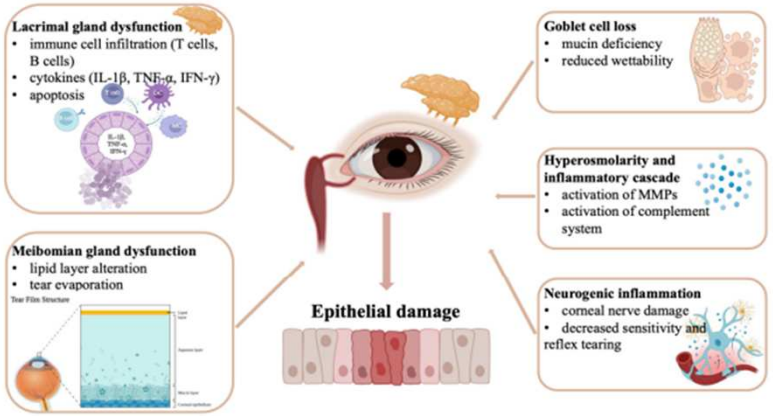
Autoimmunità

Sviluppo risposta autoimmune

3

Danno ghiandolare

Distruzione ghiandole lacrimali → deficit lacrimale acquoso



4

Circolo vizioso

Iperosmolarità → infiammazione cronica → DED perpetuo

la malattia dell'unità funzionale lacrimale estesa, cioè:
•ghiandola lacrimale
•ghiandole di Meibomio
•cellule caliciformi
•superficie oculare
•nervi

Wu KY et al. Biomolecules 2024;14:80 | Fonte: Wu et al., revisione letteratura 2016–2023

Expert Review of Clinical Immunology

ISSN: 1744-666X (Print) 1744-8409 (Online) Journal homepage: http://www.tandfonline.com/loi/ierm20

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Early diagnosis of primary Sjögren's syndrome: EULAR-SS task force clinical recommendations

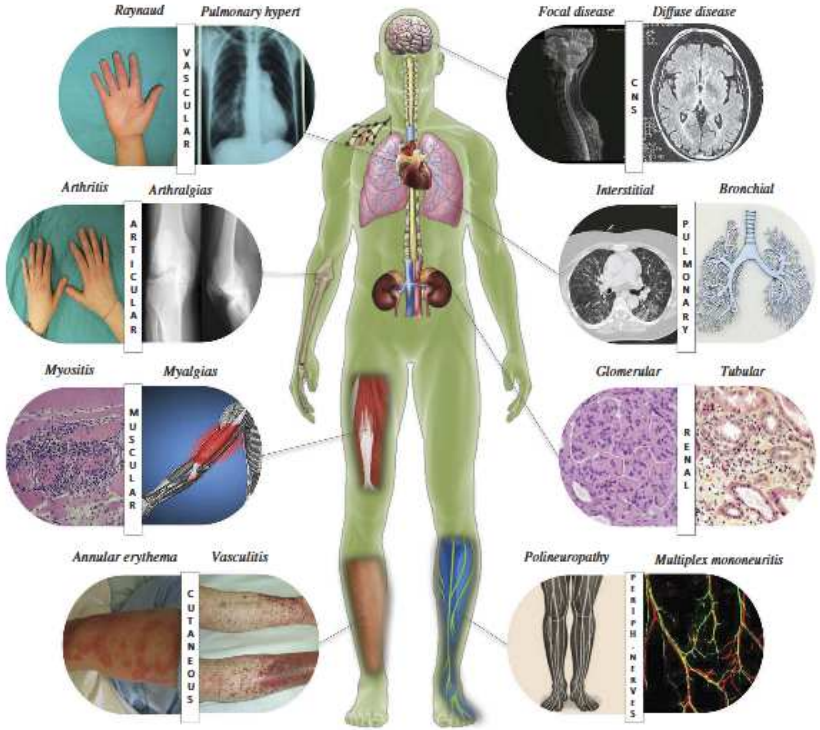
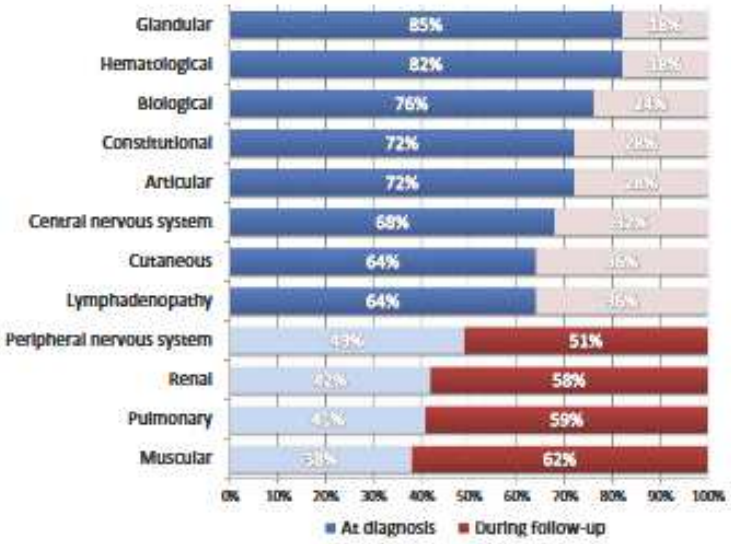


Figure 1. Organ-specific systemic involvement in primary SjS: 'Janus-faced' pattern of involvement.



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Porpora

Quadro emorragico cutaneo o muscoso caratterizzato da stravasi emorragici di dimensioni variabili che non scompaiono alla digito-vitro-pressione

Manifestazione comune a molte vasculiti diverse anche come manifestazione d'esordio:











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HCV-unrelated cryoglobulinaemic vasculitis: the results of a prospective observational study by the Italian Group for the Study of Cryoglobulinaemias (GISC)

M. Galli[1], L. Oreni[1], F. Saccardo[2], L. Castelnovo[2], D. Filippini[3], P. Marson[4], M.T. Mascia[5], C. Mazzaro[6], L. Origgi[7], E. Ossi[8], M. Pietrogrande[9], P. Pioltelli[10], L. Quartuccio[11], S. Scarpato[12], S. Sollima[1], A. Riva[1], P. Fraticelli[13], R. Zani[14], D. Giuggioli[15], M. Sebastiani[15], P. Sarzi Puttini[16], A. Gabrielli[13], A.L. Zignego[17], P. Scaini[14], C. Ferri[15], S. De Vita[11], G. Monti[2]

Table I. Baseline demographic, clinical and laboratory data relating to patients with HCV-unrelated CV (by associated disorder) or essential CV.

Baseline characteristics	Total n=175	PSS n=37	SLE n=19	AID n=19	LPD n=12	ST n=4	HBCV n=15	ECV n=69	p^*
Females [n (%)]	138 (78.9)	35 (94.6)	19 (100.0)	17 (89.5)	8 (66.7)	3 (75.0)	10 (66.7)	46 (66.7)	0.002
Age (years) [median (IQR)]	66 (55-74)	67 (61-73)	46 (37-62)	60 (46-69)	77 (67-78)	75 (70-78)	63 (55-69)	68 (56-74)	<0.001
Incident cases [n (%)] §	74 (42.3)	16 (43.2)	3 (15.8)	6 (31.6)	3 (25.0)	4 (100.0)	4 (26.7)	38 (55.1)	0.004
Purpura [n (%)]	121 (69.1)	29 (78.4)	7 (36.8)	12 (63.2)	10 (83.3)	4 (100.0)	14 (93.3)	45 (65.2)	0.005
Arthralgia [n (%)]	140 (80.0)	30 (81.1)	19 (100.0)	17 (89.5)	7 (58.3)	4 (100.0)	8 (53.3)	55 (79.7)	0.009
Fatigue [n (%)]	123 (70.3)	25 (67.6)	12 (63.2)	15 (78.9)	8 (66.7)	3 (75.0)	10 (66.7)	50 (72.5)	0.949
MF triad [n (%)]	68 (38.9)	15 (40.5)	4 (21.1)	8 (42.1)	4 (33.3)	3 (75.0)	7 (46.7)	27 (39.1)	0.493
Lower limb ulcers [n (%)]	31 (17.7)	8 (21.6)	3 (15.8)	4 (21.1)	4 (33.3)	2 (50.0)	1 (6.7)	9 (13.0)	0.234
Peripheral neuropathy [n (%)]	85 (48.6)	22 (59.5)	7 (36.8)	7 (36.8)	6 (50.0)	3 (75.0)	6 (40.0)	34 (49.3)	0.490
Renal abnormalities [n (%)]	46 (26.3)	13 (35.1)	8 (42.1)	6 (31.6)	3 (25.0)	2 (50.0)	4 (26.7)	10 (14.5)	0.075
Hyperviscosity syndrome [n (%)]	4 (2.3)	1 (2.7)	1 (5.3)	1 (5.3)	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.5)	0.999
Raynaud's phenomenon [n (%)]	46 (26.3)	10 (27.0)	9 (47.4)	6 (31.6)	3 (25.0)	0 (0.0)	0 (0.0)	18 (26.1)	0.060
Chronic urticaria or other cutaneous manifestations¶ [n (%)]	30 (17.1)	7 (18.9)	7 (36.8)	3 (15.8)	1 (8.3)	0 (0.0)	1 (6.7)	11 (15.9)	0.360
Liver abnormalities [n (%)]	41 (23.4)	4 (10.8)	2 (10.5)	2 (10.5)	3 (25.0)	1 (25.0)	12 (80.0)	17 (24.6)	<0.001
Lung abnormalities [n (%)]	26 (14.9)	7 (18.9)	2 (10.5)	4 (21.1)	0 (0.0)	1 (25.0)	3 (20.0)	9 (13.0)	0.552
Sicca syndrome [n (%)]	68 (38.9)	32 (86.5)	8 (42.1)	10 (52.6)	3 (25.0)	0 (0.0)	3 (20.0)	12 (17.4)	<0.001
Hypertension [n (%)]	66 (37.7)	17 (45.9)	3 (15.8)	8 (42.1)	7 (58.3)	2 (50.0)	7 (46.7)	22 (31.9)	0.171
Lymphadenopathy [n (%)]	34 (19.4)	13 (35.1)	6 (31.6)	2 (10.5)	3 (25.0)	2 (50.0)	3 (20.0)	5 (7.2)	0.003
Splenomegaly [n (%)]	27 (15.4)	3 (8.1)	1 (5.3)	3 (15.8)	5 (41.7)	2 (50.0)	6 (40.0)	7 (10.1)	0.002
C4 (mg/dL) [median (IQR)]	4 (2-12)	4 (2-11)	4 (3-10)	8 (1-14)	2 (1-5)	7 (4-12)	2 (1-8)	5 (2-15)	0.544
RF (kU/L) [median (IQR)]	109 (20-372)	239 (90-504)	15 (9-19)	20 (5-58)	341 (106-589)	603 (309-1433)	220 (111-2935)	101 (22-238)	0.001
Cryocrit (%) [median (IQR)]	2.0 (0.5-4.0)	2.0 (0.9-7.0)	1.0 (1.0-2.0)	0.5 (0.5-3.1)	5.5 (3.3-6.5)	6.0 (1.6-12.0)	2.0 (2.0-17.0)	1.2 (0.5-3.0)	0.061
Type of MCG [n (%)]									0.134
Type II	96 (54.9)	24 (64.9)	6 (31.6)	8 (42.1)	9 (75.0)	2 (50.0)	10 (66.7)	37 (53.6)	
Type III	79 (45.1)	13 (35.1)	13 (68.4)	11 (57.9)	3 (25.0)	2 (50.0)	5 (33.3)	32 (46.4)	

*p-values are for χ^2 or Fisher's exact test and Kruskal-Wallis test when comparing all groups in the analysis of each category. ¶ Other than palpable purpura and ulcers.
§ Diagnosed after 1 January 2004.
PSS: primary Sjögren's syndrome; SLE: systemic lupus erythematosus; AID: other auto-immune disorders; LPD: lymphoproliferative diseases. ST: solid tumours; HBCV: HBsAg positive cryoglobulinaemic vasculitis; ECV: essential cryoglobulinaemic vasculitis.

MCGs have been reported in 10–15% of patients with PSS (17, 52), which our study confirms to be a leading cause of HCV-unrelated CV. Overt purpura was present in 78% of our PSS patients, 64% of whom had type II MCGs that persisted over time in more than 70% of cases. During the study period, four PSS patients died because of NHL. It is known that PSS increases the risk of developing B-cell NHL (23, 53, 54), and PSS patients show a polyclonal pattern of B cell expansion in bone marrow more frequently than patients with HCV-related cryoglobulinaemia (46)

ILD nello Sjögren

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OECI COMPREHENSIVE Cancer Centre

COORTE PROSPETTICA OSSERVAZIONALE

PERIODO

Novembre 2019 – settembre 2022

POPOLAZIONE

257 pazienti consecutivi con Sjögren

FOLLOW-UP

42,6 ± 14,6 mesi (media ± DS)

TCAR SE

Dispnea, tosse secca ≥3 mesi o crepitii tipo velcro

23,7%

Prevalenza di ILD

61/257 all'arruolamento

0,41

Nuovi casi/100 pazienti-anno

3 casi nel follow-up

NSIP

Pattern TCAR più frequente

40,6% · UIP 31,3% · LIP 17,2%

8,2%

Mortalità complessiva

21/257 · follow-up medio 43 mesi

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Manfredi et al. Semin Arthritis Rheum 2026;76:152886 · PMID 41442876

ILD nello Sjögren: sopravvivenza e fattori associati

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SOPRAVVIVENZA COMPLESSIVA

Sjögren senza ILD

88,4%

Sjögren con ILD

66,5%

Confronto lungo il follow-up: p < 0,001

A 2 anni: 96,7% vs 98,4% (p = 0,43)

ANALISI MULTIVARIATA

Fattori associati alla ILD

- Sesso maschile: OR 7,43 · p < 0,01
- Età alla diagnosi: OR 1,05 · p < 0,01
- VES ≥40 mm/h: OR 2,34 · p = 0,02

Mortalità: associazione indipendente

- **Estensione ILD alla TCAR: HR 1,05 · p = 0,02**

Età: HR 1,05 · p = 0,18; anti-SSA/Ro: HR 0,42 · p = 0,34

Questi ultimi due risultati non sono significativi nel modello.

- linfoma del tessuto linfoide associato alle mucose (MALT) e a sede ghiandolare parotidea. Generalmente, i linfomi MALT dei pazienti con SS sono a basso grado di aggressività
- linfomi ad alto grado di aggressività, tipo diffuse large B cell lymphoma (DLBCL) sia de novo, o, come accade più spesso, come evoluzione di un linfoma a basso grado-

FATTORI PROGNOSTICI NEGATIVI CLINICI E SIEROLOGICI

- SLARGAMENTO PERSISTENTE DELLE PAROTIDI
- SPLENOMEGALIA
- LINFOADENOPATIA
- PORPORA PALPABILE
- NEUROPATIA PERIFERICA
- CRIOGLOBULINEMIA
- LINFOPENIA
- CONSUMO DEL COMPLEMEMTO
- COMPONENTE MONOCLONALE NEL SIERO O NELLE URINE
- DELLE GHIANDOLE SALIVARI

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Classe farmacologica	Esempi	Meccanismo prevalente	Evidenza di associazione con xerostomia
Antidepressivi • Triciclici (es. amitriptilina) • SSRI (es. paroxetina, sertralina)	• Amitriptilina • Clomipramina • Paroxetina • Sertralina	**Effetti antimuscarinici,** soprattutto per i triciclici; altri meccanismi anche per gli SSRI	**Associazione significativa con aumento del rischio di xerostomia** (es. *OR pooled* 4,74; IC 95% 2,69–8,32)[1]
Antipertensivi • Diuretici • Agonisti α2-adrenergici • Beta-bloccanti • ACE-inibitori / Sartani	• Idroclorotiazide • Furosemide • Clonidina • Metoprololo • Ramipril • Losartan	**Meccanismi eterogenei:** modificazioni dell'equilibrio idrico, della regolazione autonoma e della secrezione salivare	**Evidenza variabile:** alcuni studi riportano un aumento del rischio di xerostomia, con dati meno consistenti rispetto ad antidepressivi e anticolinergici[2,3]
Anticolinergici • Urologici • Antistaminici di I generazione • Antipsicotici • Antiparkinsoniani	• Ossibutinina • Tolterodina • Difenidramina • Aloperidolo • Biperidene	**Blocco dei recettori muscarinici** e riduzione della secrezione salivare	**Associazione significativa con aumento del rischio di xerostomia** (es. *OR pooled* 5,91; IC 95% 4,04–8,63)[1]

La presenza di xerostomia, soprattutto in pazienti anziani o in politerapia, richiede un'attenta revisione farmacologica prima di attribuire il sintomo a una malattia autoimmune.

1. Tan ECK et al. J Am Geriatr Soc. 2018;66:76–84. doi: 10.1111/jgs.15105. PMID: 29071719.
2. Wolff A et al. Drugs R D. 2017;17:1–28. doi: 10.1007/s40268-016-0152-9. PMID: 27853957.
3. Teoh CXW et al. BJPsych Open. 2023;9:e53. doi: 10.1192/bjo.2023.38. PMID: 36938801.

Condizioni di esclusione ACR/EULAR 2016

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- Radioterapia pregressa di testa e collo
- Epatite C attiva confermata mediante PCR; AIDS
- Sarcoidosi; amiloidosi; GVHD
- Malattia correlata a IgG4

La malattia correlata a IgG4

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La malattia correlata a IgG4 (IgG4-RD) è una patologia fibroinfiammatoria immunomediata, a decorso insidioso, caratterizzata dalla formazione di lesioni simil-tumorali in cui linfociti B e T e macrofagi si accumulano in un tessuto fibrotico. Mostra una marcata risposta ai glucocorticoidi e alla deplezione delle cellule B.

La malattia correlata a IgG4

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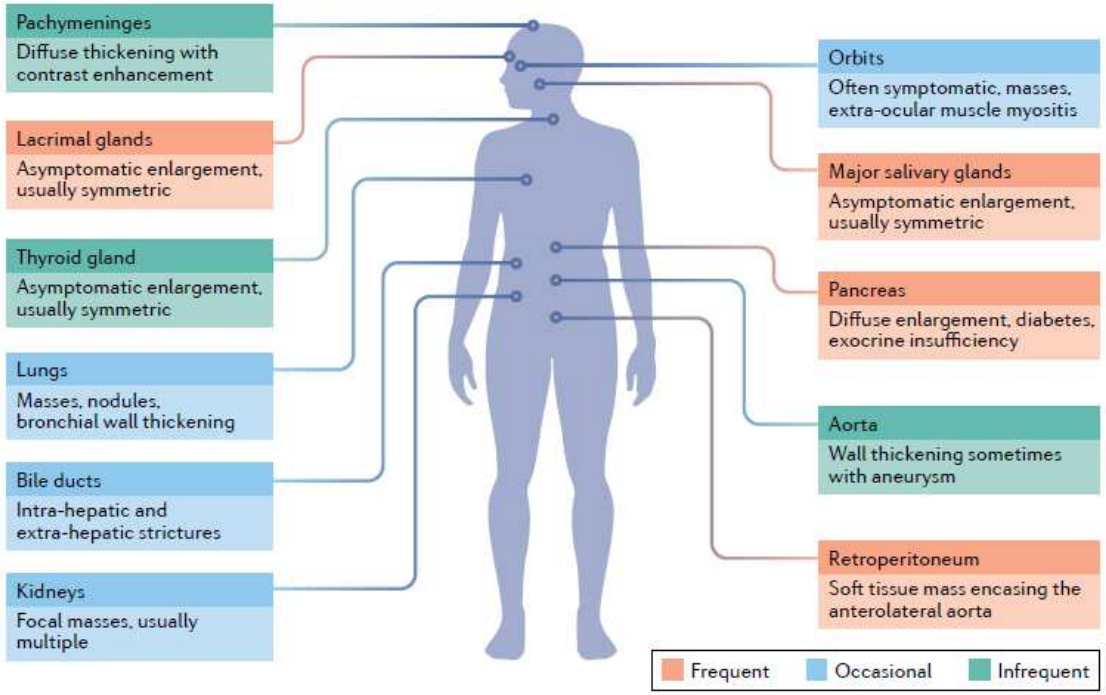
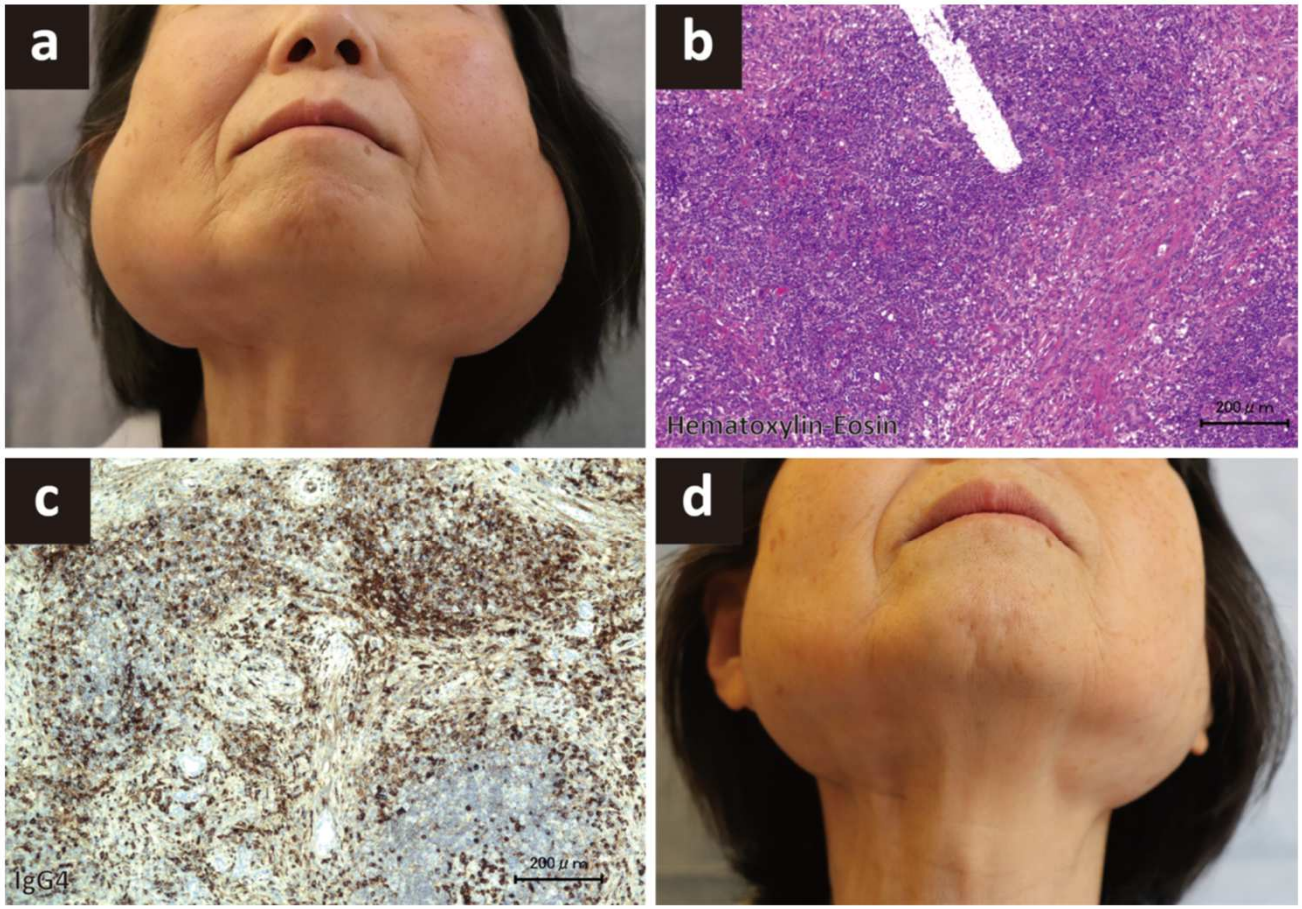


Fig. 1 | **The manifestations of IgG4-related disease.** Body schematic highlighting the 11 anatomical sites that are regarded as typically involved in IgG4-related disease according to the ACR–EULAR 2019 IgG4-related disease classification criteria. The most frequent manifestation for each organ is described. Colours indicate the relative frequency of involvement for each organ.

La malattia correlata a IgG4

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Watanabe M, Hanai S, Ito R, Nakagomi D. Immunoglobulin G4-related Parotitis. JMA J. 2024;7(1):125-126.

IgG4-related disease inclusion domains and point assignments

Domains		Points
IgG4 level	Normal	0
	Above normal and less than 2× upper limit of normal	3.7
	2× to 5× ULN	6.1
	Above 5× ULN	10.8
Histopathology and immunostaining	Uninformative biopsy	0
	Dense lymphoplasmacytic infiltrate	3.7
	DLI plus obliterative phlebitis	6.1
	DLI plus storiform fibrosis	13.3
Lacrimal and major salivary gland enlargement	One set of glands involved	5.9
	Two or more sets of glands involved	13.8
Chest and thoracic aorta	Peribronchovascular and septal thickening	3.8
	Paravertebral band–like soft tissue in the thorax	9.8
Pancreas and biliary tree	Diffuse pancreas enlargement (loss of lobulations)	8.0
	Diffuse pancreas enlargement and capsule-like rim with decreased enhancement	10.5
	Pancreas and biliary tree involvement	18.7
Kidney	Hypocomplementemia	5.8
	Renal pelvis thickening or soft tissue or both	8.1
Retroperitoneum	Diffuse thickening of the abdominal aortic wall	4.1
	Circumferential or anterolateral soft tissue around the infrarenal aorta or iliac arteries	7.8

MDedge News

Note: A patient must tally at least 19.0 points to receive IgG4-related disease classification.

Source: Dr. Stone

Wallace ZS, Naden RP. The 2019 American College of Rheumatology/European League Against Rheumatism Classification Criteria for IgG4-Related Disease. Arthritis Rheumatol. 2020 Jan;72(1):7-19.



Recommendation

EULAR recommendations for the management of Sjögren's syndrome with topical and systemic therapies

Manuel Ramos-Casals ,[1,2] Pilar Brito-Zerón,[2,3] Stefano Bombardieri,[4] Hendrika Bootsma,[5] Salvatore De Vita,[6] Thomas Dörner ,[7] Benjamin A Fisher ,[8,9] Jacques-Eric Gottenberg,[10] Gabriela Hernandez-Molina ,[11] Agnes Kocher ,[12,13] Belchin Kostov,[14,15] Aike A. Kruize,[16] Thomas Mandl,[17] Wan-Fai Ng,[18,19] Soledad Retamozo,[20,21] Raphaèle Seror,[22,23] Yehuda Shoenfeld,[24,25] Antoni Sisó-Almirall ,[14,26] Athanasios G. Tzioufas,[27] Claudio Vitali,[28] Simon Bowman,[29] Xavier Mariette,[22,23] On behalf of the EULAR-Sjögren Syndrome Task Force Group

OVERARCHING PRINCIPLES

Patients with SjS should be managed at, or in close collaboration with, centres of expertise using a multidisciplinary approach(LoE na; LoA 9.2)

The first therapeutic approach to dryness should be symptomatic relief using topical therapies (LoE na; LoA 8.9)

Systemic therapies may be considered for the treatment of active systemic disease (LoE na; LoA 9.1)

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Recommendation

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Table 1 Overarching (A–C) and specific (1–12) recommendations

	LoE	GoR	Vote (%)	LoA (0–10)
A.Patients with SjS should be managed at, or in close collaboration with, centres of expertise following a multidisciplinary approach	NA	NA	90	9.2
B.The first therapeutic approach for dryness should be symptomatic relief using topical therapies	NA	NA	93	8.9
C.Systemic therapies may be considered for the treatment of active systemic disease	NA	NA	90	9.1
1.Baseline evaluation of salivary gland function is recommended before starting treatment for oral dryness	5	D	81	8.7
2.The preferred first therapeutic approach for oral dryness according to salivary gland function may be:	1a/*1b	B	88	8.7
2.1. Non-pharmacological stimulation for mild dysfunction;				
2.2. Pharmacological stimulation* for moderate dysfunction;				
2.3. Saliva substitution for severe dysfunction				
3.The first-line therapeutic approach to ocular dryness includes the use of artificial tears and ocular gels/ointments	1a	B	98	9.5
4.Refractory/severe ocular dryness may be managed using topical immunosuppressive-containing drops* and autologous serum eye drops	1a/*1b	B/D	94	9.1
5.Concomitant diseases should be evaluated in patients presenting with fatigue/pain, whose severity should be scored using specific tools	5	D	93	9.0
6.Consider analgesics or other pain-modifying agents for musculoskeletal pain, considering the balance between potential benefits and side-effects	4	C	89	8.9
7.Treatment of systemic disease should be tailored to organ-specific severity using the ESSDAI definitions	4	C	89	9.0
8.Glucocorticoids should be used at the minimum dose and length of time necessary to control active systemic disease	4	C	85	9.6
9.Immunosuppressive agents should be mainly used as GC-sparing agents, with no evidence supporting the choice of one agent over another	4	C	82	8.9
10.B-cell targeted therapies may be considered in patients with severe, refractory systemic disease	1b	B	98	8.6
11.The systemic organ-specific therapeutic approach may follow, as a general rule, the sequential (or combined) use of GCs, immunosuppressive agents and biologics	5	D	98	8.6
12.Treatment of B-cell lymphoma should be individualised according to the specific histological subtype and disease stage	4	C	88	9.7

LoE and GoR according to the Oxford Centre for Evidence-based Medicine—LoE (March 2009). Vote (%): % of participants scoring the recommendation as at least 'important' (score of ≥4 on 5-point scale). LoA: mean score (scale of '0' as no agreement, '10' full agreement).
ESSDAI, EULAR Sjögren's syndrome disease activity index; EULAR, European League Against Rheumatism; GC, glucocorticoid; GoR, grade of recommendation; LoA, levels of agreement; LoE, levels of evidence; NA, not applicable.

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OMCEO REGGIO EMILIA

Recommendation

EULAR recommendations for the management of Sjögren's syndrome with topical and systemic therapies

Manuel Ramos-Casals ,[1,2] Pilar Brito-Zerón,[2,3] Stefano Bombardieri,[4] Hendrika Bootsma,[5] Salvatore De Vita,[6] Thomas Dörner ,[7] Benjamin A Fisher ,[8,9] Jacques-Eric Gottenberg,[10] Gabriela Hernandez-Molina ,[11] Agnes Kocher ,[12,13] Belchin Kostov,[14,15] Aike A. Kruize,[16] Thomas Mandl,[17] Wan-Fai Ng,[18,19] Soledad Retamozo,[20,21] Raphaèle Seror,[22,23] Yehuda Shoenfeld,[24,25] Antoni Sisó-Almirall ,[14,26] Athanasios G. Tzioufas,[27] Claudio Vitali,[28] Simon Bowman,[29] Xavier Mariette,[22,23] On behalf of the EULAR-Sjögren Syndrome Task Force Group

1 Baseline evaluation of salivary gland function is recommended before starting treatment for oral dryness (LoE 5, LoA 8.7)

2 The preferred first therapeutic approach for oral dryness according to salivary gland function may be: Non-pharmacological stimulation for mild dysfunction; pharmacological stimulation for moderate dysfunction*; saliva substitution for severe dysfunction (LoE 1a/*1b, LoA 8.7)

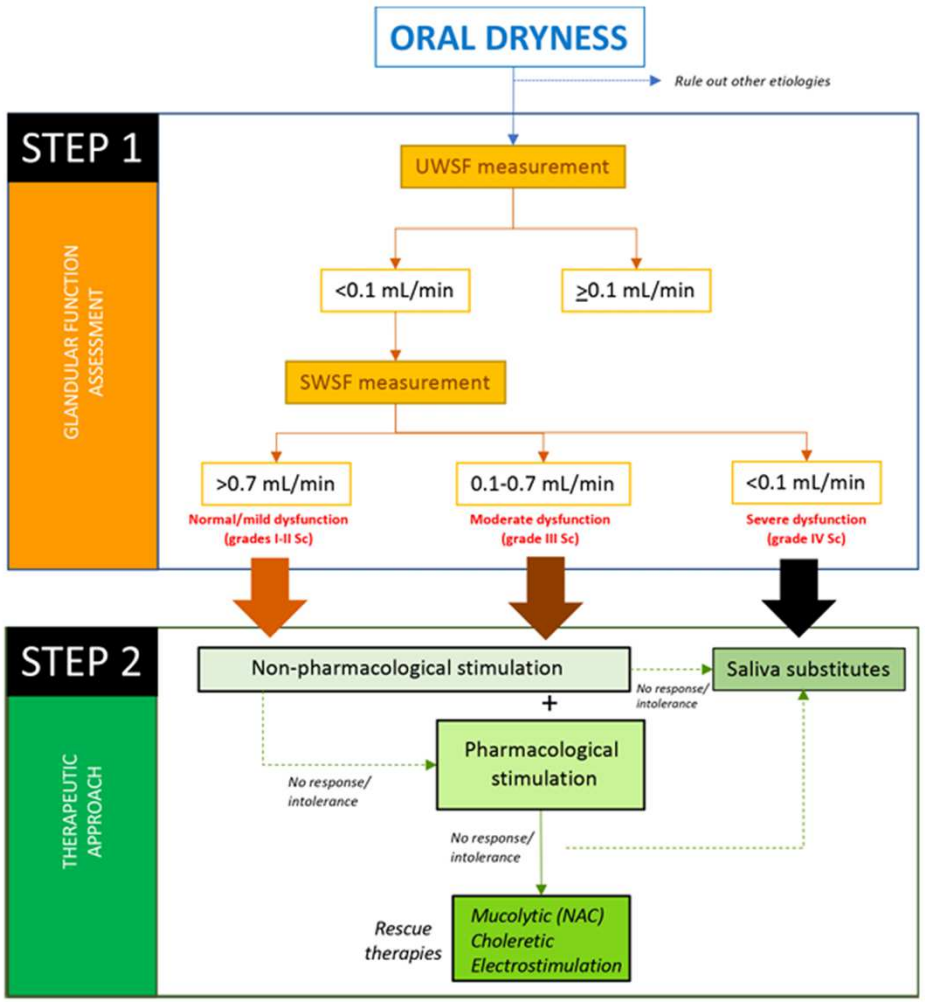


Figure 1 Algorithm of glandular function assessment and therapeutic approach in patients with primary SjS presenting with oral dryness. SjS, Sjögren syndrome; SWSF, stimulated whole salivary flows; UWSF, unstimulated whole salivary flows.

Ramos-Casals M, *et al. Ann Rheum Dis* 2020;**79**:3–18. doi:10.1136/annrheumdis-2019-216114

Identification of distinct subgroups of Sjögren's disease by cluster analysis based on clinical and biological manifestations: data from the cross-sectional Paris-Saclay and the prospective ASSESS cohorts

Yann Nguyen, Gaëtane Nocturne, Julien Henry, Wan-Fai Ng, Rakiba Belkhir, Frédéric Desmoulins, Elisabeth Bergé, Jacques Morel, Aleth Perdriger, Emmanuelle Dernis, Valérie Devauchelle-Pensec, Damien Sène, Philippe Dieudé, Marion Couderc, Anne-Laure Fauchais, Claire Larroche, Olivier Vittecoq, Carine Salliot, Eric Hachulla, Véronique Le Guern, Jacques-Eric Gottenberg, Xavier Mariette*, Raphaèle Seror*

- Those with B-cell active disease and low symptom burden **(BALS)**
- those with high systemic disease activity **(HSA)**
- those with low systemic disease activity and high symptom burden **(LSAHS)**

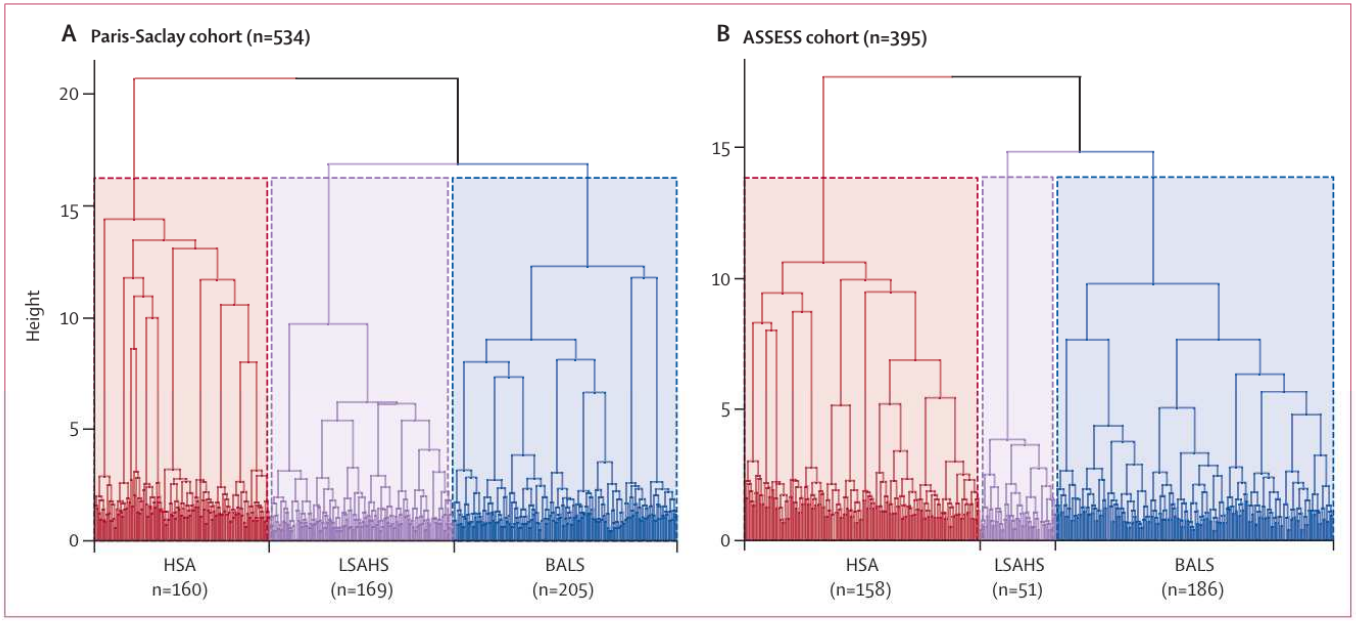


Figure 1: **Dendrogram of identified clusters**
Clusters identified in the Paris-Saclay cohort (A) and the ASSESS cohort (B). Horizontal branches represent the combination of two clusters, and vertical branches the degree of dissimilarity between combined clusters. The areas enclosed within the dotted lines represent the three groups after truncation. ASSESS=Assessment of Systemic Signs and Evolution of Sjögren's Syndrome. BALS=B-cell active disease and low symptom burden. HSA=high systemic disease activity. LSAHS=low systemic disease activity and high symptom burden.

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PATOLOGIE DELLE GHIANDOLE SALIVARI: RICONOSCERE, TRATTARE, INVIARE

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REGGIO EMILIA, 10 OTTOBRE 2026

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