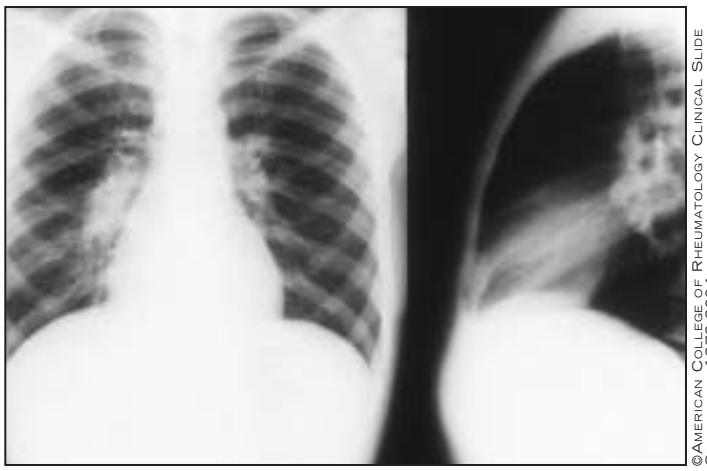

Posteroanterior (left) and lateral (right) projections demonstrate bilateral hilar adenopathy. Infiltration is present in the lower lung fields.

Anti-TNFs May Help Severe Sarcoidosis Cases

BY MITCHEL L. ZOLER
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PHILADELPHIA — Patients with sarcoidosis who have the most severe lung disease may benefit most from treatment with a tumor necrosis factor antagonist, Dr. Daniel Culver said at the annual meeting of the American College of Chest Physicians.

For the time being, the tumor necrosis factor (TNF) antagonist to use for sarcoidosis is infliximab (Remicade). It has "the best track record," said Dr. Culver, a clinician in the Respiratory Institute at the Cleveland Clinic. Based on treatment results reported so far, the best candidates for infliximab treatment among pulmonary sarcoidosis patients are those with more severe physiologic derangement, disease duration of longer than 2 years, and dyspnea as a prominent symptom of their disease, Dr. Culver said.

However, most patients have not shown substantial improvement on infliximab, he added. A more realistic goal is slowing disease progression. The most extensive experience with successful infliximab treatment in sarcoidosis is in patients who have pulmonary involvement.

The treatment has also shown some efficacy for extrapulmonary disease, such as CNS or skin involvement.

In some of these patients, the benefit has waned over time. However, other patients have had a durable, sustained effect. One very responsive group of patients with skin involvement has been those with lupus pernio.

In one recent series, 90% of sarcoidosis patients who also had lupus pernio improved while undergoing infliximab treatment, Dr. Culver said.

Despite promising reports that support infliximab use in sarcoidosis, there are still few data on the best dosage, and dose escalation has not been useful so far in patients who don't respond to infliximab. The best treatment interval seems to be an injection every 4-8 weeks. Concurrent treatment with methotrexate appears to enhance the beneficial effect from infliximab, Dr. Culver noted, and also reduces the risk that patients will develop an immune reaction to the injected drug.

As with any anti-TNF, there is a risk of activating latent tuberculosis. Dr. Culver advised screening patients for TB before starting treatment.

Ideal candidates for treatment with another TNF blocker are those with side effects from infliximab or initial responders whose response wanes over time. However, far less experience exists for treating sarcoidosis patients with adalimumab (marketed as Humira) or certolizumab (Cimzia). Etanercept (Enbrel) does not appear to be useful for sarcoidosis.

Dr. Culver cautioned that none of the anti-TNFs has a labeled indication for treating sarcoidosis. However, TNF levels are increased in sarcoidosis, and TNF plays a role in granuloma formation. Patients who don't respond to anti-TNFs may include those with low baseline C-reactive protein, smokers, those with a genetic polymorphism, and patients whose disease is not as strongly mediated by TNF.

Dr. Culver said that he has received no corporate funding or payments relevant to these drugs. ■