New PsA Treatment Guidelines Released

BY NANCY WALSH
New York Bureau

FORT LAUDERDALE, FLA. — A group of rheumatologists and dermatologists has published new recommendations for treatment of the heterogeneous manifestations of psoriatic arthritis, despite a paucity of randomized trial data.

The Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) performed a formal literature review for the symptoms of peripheral arthritis, skin and nail disease, axial disease, dactylitis, and enthesitis.

Significant challenges exist in the management of PsA, said lead author Dr. Christopher T. Ritchlin. There have been few double-blind, randomized trials that have examined the efficacy of traditional agents such as sulfasalazine and cyclosporine. There is also no evidence that these agents slow radiographic progression or are effective for axial disease, dactylitis, or enthesopathy, said Dr. Ritchlin, professor of medicine and director of clinical immunology, University of Rochester (New York) Medical Center.

"But it's not that we know these drugs don't work—the studies simply haven't been done," he said at a meeting sponsored by RHEUMATOLOGY NEWS and Skin Disease Education Foundation.

Particularly problematic is the lack of data for methotrexate, with only one older double-blind randomized clinical trial which failed to show efficacy (Arthritis Rheum. 1984;27:376-81).

Improvements in trial design in the intervening years favor newer biologics over older disease-modifying antirheumatic drugs (DMARDs). But while there have been three double-blind trials of tumor necrosis factor (TNF) inhibitors, there have been no head-to-head trials of methotrexate versus a TNF inhibitor.

The recommendations include:

► For mild peripheral arthritis, initial treatment can include nonsteroidal anti-inflammatory drugs (NSAIDs) and intra-articular glucocorticoid injections, and for moderate or severe arthritis, DMARDs or TNF inhibitors (Ann. Rheum. Dis. Oct. 24; [Epub doi:10.1136/ard.2008.094946]).

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DR. RITCHLIN

While TNF inhibitors are recommended for patients who have failed at least one DMARD, patients with poor prognoses can be considered for a TNF agent without DMARD failure. Prognosis is worse in patients with polyarticular disease, an elevated erythrocyte sedimentation rate, previous medication failure, or the presence of joint damage, loss of joint function, or diminished quality of life. Systemic corticosteroids are typically not used in PsA because of the possibility of psoriasis flare upon withdrawal.

► For skin disease, first-line therapies include phototherapy, methotrexate, fumaric acid esters, TNF inhibitors, efalizumab, and cyclosporine; second-line therapies include acitretin and alefacept; and third-line therapies include sulfasalazine and hydroxyurea. Nail disease can be managed with retinoids, oral psoralen plus ultraviolet A, cyclosporine, or TNF inhibitors.

► For mild to moderate axial disease, treatment includes NSAIDs, physiotherapy, analgesia, and injection of the sacroiliac joint. Moderate to severe involvement of the spine can be treated with TNF inhibitors.

► Mild dactylitis typically can be managed with NSAIDs and injected corticosteroids, but if symptoms are resistant DMARDs or infliximab can be tried.

► For mild enthesitis, typically of the Achilles' tendon area, NSAIDs, physical therapy, and corticosteroids can be used. Moderate disease can be treated with DMARDs. Severe enthesitis may respond to a TNF inhibitor.

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