Prednisone Aids Disease Control in Early RA

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The addition of low-dose prednisone to a methotrexate-based, tight-control strategy leads to better outcomes in early rheumatoid arthritis, according to study results reported by Marije F. Bakker, Ph.D.

Compared with patients who received methotrexate (MTX) with placebo, those receiving MTX with 10 mg/day prednisone had better control of their disease and less erosive damage to their joints, Dr. Bakker said in an interview.

"The existing strategies leave room for improvement, especially for the number of patients who reach remission," said Dr. Bakker of University Medical Center Utrecht (the Netherlands) in explaining the study's rationale. "Besides, it is important to determine which strategy steps are useful in the tight-control treatment strategies. Also, it is important to decide at which moment early in the treatment of [rheumatoid arthritis] medication should be added to the strategy."

The CAMERA-II (Computer-Assisted Management of Early Rheumatoid Arthritis–II) trial was designed specifically to test the hypothesis that the addition of prednisone to a tight-control strategy of early RA using disease-modifying antirheumatic drugs would result in better disease control.

In the randomized, double-blind, placebo-controlled trial, 117 patients received MTX plus prednisone and 119 received MTX with placebo. All patients had early RA, with an onset less than 1 year before enrollment. Patients were at least 18 years old and had no previous DMARD therapy.

Patients were excluded from the trial if they had major comorbidities such as malignancies or severe diabetes mellitus; abnormal liver or kidney function; leukopenia or thrombocytopenia; evidence of drug or alcohol abuse; treatment with cytotoxic or immunosuppressive drugs within 3 months of the study; or osteoporotic vertebral fractures.

The investigators tailored the MTX treatment to each patient with the goal of achieving remission. If patients did not achieve remission with the maximum tolerable oral MTX dose, investigators first switched the patient to subcutaneous MTX and then added adalimumab to the regimen.

Time to sustained remission was 6 months in the experimental group and 11 months in the control group.

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After 2 years, patients in the MTX plus prednisone group had significantly less radiographically confirmed erosive joint damage, as measured by their Sharp/van der Heijde scores. Patients on the MTX with prednisone regimen had significantly lower scores on the DAS28 (Disease Activity Score using a 28-joint count) questionnaire, and lower disability scores on the HAQ (Health Assessment Questionnaire).

A significantly lower proportion of patients in the experimental group required biologic treatment, compared with those on placebo (14% vs. 36%). The time to sustained remission was 6 months in the experimental group and 11 months in the control group, a significant difference. In addition, patients in the experimental group appeared to be somewhat more likely to achieve sustained remission, although this result did not achieve statistical significance (72% vs. 61%; $P = .09$).

Rates of adverse events were similar (29% in the MTX-prednisone group and 35% in the MTX-placebo group).

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