Anti-TNFs May Beat Methotrexate In Treatment of Psoriatic Arthritis

BY DIANA MAHONEY
New England Bureau

BOSTON — Rheumatologists must rethink their reflex to prescribe methotrexate for psoriatic arthritis, given data showing anti–tumor necrosis factor agents are more effective for this indication, Dr. Christopher Ritchlin said at a rheumatology conference sponsored by Harvard Medical School.

"About 70%-80% of clinicians around the world who treat psoriatic arthritis say methotrexate is the first drug that they use, yet the only double-blind randomized controlled trial addressing the question was too underpowered and underdosed to make any conclusions regarding efficacy," he added.

Another concern is liver toxicity with methotrexate, since psoriasis patients tend to have higher alcoholism rates. And there is evidence of progression of fibrosis in psoriatic arthritis patients on methotrexate, said Dr. Ritchlin, of the University of Rochester, N.Y. Also, unlike rheumatoid arthritis, there is no evidence that methotrexate is synergistic with other disease-modifying antirheumatic drugs (DMARDs) in psoriatic arthritis.

In contrast, the production of TNF-α has been shown to play a central role in the development of psoriasis and psoriatic arthritis by sustaining the inflammatory process in the skin and the joints, and anti-TNF-α agents appear to effectively block that activity, said Dr. Ritchlin. Dr. Marte Schrumpf Heiberg of Diakonhjemmet Hospital, Oslo, has reported data from 526 patients with psoriatic arthritis. After 6 months, patients on anti-TNF-α treatment demonstrated significantly greater clinical improvement in disease measures, versus those on methotrexate monotherapy (Ann. Rheum. Dis. 2007;66:1038-42).

Anti-TNF-α agents come closest to achieving the goal of a treatment that is as simple and minimally toxic as possible.

DR. RITCHLIN

And Dr. Filip van den Bosch of University Hospital, in Gent (Belgium), and colleagues presented data showing adalimumab in 414 patients with psoriatic arthritis resulted in clinically meaningful joint and skin improvements at 12 weeks and was well tolerated. In a separate study, the researchers linked adalimumab with clinically important gains in psoriatic nail disease.

Anti-TNF-α therapy also seems to impact the enthesopathic pathology of psoriatic arthritis. Dr. Helena Marzo-Ortega of Chapel Allerton Hospital in Leeds (England), and colleagues have shown infliximab is tied to improvements in MRI-determined bone edema in psoriatic arthritis (Ann. Rheum. Dis. 2007;66:778-81).

Other potential therapeutic targets for psoriatic arthritis include B cells and T cells, as well as the interleukin-23/Th17 pathway, which is directly tied to psoriasis. Anti-p40 therapy targets an interleukin-23 subunit.

"Psoriatic arthritis, unlike rheumatoid arthritis, is quite complex in its disease manifestation," Dr. Ritchlin. "Traditionally, psoriatic arthritis was defined as an inflammatory arthritis associated with psoriasis. More and more, however, it has become clear that psoriasis is a systemic disease."

Anti-TNF-α agents come closest to achieving the goal of a treatment that is as simple and minimally toxic as possible, said Dr Ritchlin. ■

IMAGE OF THE MONTH

The boy had back pain for more than a year. Neither physical therapy nor anti-inflammatory drugs had helped. He had no significant history of injury and no family history of lower back pain. He had no skin rashes, colitis, or other complaints. He previously had an MRI of his lumbar spine, which appeared normal, and a normal CT scan of his pelvis,

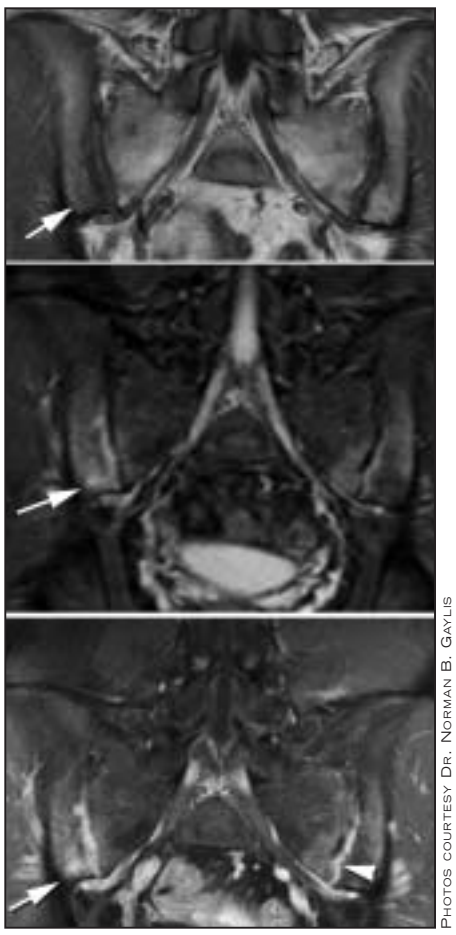
When he presented to a neurosurgeon, he had lower back pain and significant limitation of movement in his lumbar spine. An MRI of the sacroiliac revealed significant inflammation on both sides of the joint (see images), compatible with sacroiliitis, a finding highly suggestive of ankylosing spondylitis (AS). He was referred to Dr. Norman B. Gaylis, a rheumatologist in Miami.

Patients with AS tend to present with sacroiliitis, especially when they are human leukocyte antigen B27-positive. "Many patients with back pain have their diagnosis missed," he said, because either physicians don't think of AS or the x-ray is negative. If an MRI is done, it is typically on the lumbar spine.

The differential diagnosis for lower back pain includes disk damage, trauma, or muscle strain, but sometimes patients are dismissed as imagining the pain.

Historically, diagnosis of AS has depended on the radiographic finding of sacroiliitis. "The findings on MRI [for AS], similar to those for rheumatoid arthritis, occur far earlier than you will see on x-ray," said Dr. Gaylis. MRI findings of AS—synovitis and intense enhancing bone marrow edema/osteitis, as in this case—can precede x-ray evidence by 3 years (J. Rheumatol. 1999;26:1953-8).

—Kerri Wachter



PHOTOS COURTESY DR. NORMAN B. GAYLIS

MRIs show synovitis and intense enhancing bone marrow edema/osteitis.

Mortality in RA Same Today as In 1950s, Despite New Therapies

Rheumatoid arthritis patients have not experienced a decline in mortality, despite a dramatically increased life expectancy in the general population since the 1950s, according to investigators reporting on a cohort study.

In an interview, study investigator Dr. Hilal Maradit Kremers, of the Mayo Clinic in Rochester, Minn., said, "One assumes that since rheumatologists are trying to manage [RA] more aggressively, it must have a positive impact on mortality. … But all of our research is showing that the mortality in the RA patients did not change."

In a population-based incidence cohort study, researchers looked at all 822 adult residents of Rochester in whom RA was first diagnosed between 1955 and 1995 and all adult residents of Olmsted County in whom RA was diagnosed between 1995 and 2000. The patients were followed up through medical records until their death or Jan. 1, 2007. The mean age at incidence was 58 years. Nearly three-quarters were women. The median length of follow-up was 11.7 years (Arthritis Rheum. 2007;56:3583-7).

RA patients' mortality was unchanged in each of the five study periods: from 1955 to 1964, 1965 to 1974, 1975 to 1984, 1985 to 1994, and 1995 to 2000. Female mortality hovered around 2.4 per 100 person-years, and male mortality was constant at about 2.5 per 100 person-years. In contrast, mortality in women in the Minnesota general population declined from 1.0 per 100 person-years in 1965 to 0.2 per 100 person-years in 2000. For men, the rate went from 1.2 to 0.3 per 100 person-years.

"Patients in whom RA was diagnosed in more recent years had a mortality rate similar to that of their peers in whom RA was diagnosed in the 1950s and 1960s. … The dramatic changes in therapeutic strategies for RA in the last 4-5 decades have not had a major impact on the excess mortality."

Dr. Kremers reported no conflicts of interest in relation to this study.

—Denise Napoli

Study: Nonwhite Patients Wait Longer for DMARD Therapy

BY DENISE NAPOLI
Assistant Editor

African American and Hispanic rheumatoid arthritis patients treated at public clinics wait longer to start disease-modifying antirheumatic drug therapy than do their white counterparts receiving care at private clinics.

Early intervention with DMARDs has been shown to delay joint damage.

Dr. Maria E. Suarez-Almazor, rheumatology section chief at the University of Texas M.D. Anderson Cancer Center, Houston, reported data from her retrospective cohort study of all medical records of new patients with a rheumatoid arthritis diagnosis seen at a public clinic (n=118) and a private clinic (n=167).

Both facilities are affiliated with the Baylor College of Medicine, Houston, staffed by Baylor rheumatology fellows and faculty, and considered tertiary-level care facilities. The public clinic cares for mostly minority, disadvantaged, or uninsured patients. Most of the private clinic patients had private insurance.

Socioeconomic status was inferred from insurance status and attendance at the public or private clinic, an admittedly imperfect method. Patients were classified as white, African American, Hispanic, or other. Nonwhites accounted for 83% of the patients seen in the public clinic versus 18% in the private clinic, a highly significant statistical difference.

The median time to initiation of DMARDs was 7 years for public clinic patients and 3 years for private clinic patients. The median time to initiation of steroids was 23 years for public patients and 1 year for private patients. And in all patients at both clinics, the median time to initiation of DMARDs for white patients was 3 years, versus 7 years for nonwhites (J. Rheumatol. 2007 Nov. 1 [Epub ahead of print]).

In an interview, Dr. Suarez-Almazor questioned whether the disparity is related to a communication problem between patients and doctors, such that physicians are unable to communicate the importance of expensive DMARDs.

She reported no conflicts of interest in relation to this study. ■