Early RA Remits in Half After a Year of DMARDs

BY NANCY WALSH
New York Bureau

AMSTERDAM — Initial therapy using traditional disease-modifying antirheumatic drugs—even early, aggressively, and in combination—is inadequate for a significant proportion of patients with inflammatory arthritis, according to preliminary data from a prospective Canadian study.

In rheumatoid arthritis (RA), joint damage and the resulting disability occur during the first years of disease, and current therapeutic strategies aim to be aggressive in minimizing inflammation and preventing irreversible damage.

But among a cohort of 79 patients followed for 12 months in a real-world setting, fewer than half achieved remission with disease-modifying antirheumatic drug (DMARD) treatment, Dr. Vivian P. Bykerk said at the annual European Congress of Rheumatology.

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For inclusion in the Toronto Early Arthritis Cohort, patients were required to be at least 16 years old and to have had symptoms for at least 6 weeks but less than 1 year. They had to have at least two swollen joints or one swollen metacarpophalangeal joint or proximal interphalangeal joint and to have more than one of the following characteristics: rheumatoid factor positive, anti-CCP positive, morning stiffness exceeding 45 minutes' duration, a response to nonsteroidal anti-inflammatory drugs, and a painful metatarsophalangeal joint squeeze test.

At baseline the mean patient age was 45.5 years, and 80% were female. Median duration of symptoms was 161 days at the time of evaluation.

Mean erythrocyte sedimentation rate was 28 mm/h, and mean C-reactive protein level was 13 mg/L. The mean tender joint count was 19, mean swollen joint count was 11, and mean Disease Activity Score (DAS) was 5.3. A total of 28% of patients were rheumatoid factor positive, and 67% met the criteria for RA. In addition, 26% already had erosions present in the hands or feet.

Recommended initial treatment for RA in Canada involves combination therapy, but only 60% of patients in this cohort were started on more than one DMARD. This probably reflects a lower disease burden and also possibly patient preference, said Dr. Bykerk of Mount Sinai Hospital, Toronto.

When combination therapy was used, it generally was methotrexate plus hydroxychloroquine or sulfasalazine. The methotrexate dose was 15-25 mg/week, the mean dose at 12 months was 18 mg/week, and for two-thirds of patients the dose exceeded 20 mg/week. A third of the patients opted to take their methotrexate subcutaneously, she said. "In Canada we are strong proponents of subcutaneous methotrexate in doses of 20-25 mg early on," she said.

The sulfasalazine dose was 2 g/day, and the hydroxychloroquine dose was 400 mg/day.

"Very few patients received biologics at the outset, because it's very difficult to access these drugs in our province and country using public health drug coverage," she said at the meeting, sponsored by the European League Against Rheumatism. Only after 6-9 months can patients in Canada begin to access biologics, she said.

By 12 months, only 47% of patients achieved remission as defined as a DAS28 less than 2.6, even when receiving an aggressive DMARD strategy followed by biologic therapies in patients whose disease responded inadequately at 6 months.

"Although the data are still preliminary, for a significant proportion of patients with early RA or inflammatory arthritis, a different strategy than early DMARD therapy may be required," she said.

Studies are needed to validate that the earlier use of biologics is more effective in protecting the joint against the destruction of RA and inflammatory arthritis and to identify prognostic factors or biomarkers that can predict who will not respond to an initial DMARD strategy including high-dose methotrexate, according to Dr. Bykerk. ■