with moderately severe autoimmune rheumatoid arthritis and Crohn’s disease treated with REMICADE in clinical trials with a duration of 2 to 4 years. More than 1,100 patients received REMICADE for at least 2 years. In a 2-year follow-up of 1,100 patients, 57.5% of patients were treatment responders at the time of follow-up. In addition, an observational study of 120 patients treated with REMICADE for a minimum of 4 years found that 84% of patients were treatment responders at the time of follow-up.

In general, patients who receive REMICADE for the treatment of autoimmune diseases experience a gradual improvement in symptoms over time. However, individual responses may vary depending on the specific disease and patient factors. The duration of treatment and follow-up can also impact the assessment of treatment outcomes.

New Raynaud’s: Nail Folds Predict Scleroderma

BY KATE JOHNSON
Montreal Barouc

Snowmass, Colo. — The most significant predictor of progression to scleroderma in a patient with new onset Raynaud’s phenomenon is the presence of capillary abnormalities at the proximal nail fold, according to David H. Collier, M.D.

Although scleroderma is primarily managed by rheumatologists, it is dermatologists who most commonly identify the early skin manifestations of the disorder, said Dr. Collier of the University of Colorado, Denver, and chief of rheumatology at Denver Health Medical Center.

In addition to Raynaud’s, these manifestations include skin thickening, ulceration, telangiectases, calcinosis, and pigmentation changes.

Speaking at a clinical dermatology seminar sponsored by Medis, Dr. Collier explained that Raynaud’s phenomenon is an almost universal component of systemic sclerosis, and yet the vast majority of patients with Raynaud’s never progress to scleroderma.

“Up to 60% of adult women have Raynaud’s, and less than 0.1% can go on to develop scleroderma,” he said in an interview, adding that about 77% of Raynaud’s patients are female.

By examining the perigual area of the finger, under gel with an ophthalmoscope, the physician can easily assess capillary abnormalities at the proximal nail fold, he said.

“Instead of thin little loops of capillaries that you would see in a normal person, you see capillary dilation and areas that are demodulated or dropped altogether,” he said, explaining that capillary dilation occurs early in the disease, and after about 10 years, only denudation is typically visible.

“A patient with abnormal capillaries should be followed every 3-6 months for signs of progression to systemic sclerosis,” he advised, adding that early identification of scleroderma patient can allow for prompt pulmonary evaluation and establishment of gastroesophageal reflux prevention/management.

Pitting or ulceration of the fingertips is another indication that a Raynaud’s patient has scleroderma, said Dr. Collier.

“Primary Raynaud’s disease does not give you pitting. So if you see pits—especially fingertip pits and ulceration—that’s a red light (indicating) that you’re dealing with an autoimmune disease. It’s almost always Raynaud’s secondary to scleroderma or mixed connective tissue disease, or occasionally lupus,”” he said.

In addition to the evaluation for capillary abnormalities, the scleroderma screen for patients presenting with Raynaud’s should also include autoantibody testing, he said.

If they also have the antibodies, that’s the subgroup that I worry about the most for progressing to scleroderma, but it’s not universal. I’ve certainly followed people with autoantibodies, and they didn’t progress.

Anticonvulsant antibodies are seen in 20%-30% of scleroderma patients and are the most predictive of risk to progression to limited systemic sclerosis, although they are also commonly seen in primary biliary cirrhosis and, rarely, in other connective tissue diseases, such as rheumatoid arthritis, systemic lupus erythematosus, mixed connective tissue disease, and polymyositis, he said.

Anti-topoisomerase-1 antibodies (e.g., anti-scleroderma [Scl]-70) are present in 9%-20% of scleroderma patients. Anti-RNA polymerase-1-4 antibodies are seen in 20%. Anti-β2-glycoprotein-I/-anti-cardiolipin antibodies are seen in 10%, and anti-neutrophil cytoplasmic antibodies (ANCAs) are seen in about 4%, though mostly in patients with diffuse systemic sclerosis. Finally, antiphospholipid syndrome (SLE-anti-CM) and anti-thyroid antibodies (which recognizes certain RNA- and protein-encoding enzymes) antibodies are seen in about 2% of scleroderma patients.

A Rare Scleroderma Look-Alike: Nephrogenic Fibrosing Dermalpathy

Recently described cutaneous fibrosis disorder could be mistaken for scleroderma, but there are some key differences, said Dr. Collier.

Worldwide, there have only been 170 cases of nephrogenic fibrosing dermopathy (NFD) reported since it was first described in 1997.

Yet I think it’s far more common than we’re led to believe,” he added.

The typical presentation of NFD consists of acute, plaquelike indurations involving the lower limbs and occasionally the upper limbs and torso, he said.

NFD plaques typically take on a peau d’orange appearance.

Although NFD often causes severe sharp pains in the affected areas, and regional insufficiency is necessary for the diagnosis. The biopsy will show deposits of collagen and amiodarotic projections and islands of sparing within the indurated plaque. Eventually, the skin becomes markedly thickened and woody. Pruritis and calcifications are prominent features.

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