Keep Young Athletes With Arthritis in the Game

BY NANCY WALSH
New York Bureau

A MSTERDAM — Reassuring data on the use of etanercept in patients with juvenile idiopathic arthritis are emerging from a multicenter Spanish registry, with significant improvements being seen on all clinical parameters and no serious adverse events being reported, Dr. Inmaculada Calvo said at the annual European Congress of Rheumatology.

Etanercept was approved for the treatment of JIA in 1999, but few phase IV studies have been done evaluating the long-term safety and efficacy of tumor necrosis factor (TNF)-α blockade in these patients, noted Dr. Calvo. A total of 103 patients have been enrolled in the registry, with follow-up extending as long as 48 months.

Fifty-three of the patients were female, the median patient age was 12.3 years, and the median age at disease onset was 5.6 years. During the 3 years prior to recruitment, 91.8% had undergone treatment with methotrexate but had shown an inadequate response, according to Dr. Calvo of the Hospital Infantil la Fe, Valencia, Spain.

All patients had polyarticular disease, 35.3% were seronegative, and 15.9% had systemic-onset disease.

At baseline the mean patient age was 45.5 years, and 80% were female. Median disease duration before treatment was 167 days.

At the time of analysis, 83 patients (80.6%) had been followed for at least 6 months; 72 (69.9%) had been followed for 12 months, and 49 (47.6%) had been followed for 24 months. In addition, 29 (28.2%) and 19 (18.5%) had been followed for 36 and 48 months, respectively.

No serious adverse events have been observed, and the infections reported were typical for patients of this age (see box). The median number of tender joints and swollen joints decreased from 9.09 to 0.3 and 9.24 to 3.13, respectively. Dr. Calvo wrote in a poster session at the meeting, sponsored by the European League Against Rheumatism.

Physician global assessment decreased from a median of 5.96 to 1.13, and patient global assessment fell from a median of 5.43 to 1.90. The Childhood Health Assessment Questionnaire index also decreased, from a median of 1.61 to 0.44. Laboratory parameters also improved, with the erythrocyte sedimentation rate falling from 43 to 11 mm/h and C-reactive protein level decreasing from 12 to 0.1 mg/L.

No serious adverse events have been reported, and the infections reported were typical for patients of this age (see box). The median number of tender joints and swollen joints decreased from 9.09 to 0.3 and 9.24 to 3.13, respectively. Dr. Calvo wrote in a poster session at the meeting, sponsored by the European League Against Rheumatism.

Physician global assessment decreased from a median of 5.96 to 1.13, and patient global assessment fell from a median of 5.43 to 1.90. The Childhood Health Assessment Questionnaire index also decreased, from a median of 1.61 to 0.44. Laboratory parameters also improved, with the erythrocyte sedimentation rate falling from 43 to 11 mm/h and C-reactive protein level decreasing from 12 to 0.1 mg/L.

DMARDs Alone Inadequate For Early Rheumatoid Arthritis

BY NANCY WALSH
New York Bureau

A MSTERDAM — 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.

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 metacarpophalangeal joint squeeze test.

At baseline the mean patient age was 45.5 years, and 80% were female. Median disease duration before treatment was 167 days.

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/wk, the mean dose at 12 months was 18 mg/wk, and for two-thirds of patients the dose exceeded 20 mg/wk. 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 at the meeting, sponsored by the European League Against Rheumatism.

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

By 12 months, only 47% of patients achieved remission as defined as a DAS28 less than 2.6, even using an aggressive DMARD strategy followed by biologic therapies in those who were inadequate responders at 6 months.

“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 the earlier use of biologics and to identify prognostic factors.