Obesity Derails RA Remission; Infliximab Helps

BY NANCY WALSH
New York Bureau

BOSTON — Overweight patients with early rheumatoid arthritis were less likely to achieve remission during treatment with conventional disease-modifying drugs than were those with a normal body mass index.

Overweight and obese patients fared better on a regimen that included infliximab, Dr. Marjatta Leirisalo-Repo, professor of rheumatology at Helsinki University Central Hospital and the University of Helsinki, said at the annual meeting of the American College of Rheumatology.

The study enrolled 100 patients with rheumatoid arthritis (RA) of less than 1 year's duration from 15 centers, randomizing them to methotrexate, sulfasalazine, hydroxychloroquine, and prednisone plus either infliximab or placebo for 6 months. Mean age was 46 years, median symptom duration was 4 months, mean number of swollen joints was 15 and of tender joints, 20. All had morning stiffness of 45 minutes or more. The mean baseline erythrocyte sedimentation rate (ESR) was 33 mm/hr and mean Health Assessment Questionnaire (HAQ) score was 1. In all, 67% were female and 68% were rheumatoid factor positive. None had prior disease-modifying antirheumatic drug (DMARD) treatment.

The DMARD regimens were individually tailored, with maximum dosages of methotrexate of 25 mg/wk and maximum dosages of sulfasalazine of 2 g/day. Hydroxychloroquine was given in dosages of 35 mg/kg a week and prednisone in dosages of 7.5 mg/day. Patients randomized to receive infliximab had the tumor necrosis factor blocker in dosages of 3 mg/ kg at weeks 4, 6, 10, 18, and 26. Remission was defined as less than 15 minutes of morning stiffness; no fatigue or painful, swollen, or tender joints; and an ESR less than 30 mm/h.

At 6 months, an overall total of 53% of patients had achieved remission. The percentages of patients in remission at 6 months in the infliximab and placebo groups were 58% and 47%, respectively (58% and 52% at 12 months).

At 6 months, 63% of placebo patients with a body mass index (BMI) of less than 25 kg/m^2 had achieved remission, compared with 35% of overweight (BMI 25-29.9) patients and 25% of obese (BMI 30 or greater) patients. No such association was seen in the infliximab-treated patients. Remission rates in the normal, overweight, and obese groups receiving the biologic agent at 6 months were 55%, 68%, and 46%, respectively. At 12 months, the rates for normal, overweight, and obese placebo patients in the placebo group were 58%, 35%, and 25%, and those in the infliximab group were 45%, 74%, and 55%.

Obesity is associated with a lack of response to conventional DMARDs, but infliximab was able to overcome this resistance, said Dr. Leirisalo-Repo, who disclosed she has received research grants from Schering-Plough Oy in Finland. ■

Variability Key to Lumbar Diagnosis

BY BRUCE JANCIN
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SNOWMASS, COLO. — The neurogenic or pseudoclaudication symptoms characteristic of lumbar spinal stenosis can be distinguished from peripheral vascular disease by their day-to-day variability, Dr. Zacharia Isaac said at a symposium sponsored by the American College of Rheumatology.

The patient with true peripheral vascular claudication usually has a consistent walking limit—perhaps a block, or three, or six—beyond which the leg pain becomes too great to continue. When patients with spinal stenosis develop leg pain or cramping with ambulation, it usually is caused by mechanical compression and choking off of the microvascular supply to the spinal nerve. These patients tend to have good and bad days in terms of walking distance, explained Dr. Isaac, medical director of the comprehensive spine care center at Brigham and Women's Hospital, Boston.

Lumbar spinal stenosis (LSS) involves encroachment upon the spinal canal caused by several forms of spinal degeneration. The L4-5 and L3-4 segments are most commonly involved.

LSS occurs most often after about age 55 years. However, patients with congenital or developmental spinal stenosis may present in their 40s because they have less spinal canal capacity to start

with and will experience compromise with a smaller amount of disk bulging.

It's important to distinguish LSS from disk herniation as the cause of lumbar radiculopathy. The physical therapy programs for the two are completely opposite.

For the spinal stenotic patients, "you'll want to do a more flexion-oriented program working on strengthening their abs and not too much extension, at least early on, because that will aggravate their symptoms. For patients with disk herniation or discogenic pain, you'll want a more extension-oriented program with recruitment of back muscles, which have been deconditioned," he said.

Physical examination is helpful in differentiating the two etiologies. A patient with LSS usually has a negative straight leg raise test because LSS is a far less inflammatory condition than a herniated disk.

Studies indicate a positive straight leg raise that elicits excruciating sciatica-like pain has 80% sensitivity and 40% specificity for a herniated disk. The test tends to irritate the L5 and S1 nerve roots. The straight leg raise is not a good test for herniated disks at L2-4; the femoral stretch test is better for those spinal nerves.

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DR. ISAAC

The patient with LSS usually has no clear myotomal deficit, again unlike in disk herniation. Sustained extension of the spine during physical examination elicits extremity symptoms in patients with LSS. They also have a distal symmetric loss of vibratory sensation, similar to that experienced by patients with peripheral neuropathy. The patient with more advanced LSS typically has a forward-stooped gait as an accommodation to the stenosis; this posture straightens the encroaching buckled ligamentum flavum and eases pain.

NSAIDs, acetaminophen, and physical therapy are the mainstays of conservative treatment of LSS. Use of opiates results in a mere 2.5-point average improvement on visual analog pain scales, which is too modest to justify the use of such problematic medications. Epidural steroid injections bring short-term pain relief. They need to be done under fluoroscopic guidance; without it, the miss rate is 30%. ■