Review Shows Anti-TNF Treatment Is Best in AS

BY NANCY WALSH
New York Bureau

BIRMINGHAM, ENGLAND — Tumor necrosis factor antagonists are the most effective treatment available for ankylosing spondylitis, according to the results of a systematic review of randomized placebo-controlled trials comparing the biologics with conventional drugs.

Prior to the introduction of biologic agents, treatment for ankylosing spondylitis (AS) was largely limited to physiotherapy and nonsteroidal anti-inflammatory drugs (NSAIDs). Other drugs such as methotrexate and sulfasalazine have not shown the same efficacy for ankylosing spondylitis as they have for rheumatoid arthritis, Sarah Levy, M.D., said at the joint meeting of the British Society for Rheumatology and the German Society for Rheumatology.

From a search on Medline and Embase, Dr. Levy and her associates at University Hospital Lewisham, London, identified 14 trials of pharmacologic management of AS; 9 of the trials were of adequate quality and produced data that were comparable across all studies, she said. Two of the studies evaluated NSAIDs, three evaluated sulfasalazine, and four evaluated TNF-α blocking agents.

Spinal pain visual analog scale scores were available for all treatments, but the Bath Ankylosing Spondylitis Functional Index (BASFI) was available only for NSAIDs and anti–TNF-α treatment, said Dr. Levy, a rheumatologist at the hospital.

Treatment with NSAIDs and sulfasalazine did show significant benefit in BASFI and spinal pain, but the effect sizes were small. (See box.) Most of the effect of treatment with sulfasalazine was seen in patients with both axial and peripheral disease, rather than in those with axial disease alone. In contrast, anti-TNF-α treatment showed highly significant benefits and the largest effect size on both BASFI and spinal pain scores, she said in a poster session.

Four trials evaluating physical exercise regimens also were identified and showed no benefit in spinal pain scores compared with placebo. ■

Treatment Comparisons

Treatment	Effect Size for Spinal Pain	Effect Size for BASFI*
NSAIDs	0.38	0.38
Sulfasalazine	0.24	n/a
Anti–TNF-α drugs	**3.67**	**2.24**
Physiotherapy	0.07	n/a

*Bath Ankylosing Spondylitis Functional Index.
Source: Dr. Levy

Etanercept Shows Sustained Benefit for Psoriatic Arthritis

NEW ORLEANS — Psoriatic arthritis patients receiving etanercept reported sustained clinical benefits for up to 2 years, according to data from an open-label extension study.

Patients treated with the drug reported inhibition of disease as well as significant improvements in physical functioning and quality of life, Philip J. Mease, M.D., reported at the annual meeting of the American Academy of Dermatology.

After an initial 24-week blinded phase of the study and a maintenance phase of up to 24 weeks, during which patients were kept on their blinded drug, 169 patients received 25 mg of etanercept (Enbrel) twice weekly for an additional 48 weeks during the open-label extension phase.

Patient-reported outcomes included the physical and mental components of the Short-Form (SF-36) Health Survey and the Health Assessment Questionnaire–Disability Index (HAQ-DI). During the placebo-controlled phase, etanercept-treated patients had a mean improvement of 9.3 points on the SF-36 physical component summary scale; placebo patients improved only 0.7 on the scale.

In the open-label phase, patients originally randomized to etanercept maintained their improvements (mean 12.6 points), and patients switched to etanercept from placebo improved almost to the same level as those on continuous etanercept, said Dr. Mease, a rheumatologist at the Swedish Medical Center, the University of Washington, Seattle. Both groups had normal mental health at baseline and maintained it throughout the industry-sponsored trial.

In the placebo-controlled phase, the HAQ-DI improved from 1.1 to 0.5 in the etanercept group and from 1.1 to 1 in the placebo group. At 48 weeks, 40 (53%) of 75 patients originally randomized to etanercept had an HAQ-DI of zero, indicating no disability in performing activities of daily living. The mean HAQ-DI score at 48 weeks was 0.4 for patients continuously treated with etanercept and 0.6 for 70 patients switched from placebo to the drug.

—Patrice Wendling

Treatment With Low-Dose Biologics For Rheumatic Disease Cuts Costs

BY NANCY WALSH
New York Bureau

BIRMINGHAM, ENGLAND — One promising strategy for holding down the cost of biologic therapy for patients with rheumatic diseases is to prescribe low doses when possible, results from two new studies have suggested.

With infliximab, for example, the typical dosage regimen in ankylosing spondylitis (AS) is 5 mg/kg given by infusion at weeks 1, 2, and 6 and then every 8 weeks. This is higher than the usual regimen for rheumatoid arthritis (RA).

"Because of cost pressures, we tried using conventional RA doses of 3 mg/kg in 13 AS patients," Ramesh N. Jois, M.D., said at the joint meeting of the British Society for Rheumatology and the German Society for Rheumatology.

All patients had Bath AS Disease Activity Index (BASDAI) scores greater than 4 at baseline. Mean disease duration of these patients, 12 of whom were male, was 16.9 years.

Clinical response was judged to be a 50% or greater reduction in the BASDAI score at 3 months.

One patient did not respond to the low-dose regimen and required an increase to the higher dose. All other patients showed statistically significant improvements across multiple measures of efficacy, said Dr. Jois of the department of rheumatology, Norfolk and Norwich (England) University Hospital.

Some patients now have been on the regimen for 12 months, with persisting benefits. (See chart.)

Five patients have been able to reduce their methotrexate dose (mean reduction 14 mg/wk). One stopped cyclosporine, another stopped sulfasalazine, and five discontinued nonsteroidal anti-inflammatory drugs altogether, he said.

No side effects were seen with the low-dose infliximab therapy.

Use of this regimen has led to a significant cost savings of approximately $29,000 per patient per year, for a total cost savings of $315,000 to the unit in the past year, Dr. Jois said in a poster session. "We advise starting all AS patients on low-dose infliximab. Consider increasing to the higher dose only if they fail to respond," he said.

Dr. Jois disclosed that his department has received research grant support from Wyeth, Schering-Plough, and Abbott Pharmaceuticals.

In a second study, 36 patients with RA and 3 patients with AS were treated with the standard etanercept regimen of 25 mg twice weekly for at least 3 months. Those with RA who achieved a Disease Activity Score (DAS)–28 below 3.2 and those with AS who achieved a very good response then were asked to gradually increase the interval between their etanercept injections from twice weekly to once weekly, said Veronica E. Abernethy, M.D., of the rheumatology practice development unit, St. Helens and Knowsley NHS Hospitals, Merseyside, England.

Currently, 7 of the 39 have successfully reduced their etanercept to once weekly without any deterioration in disease activity, which has resulted in a cost savings of $67,675 per year. This figure represents 9% of the total etanercept cost for the 39 patients, Dr. Abernethy said in a poster session. ■

Mean Response to Low-Dose Infliximab in AS Patients

	Baseline (n = 12)	3 Months (n = 12)	6 Months (n = 9)	12 Months (n = 8)
Bath AS Disease Activity Index	6.17	3.03	2.08	1.88
Bath AS Functional Index	6.31	3.61	2.11	2.56
Bath AS Metrology Index	5.08	4.46	2.95	3.67
Erythrocyte sedimentation rate	35.08 mg/L	11.22 mg/L	9.22 mg/L	14.14 mg/L
C-reactive protein	27.90 mm/hr	7.36 mm/hr	8.66 mm/hr	9.85 mm/hr

Source: Dr. Jois

Ankylosing Spondylitis: Risk for Renal Stones

CHICAGO — Renal stones are more prevalent in ankylosing spondylitis patients than in those with rheumatoid arthritis, according to the results of a preliminary study presented at the combined annual meeting of the Central Society for Clinical Research and the Midwestern section of the American Federation for Medical Research.

The investigation, led by Susan A. Leonard, M.D., of the University of Minnesota, Minneapolis, was the first to describe an association between nephrolithiasis and spondyloarthritis since a Croatian study that was published more than 30 years ago (Reumatizam 1973;20:106-10), according to Hollis E. Krug, M.D., who presented the latest data in a poster session at the meeting.

In their retrospective cohort study of 44 patients with spondyloarthritis and 51 controls with RA undergoing treatment at the Minneapolis Veterans Affairs Medical Center, the Minnesota-based researchers found a statistically significant greater prevalence of renal calculi in patients with ankylosing spondylitis compared with those with RA (38.6% versus 15.7%).

"There didn't seem to be a higher rate of coexistent disease in spondyloarthritis patients that could increase the risk for renal stones," Dr. Krug said. However, medication use at diagnosis of nephrolithiasis was not documented in the patients' charts, and that may have played a role in formation of kidney stones, she told this newspaper.

The Minneapolis group plans to study more patients in an attempt to explain the reason for this association.

—Kathleen Louden