

# Therapies for RA, Psoriatic Arthritis Scrutinized

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“Evidence is insufficient to draw firm conclusions” ... “We did not find any head-to-head randomized controlled trials.”

Those are phrases that appear frequently in a 151-page report, based on a literature review and released by the Agency for Healthcare Research and Quality, titled “Comparative Effectiveness of Drug Therapy for Rheumatoid Arthritis and Psoriatic Arthritis in Adults.”

“The gaps in information for specific RA therapies are substantial,” wrote the researchers of the RTI International–University of North Carolina Evidence-Based Practice Center, under contract to AHRQ.

Despite the paucity of data, the researchers draw some conclusions from the best available medical literature about the benefits and harms of three classes of

fair quality, which was defined as susceptible to some bias but probably not sufficient to invalidate their results. Only one-quarter of the studies were rated good quality, which was defined as having the least bias and results that are considered to be valid.

The researchers found that combining prednisone with hydroxychloroquine, methotrexate, or sulfasalazine works better than using only a synthetic DMARD to reduce joint swelling and tenderness and to improve function. There are also no mean-

ingful differences between methotrexate and either leflunomide or sulfasalazine.

Other findings include the following:  
▶ There is not enough evidence to conclude that combining two biologic DMARDs is better than using one biologic DMARD.

▶ An estimated 17 out of every 1,000 people who take a biologic DMARD for 3-12 months develop serious infection. Combining biologic DMARDs increases this risk.

▶ Painful injection-site reactions occur

more often among patients who take anakinra (67%), compared with those who take etanercept (22%) or adalimumab (18%).

In the report’s conclusion, the researchers emphasized the need for long-term studies of arthritis medications, including head-to-head trials “assessing combination therapies involving synthetic DMARDs in comparison with those involving biologic DMARDs,” they wrote. ■



The report is reflective of common practice. ‘It tries not to tilt toward one therapy or another.’

DR. ABRAMSON

medications for RA and psoriatic arthritis: synthetic disease-modifying antirheumatic drugs (DMARDs), biologic DMARDs, and corticosteroids. For example, they found that combining the synthetic DMARD methotrexate with one of the biologic DMARDs (abatacept, adalimumab, anakinra, etanercept, infliximab, or rituximab) works better than using methotrexate or one of the biologic DMARDs alone.

In addition, they found that methotrexate works as effectively as adalimumab and etanercept for patients with early RA. “Radiographic outcomes, however, were statistically significantly better in patients treated with biologic DMARDs than [in] patients treated with methotrexate,” the researchers wrote. “How such intermediate outcomes translate to the long-term clinical progression of the disease remains unclear.”

Dr. Steven B. Abramson, director of the division of rheumatology at New York University Medical Center, called the report “very comprehensive and useful” and “reflective of what I think is our common practice. It tries not to tilt toward one therapy or another. It’s a good summation of several years of literature.”

The team of researchers, led by Dr. Katrina E. Donahue of the department of family medicine at the University of North Carolina at Chapel Hill, reviewed 156 articles in the medical literature based on 103 studies of synthetic DMARDs, biologic DMARDs, and corticosteroids. Of these studies, 50% were supported by pharmaceutical companies, 20% were supported by government or independent funds, and 11% had a combination of pharmaceutical and government funding. The source of funding could not be determined in the remaining 19% of the studies.

Most of the studies were found to be of

**Cardiac Risk Factors**

Serving Size: 1 Adult Male  
Servings Per Container: 1

Amount Per Serving	
Age	48
Weight	243
Total Cholesterol	259
LDL	169
HDL	47
Coronary Calcium Score	397
Body Mass Index	37
Waist Circumference	48
Blood Pressure	
Systolic	150
Diastolic	90
Fasting Blood Glucose	146


**Ingredients for Coronary Artery Disease Risk:**  
Family History, Diabetes, Hypertension, Smoker, Occasional Chest Discomfort

**Refer**

Nuclear stress testing for reliable diagnostic and prognostic results<sup>1,2</sup>

1. Klocke FJ, et al. *Circulation*. 2003;108:1404-1418.  
2. Hachamovitch R, et al. *Circulation*. 1998;97:535-543.

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