Rituximab Effective as First-Line Biologic for RA

BY NANCY WALSH
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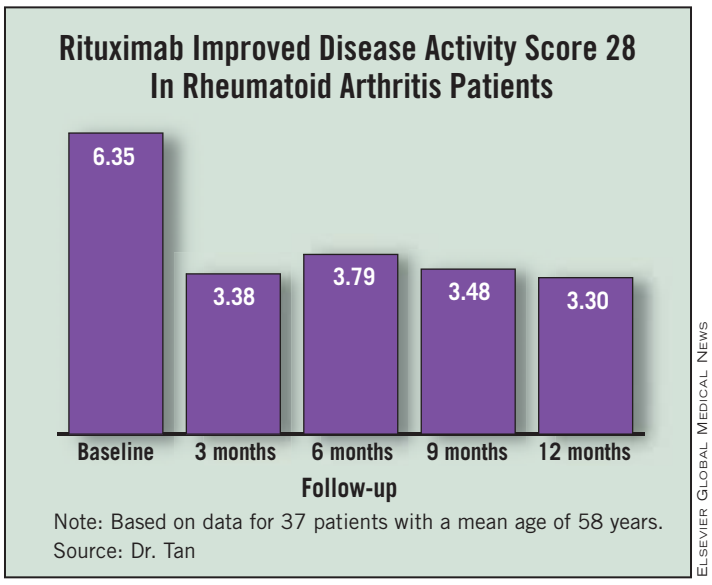
LIVERPOOL, ENGLAND — Rituximab has been used successfully in a real-world setting as a first-line biologic therapy for rheumatoid arthritis that does not respond to conventional disease-modifying drugs, Dr. Ai Lyn Tan reported at the annual meeting of the British Society for Rheumatology.

Rituximab is licensed in the United Kingdom for the treatment of adults with rheumatoid arthritis (RA) who have had an inadequate response to, or who are intolerant of, conventional disease-modifying anti-rheumatic drugs (DMARDs) and to one or more tumor necrosis factor (TNF) inhibitors. In the United States, it is licensed for use in combination with methotrexate for management of moderately to severely active RA that has not responded to treatment with one or more anti-TNF agents.

Dr. Tan and her colleagues at the University of Leeds (England) and Chapel Allerton Hospital, Leeds, have studied a total of 39 patients who had failed at least one DMARD and who received two initial infusions of rituximab 2 weeks apart. In 17 patients, the doses were 1,000 mg each, and in 22, the doses were 500 mg each.

Two-thirds of the patients were women. Their median age was 58 years and median disease duration was 7 years. Thirty were rheumatoid factor (RF) positive at baseline, and 16 were also antinuclear antibody (ANA) positive. Clinical outcome data were available for 37 patients and safety data for all 39.



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Clinical assessments using the Disease Activity Score (DAS) 28 and EULAR response criteria were done at 3, 6, 9, and 12 months. The EULAR response criteria use the change in DAS and the level of DAS achieved to classify patients as good, moderate, or nonresponders.

At all time points, there was a significant improvement in DAS28 (see the chart). EULAR good responses were seen in 40% of patients at 3 months and in 50% of patients at 12 months, while overall EULAR responses were seen in 88% and 77%, respectively, at those time points.

By 6 months, ANA became negative in 40% of patients in whom it had been positive at baseline, and in 88% of RF-positive patients the antibody level had fallen. Four of the previously RF-positive patients became seronegative by 6 months, and these reductions were sustained at 12 months, Dr. Tan wrote in a poster presentation.

Slightly better responses were seen in patients who received the higher dose, with 82% in the 500-mg group and 94% of those in the 1,000-mg group achieving EULAR responses. Nonetheless, she suggested that it might be "prudent" to start on lower doses since treatment is likely to be needed long term.

Thus far, 25 patients have been re-treated, at a median of 13 months after the initial infusions, and 7 have received a third treatment, at a median of 11 months after the second treatment. Two patients were switched to anti-TNF therapy after early treatment failure, and a third was switched after an allergic reaction to the second infusion of rituximab, said Dr. Tan, who declared no conflicts of interest.

A 67-year-old patient with preexisting lung disease died 3 months after treatment from presumed bilateral bronchopneumonia and possible methotrexate pneumonitis, and a 61-year-old man died of a myocardial infarction while awaiting coronary angiography for angina pectoris. The outcome was not considered related to therapy.

In an interview, Dr. Tan said the data showed rituximab is effective as first-line therapy for severe RA. "This is important because it can be used in patients in whom the TNF blockers are contraindicated." ■

Chest X-Ray Warranted in New RA

LIVERPOOL, ENGLAND — All patients with newly diagnosed rheumatoid arthritis should have a chest x-ray to rule out rare conditions that can cause arthralgias and inflammation.

Dr. Sarah E. Medley based this advice on a case in which a 52-year-old woman with a 45 pack-year history of smoking presented to the orthopedics department of Queen Elizabeth Hospital, Woolwich, England, with arthralgias affecting the knees, shins, and wrists. Although synovial biopsy of the right knee revealed no synovitis, the patient was diagnosed with rheumatoid arthritis (RA) and treated with methotrexate and then sulfasalazine with prednisone and intramuscular corticosteroids. She was subsequently given an additional diagnosis of facet joint arthritis and given tramadol, meloxicam, and gabapentin for pain.

Rheumatoid factor was negative and erythrocyte sedimentation rate rose from 27 to 101 mm/h, while the woman's disease activity score was very high, at 8.2.

Because conventional treatment was unsuccessful, anti–tumor necrosis factor therapy was planned. Only then was a chest x-ray ordered—as is needed to rule out tuberculosis in patients embarking on biologic therapy. The x-ray revealed a large right apex mass that proved to be a squamous cell carcinoma of the lung. Subsequent resection resulted in rapid and significant improvement in the patient's articular symptoms, and other medications—except analgesics—were stopped because she was receiving adjuvant chemotherapy, Dr. Medley wrote in a poster presented at the annual meeting of the British Society for Rheumatology.

"This case illustrates the need for a chest x-ray in new RA, and emphasizes the fact that atypical unresponsive RA requires review of the diagnosis rather than just treatment escalation," Dr. Medley wrote.

—Nancy Walsh