

New RA Guidelines Stress Early Intervention

BY DENISE NAPOLI

FROM THE AMERICAN COLLEGE OF RHEUMATOLOGY AND THE EUROPEAN LEAGUE AGAINST RHEUMATISM

The promised overhaul of treatment guidelines for rheumatoid arthritis has finally arrived, and with it, a “new paradigm” that focuses on early identification and treatment of the disabling disease.

The guidelines, which were developed by a joint committee from the American College of Rheumatology and the European League Against Rheumatism, are the latest update since the current guidelines were created in 1987.

Published jointly in the EULAR journal *Annals of the Rheumatic Diseases* (2010;69:1580-8) and the *ACR's Arthritis & Rheumatism* (2010;62:2569-81), the new guidelines were created in

three phases over 2 years.

In the first phase, the goal was to “to identify the contributions of clinical and laboratory variables that in practice were the most predictive of the decision to initiate [disease-modifying antirheumatic drug] therapy in a population of patients with early undifferentiated synovitis,” wrote the authors, led by Dr. Daniel Aletaha of the Medical University of Vienna.

To do this, a working group from both societies looked at data from 3,115 patients, and correlated whether or not the patients were ultimately prescribed methotrexate to an “agreed-upon list of standardized clinical and laboratory variables collected at baseline.”

The odds of eventual methotrexate initiation were calculated for each variable. For example, swelling of the metacarpophalangeal joint had an odds ratio of

reported in another clinical trial, and may not reflect the rates actually observed in clinical practice.

The frequencies of treatment-emergent adverse events during LANTUS clinical trials in patients with type 1 diabetes mellitus and type 2 diabetes mellitus are listed in the tables below.

Table 1: Treatment-emergent adverse events in pooled clinical trials up to 28 weeks duration in adults with type 1 diabetes (adverse events with frequency \geq 5%)

	LANTUS, % (n=1257)	NPH, % (n=1070)
Upper respiratory tract infection	22.4	23.1
Infection*	9.4	10.3
Accidental injury	5.7	6.4
Headache	5.5	4.7

*Body System not Specified

Table 2: Treatment-emergent adverse events in pooled clinical trials up to 1 year duration in adults with type 2 diabetes (adverse events with frequency \geq 5%)

	LANTUS, % (n=849)	NPH, % (n=714)
Upper respiratory tract infection	11.4	13.3
Infection*	10.4	11.6
Retinal vascular disorder	5.8	7.4

*Body System not Specified

Table 3: Treatment-emergent adverse events in a 5-year trial of adults with type 2 diabetes (adverse events with frequency \geq 10%)

	LANTUS, % (n=514)	NPH, % (n=503)
Upper respiratory tract infection	29.0	33.6
Edema peripheral	20.0	22.7
Hypertension	19.6	18.9
Influenza	18.7	19.5
Sinusitis	18.5	17.9
Cataract	18.1	15.9
Bronchitis	15.2	14.1
Arthralgia	14.2	16.1
Pain in extremity	13.0	13.1
Back pain	12.8	12.3
Cough	12.1	7.4
Urinary tract infection	10.7	10.1
Diarrhea	10.7	10.3
Depression	10.5	9.7
Headache	10.3	9.3

Table 4: Treatment-emergent adverse events in a 28-week clinical trial of children and adolescents with type 1 diabetes (adverse events with frequency \geq 5%)

	LANTUS, % (n=174)	NPH, % (n=175)
Infection*	13.8	17.7
Upper respiratory tract infection	13.8	16.0
Pharyngitis	7.5	8.6
Rhinitis	5.2	5.1

*Body System not Specified

LANTUS® (insulin glargine [rDNA origin] injection) solution for subcutaneous injection

• *Severe Hypoglycemia*

Hypoglycemia is the most commonly observed adverse reaction in patients using insulin, including LANTUS [See Warnings and Precautions (5.3)]. Tables 5 and 6 summarize the incidence of severe hypoglycemia in the LANTUS individual clinical trials. Severe symptomatic hypoglycemia was defined as an event with symptoms consistent with hypoglycemia requiring the assistance of another person and associated with either a blood glucose below 50 mg/dL (\leq 56 mg/dL in the 5-year trial) or prompt recovery after oral carbohydrate, intravenous glucose or glucagon administration.

The rates of severe symptomatic hypoglycemia in the LANTUS clinical trials (see Section 14 in the full prescribing information for a description of the study designs) were comparable for all treatment regimens (see Tables 5 and 6). In the pediatric phase 3 clinical trial, children and adolescents with type 1 diabetes had a higher incidence of severe symptomatic hypoglycemia in the two treatment groups compared to the adult trials with type 1 diabetes. (see Table 5) [See Clinical Studies (14) in the full prescribing information].

Table 5: Severe Symptomatic Hypoglycemia in Patients with Type 1 Diabetes

	Study A Type 1 Diabetes Adults 28 weeks In combination with regular insulin		Study B Type 1 Diabetes Adults 28 weeks In combination with regular insulin		Study C Type 1 Diabetes Adults 16 weeks In combination with insulin lispro		Study D Type 1 Diabetes Pediatrics 26 weeks In combination with regular insulin	
	LANTUS	NPH	LANTUS	NPH	LANTUS	NPH	LANTUS	NPH
Percent of patients (n/total N)	10.6 (31/292)	15.0 (44/293)	8.7 (23/264)	10.4 (28/270)	6.5 (20/310)	5.2 (16/309)	23.0 (40/174)	28.6 (50/175)

Table 6: Severe Symptomatic Hypoglycemia in Patients with Type 2 Diabetes

	Study E Type 2 Diabetes Adults 52 weeks In combination with oral agents		Study F Type 2 Diabetes Adults 28 weeks In combination with regular insulin		Study G Type 2 Diabetes Adults 5 years In combination with regular insulin	
	LANTUS	NPH	LANTUS	NPH	LANTUS	NPH
Percent of patients (n/total N)	1.7 (5/289)	1.1 (3/281)	0.4 (1/259)	2.3 (6/259)	7.8 (40/513)	11.9 (60/504)

• *Retinopathy*

Retinopathy was evaluated in the LANTUS clinical studies by analysis of reported retinal adverse events and fundus photography. The numbers of retinal adverse events reported for LANTUS and NPH insulin treatment groups were similar for patients with type 1 and type 2 diabetes.

LANTUS was compared to NPH insulin in a 5-year randomized clinical trial that evaluated the progression of retinopathy as assessed with fundus photography using a grading protocol derived from the Early Treatment Diabetic Retinopathy Scale (ETDRS). Patients had type 2 diabetes (mean age 55 yrs) with no (86%) or mild (14%) retinopathy at baseline. Mean baseline HbA1c was 8.4%. The primary outcome was progression by 3 or more steps on the ETDRS scale at study endpoint. Patients with pre-specified post-baseline eye procedures (pan-retinal photocoagulation for proliferative or severe nonproliferative diabetic retinopathy, local photocoagulation for new vessels, and vitrectomy for diabetic retinopathy) were also considered as 3-step progressors regardless of actual change in ETDRS score from baseline. Retinopathy graders were blinded to treatment group assignment. The results for the primary endpoint are shown in Table 7 for both the per-protocol and Intent-to-Treat populations, and indicate similarity of Lantus to NPH in the progression of diabetic retinopathy as assessed by this outcome.

Major Finding: A new criteria set for rheumatoid arthritis identifies early disease based on a score of 6 or higher out of 10.

Data Source: An international committee of rheumatologists from both the European League Against Rheumatism and the American College of Rheumatology.

Disclosures: Several of the authors of the guidelines disclosed financial relationships with multiple drug makers.

1.5, as did swelling of the proximal interphalangeal joint and the wrist. Tenderness of the hand (either the MCP, PIP,

or wrist) was assigned an odds ratio of 2.0.

A moderate elevation of C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) was assigned an OR of 1.0; a high elevation of either assay carried an OR of 2.0.

Finally, moderate levels of either rheumatoid factor or anti-citrullinated protein antibodies had an OR of 2.0 for the eventual prescription of a DMARD; high levels had an OR of 4.0.

In phase II, an “expert panel” of 12

rheumatologists related the above clinical and laboratory factors to the “probability of developing ‘persistent inflammatory and/or erosive arthritis that is currently considered to be RA.’”

The panel also looked at duration of symptoms (longer or shorter than 6 weeks) and the number and size of joints (large or small), in addition to the variables that were assessed in phase I. Using a computer program, the panel assigned each variable a point value of 1-100, with high scores indicating greater likelihood of RA.

Finally, phase III aimed to utilize the

results of phases I and II “to develop a scoring system that would be applicable to newly presenting patients with undifferentiated inflammatory arthritis, to permit identification of those with a high probability of developing persistent and/or erosive RA.”

This final score assigns points in the following manner:

► One swollen “large joint” (defined as shoulders, elbows, hips, knees, and ankles) gets 0 points; involvement of 2-10 large joints gets 1 point.

► Involvement of 1-3 “small” joints (defined as metacarpophalangeal joints, proximal interphalangeal joints, second to fifth metatarsophalangeal joints, thumb interphalangeal joints, and wrists) gets 2 points, regardless of large-joint involvement; involvement of 4-10 small joints gets 3 points.

► Involvement of more than 10 joints, including at least one small joint, gets 5 points.

► Both a negative rheumatoid factor (RF) test and a negative anti-citrullinated protein antibody test (ACPA) gets 0 points, whereas having a “low-positive” RF or ACPA (defined as lower than three times the upper limit of normal) gets 2 points. A “high-positive” of either test gets 3 points.

► A normal CRP and normal ESR get 0 points, whereas at least one abnormal test gets 1 point.

► Symptom duration of fewer than 6 weeks gets 0 points; duration of 6 weeks or longer gets 1 point.

Scores of 6 or more out of 10 are classified as “definite RA.”

Commenting on the new criteria in an interview, Dr. Eric L. Matteson, who is a professor of medicine at the division of rheumatology at the Mayo Clinic in Rochester, Minn., and was not involved in the study, said, “A major useful feature is that the new guidelines do not require multiple joints to be inflamed before a diagnosis can be [made] of early inflammatory rheumatoid arthritis.”

Indeed, a patient may score 6 points without multiple joint inflammation, according to the new guidelines.

The authors also pointed out that symmetry is not a criterion for diagnosis, as it did not show significance in either phase of the new guidelines’ development. Nevertheless, they wrote, “Inevitably, . . . the greater the number of involved joints the higher the likelihood of bilateral involvement.”

When Dr. Matteson was asked what was missing from the new guidelines, he pointed to a lack of awareness of extra-articular components of RA, which also can occur early in the course of the disease.

“When they do [occur], they can be very useful in identifying the disease, and they are important markers and predictors of disease severity and need for therapy,” he said.

The guidelines also lack biomarkers for treatment response, he added.

Several of the guideline authors disclosed financial and other relationships with multiple pharmaceutical companies; Dr. Matteson stated that he had no financial disclosures relative to his comments. ■

Table 7. Number (%) of patients with 3 or more step progression on ETDRS scale at endpoint

	Lantus (%)	NPH (%)	Difference*† (SE)	95% CI for difference
Per-protocol	53/374 (14.2%)	57/363 (15.7%)	-2.0% (2.6%)	-7.0% to +3.1%
Intent-to-Treat	63/502 (12.5%)	71/487 (14.6%)	- 2.1% (2.1%)	-6.3% to +2.1%

*Difference = Lantus – NPH

†Using a generalized linear model (SAS GENMOD) with treatment and baseline HbA1c strata (cutoff 9.0%) as the classified independent variables, and with binomial distribution and identity link function

• **Insulin initiation and intensification of glucose control**

Intensification or rapid improvement in glucose control has been associated with a transitory, reversible ophthalmologic refraction disorder, worsening of diabetic retinopathy, and acute painful peripheral neuropathy. However, long-term glycemic control decreases the risk of diabetic retinopathy and neuropathy.

• **Lipodystrophy**

Long-term use of insulin, including LANTUS, can cause lipodystrophy at the site of repeated insulin injections. Lipodystrophy includes lipohypertrophy (thickening of adipose tissue) and lipoatrophy (thinning of adipose tissue), and may affect insulin absorption. Rotate insulin injection or infusion sites within the same region to reduce the risk of lipodystrophy. [See *Dosage and Administration* (2.1)].

• **Weight gain**

Weight gain can occur with insulin therapy, including LANTUS, and has been attributed to the anabolic effects of insulin and the decrease in glucosuria.

• **Peripheral Edema**

Insulin, including LANTUS, may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

• **Allergic Reactions**

Local Allergy

As with any insulin therapy, patients taking LANTUS may experience injection site reactions, including redness, pain, itching, urticaria, edema, and inflammation. In clinical studies in adult patients, there was a higher incidence of treatment-emergent injection site pain in LANTUS-treated patients (2.7%) compared to NPH insulin-treated patients (0.7%). The reports of pain at the injection site did not result in discontinuation of therapy.

Rotation of the injection site within a given area from one injection to the next may help to reduce or prevent these reactions. In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique. Most minor reactions to insulin usually resolve in a few days to a few weeks.

Systemic Allergy

Severe, life-threatening, generalized allergy, including anaphylaxis, generalized skin reactions, angioedema, bronchospasm, hypotension, and shock may occur with any insulin, including LANTUS and may be life threatening.

• **Antibody production**

All insulin products can elicit the formation of insulin antibodies. The presence of such insulin antibodies may increase or decrease the efficacy of insulin and may require adjustment of the insulin dose. In phase 3 clinical trials of LANTUS, increases in titers of antibodies to insulin were observed in NPH insulin and insulin glargine treatment groups with similar incidences.

6.2 Postmarketing experience

The following adverse reactions have been identified during post-approval use of LANTUS.

Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to estimate reliably their frequency or establish a causal relationship to drug exposure.

Medication errors have been reported in which other insulins, particularly short-acting insulins, have been accidentally administered instead of LANTUS [See *Patient Counseling Information* (17) in the full prescribing information]. To avoid medication errors between LANTUS and other insulins, patients should be instructed to always verify the insulin label before each injection.

7. DRUG INTERACTIONS

A number of drugs affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring.

The following are examples of drugs that may increase the blood-glucose-lowering effect of insulins including LANTUS and, therefore, increase the susceptibility to hypoglycemia: oral anti-diabetic products, pramlintide, angiotensin converting enzyme (ACE) inhibitors, disopyramide, fibrates, fluoxetine, monoamine oxidase inhibitors, propoxyphene, pentoxifylline, salicylates, somatostatin analogs, and sulfonamide antibiotics.

The following are examples of drugs that may reduce the blood-glucose-lowering effect of insulins including LANTUS: corticosteroids, niacin, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), glucagon, iso-

LANTUS® (insulin glargine [rDNA origin] injection) solution for subcutaneous injection

niazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives), protease inhibitors and atypical antipsychotic medications (e.g. olanzapine and clozapine).

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia.

The signs of hypoglycemia may be reduced or absent in patients taking sympatholytic drugs such as beta-blockers, clonidine, guanethidine, and reserpine.

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C: Subcutaneous reproduction and teratology studies have been performed with insulin glargine and regular human insulin in rats and Himalayan rabbits. Insulin glargine was given to female rats before mating, during mating, and throughout pregnancy at doses up to 0.36 mg/kg/day, which is approximately 7 times the recommended human subcutaneous starting dose of 10 Units/day (0.008 mg/kg/day), based on mg/m². In rabbits, doses of 0.072 mg/kg/day, which is approximately 2 times the recommended human subcutaneous starting dose of 10 Units/day (0.008 mg/kg/day), based on mg/m², were administered during organogenesis. The effects of insulin glargine did not generally differ from those observed with regular human insulin in rats or rabbits. However, in rabbits, five fetuses from two litters of the high-dose group exhibited dilation of the cerebral ventricles. Fertility and early embryonic development appeared normal.

There are no well-controlled clinical studies of the use of LANTUS in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is essential for patients with diabetes or a history of gestational diabetes to maintain good metabolic control before conception and throughout pregnancy. Insulin requirements may decrease during the first trimester, generally increase during the second and third trimesters, and rapidly decline after delivery. Careful monitoring of glucose control is essential in these patients.

8.3 Nursing Mothers

It is unknown whether insulin glargine is excreted in human milk. Because many drugs, including human insulin, are excreted in human milk, caution should be exercised when LANTUS is administered to a nursing woman. Use of LANTUS is compatible with breastfeeding, but women with diabetes who are lactating may require adjustments of their insulin doses.

8.4 Pediatric Use

The safety and effectiveness of subcutaneous injections of LANTUS have been established in pediatric patients (age 6 to 15 years) with type 1 diabetes [see *Clinical Studies* (14) in the full prescribing information]. LANTUS has not been studied in pediatric patients younger than 6 years of age with type 1 diabetes. LANTUS has not been studied in pediatric patients with type 2 diabetes.

Based on the results of a study in pediatric patients, the dose recommendation when switching to LANTUS is the same as that described for adults [see *Dosage and Administration* (2.3) and *Clinical Studies* (14) in the full prescribing information]. As in adults, the dosage of LANTUS must be individualized in pediatric patients based on metabolic needs and frequent monitoring of blood glucose.

8.5 Geriatric Use

In controlled clinical studies comparing LANTUS to NPH insulin, 593 of 3890 patients (15%) with type 1 and type 2 diabetes were ≥65 years of age and 80 (2%) patients were ≥75 years of age. The only difference in safety or effectiveness in the subpopulation of patients ≥65 years of age compared to the entire study population was a higher incidence of cardiovascular events typically seen in an older population in both LANTUS and NPH insulin-treated patients.

Nevertheless, caution should be exercised when LANTUS is administered to geriatric patients. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly [See *Warnings and Precautions* (5.3)].

10. OVERDOSAGE

An excess of insulin relative to food intake, energy expenditure, or both may lead to severe and sometimes prolonged and life-threatening hypoglycemia. Mild episodes of hypoglycemia can usually be treated with oral carbohydrates. Adjustments in drug dosage, meal patterns, or exercise may be needed.

More severe episodes of hypoglycemia with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid recurrence of hypoglycemia.

Rev. September 2009

sanofi-aventis U.S. LLC

Bridgewater, NJ 08807

©2009 sanofi-aventis U.S. LLC

GLA-BPLR-AS2-SEP09