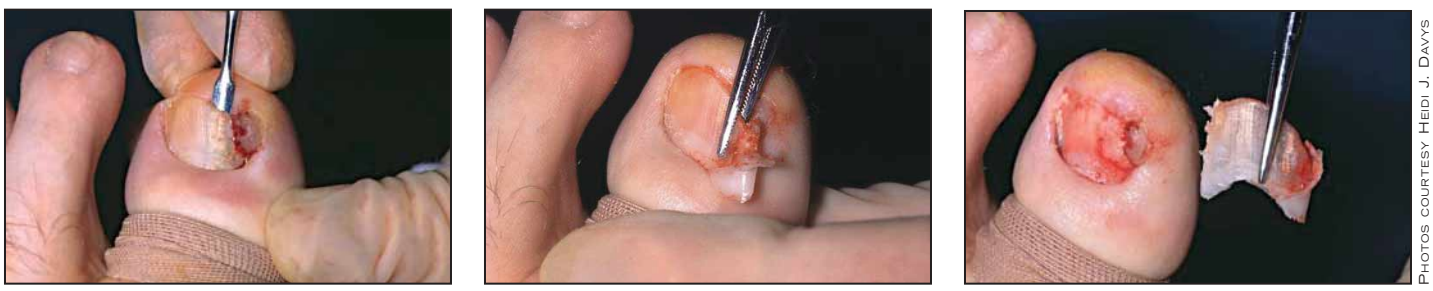
Onychocryptosis Strikes RA Patients on Biologics

BY NANCY WALSH
New York Bureau

GLASGOW, SCOTLAND — Onychocryptosis poses a particular risk to patients with rheumatoid arthritis being treated with biologics, so vigilance should be practiced in the foot care of these patients, reported Heidi J. Davys.

Onychocryptosis can be accompanied by local sepsis, which is a serious concern in patients on anti–tumor necrosis factor–α therapy, Ms. Davys noted in a poster session at the annual meeting of the British Society for Rheumatology.

The full extent and impact of foot problems in these patients is not clear, but a retrospective 14-month audit in the rheumatology foot clinic at Leeds (England) General Infirmary, identified nine cases of onychocryptosis developing in rheumatoid arthritis (RA) patients on biologic therapy.



PHOTOS COURTESY HEIDI J. DAVYS

Toenail surgery by a podiatrist is often required to repair onychocryptosis. Eight of the nine rheumatoid arthritis patients in the study had to undergo partial or total nail avulsion. All outcomes were successful, allowing reinstitution of biologic therapy.

Five of the affected patients were female, mean age was 43 years, and mean disease duration was 10.9 years. Etanercept was the drug being used in seven cases, and infliximab and abatacept each were being used by one patient.

None of the patients had experienced previous episodes of onychocryptosis. The mean time between commencement of biologic therapy and symptom onset was 20 weeks, wrote Ms. Davys, who is a specialist in rheumatologic podiatry, Leeds Teaching Hospitals NHS Trust.

Therapy with the biologic was suspended in all patients prior to nail treatment for an average duration of 2 weeks, until healing was complete. Eight of the patients underwent partial or total nail avulsion, three with matrix phenolization to prevent regrowth. All patients also were treated with systemic antibiotics. The outcome was successful in all nine patients, allowing reinstitution of biologic therapy.

Prompt referral to a podiatry service is necessary if onychocryptosis develops in a patient. Podiatrists performing surgical procedures such as avulsion should be aware of current perioperative guidelines, and should work closely with the rheumatology team, wrote Ms. Davys. ■

Some Biologic Response Modifiers, Surgery Don't Mix

Perioperative management of patients taking immunosuppressive drugs has been a challenging issue.

Concerns are particularly significant with the biologic response modifiers, because of the risk of serious infection associated with their use.

Published treatment guidelines are based on the perioperative use of infliximab among patients with Crohn's disease and on animal model and tissue culture investigations. Until more evidence-based clinical data are available, the following are considered reasonable:

► **Infliximab.** This drug can be continued without interruption or discontinued 1 week before surgery and resumed 1-2 weeks after.

► **Etanercept and anakinra.** Experiments in animal models suggest that these drugs should be withdrawn the week of the procedure and resumed 1-2 weeks later.

► **Adalimumab and rituximab.** No data are available. These agents should be discontinued at least 1 week before surgery and resumed 1-2 weeks later.

Source: Curr. Opin. Rheumatol. 2004;16:192-8.

HLA-B27 Testing Still Useful

Probability *from page 1*

Using these clinical features, along with laboratory and imaging tests, Dr. Rudwaleit and his colleagues formulated a probability approach to diagnosis.

From the literature, they determined that among patients with chronic back pain there is a 5% probability of spondyloarthritis, and if the back pain is identified as inflammatory in nature, the probability of AS is 14%. If three or more features of AS also are present the probability is 80%-95% (Ann. Rheum. Dis. 2004;63:535-43).

But if only one or two features of AS are present in a patient with inflammatory back pain, the disease probability ranges from 35%-70%, and if no AS features are present the probability remains low, at 14%. In this subgroup of patients, whose diagnosis remains uncertain, HLA-B27 testing becomes important, according to Dr. Rudwaleit.

"Rheumatologists and other doctors have been taught for 20 years not to rely on HLA-B27 testing to diagnose ankylosing spondylitis," he said. The debate about the utility of this inherited gene marker found in approximately 90% of patients with confirmed AS—but also in many people without the disease—derives from earlier studies in which it was considered the sole probability factor and was found to be nonspecific.

In a patient who simply has chronic back pain, a positive HLA-B27 test only increases the likelihood of AS to 32%. That is not diagnostic. However, if the patient has back pain of the inflammatory type as well as heel enthesitis, a positive HLA-B27 test gives you a disease probability of approximately 80%.

MRI also has acquired diagnostic importance in Dr. Rudwaleit's approach. For example, if a patient with inflammatory back pain but no features of spondyloarthropathy tests positive for HLA-B27, the probability of AS increases from 14% to 59%. And if that patient then is found to have changes such as enthesitis on MRI, the probability increases to 80%-95%.

Dr. Rudwaleit and colleagues are currently evaluating the probability approach to spondyloarthritis diagnosis in their Berlin clinic. In their initial group of 342 patients, they were able to diagnose AS in 85 patients and preradiographic AS in 75 patients using this approach. The disease was ruled out in 150 patients, and the remaining 32 were considered to possibly have AS.

"The median probability of AS in the preradiographic stage of disease was found to be 96%, and in the patients considered possible—and among those in whom AS was ruled out—the probability was 1%," he said, adding that these are the first data suggesting the accuracy of the probability approach. ■

Previous Cancer Ups Anti-TNF Risk

BY NANCY WALSH
New York Bureau

GLASGOW, SCOTLAND — Data from a large cohort of patients with rheumatoid arthritis receiving anti–tumor necrosis factor–α therapy has determined that those with a history of malignancy are at heightened risk for additional cancers, and therefore such treatment should be used "with extreme caution" in these patients, according to Kath D. Watson, Ph.D.

Because anti–tumor necrosis factor (anti-TNF) plays an important role in the immune system's tumor surveillance, its blockade could potentially increase the risk of cancer, Dr. Watson said at the annual meeting of the British Society for Rheumatology. Although there have been reports of malignancies such as lymphoma associated with biologic response modifiers, the data thus far have been insufficient to precisely quantify the degree of risk—or to sort out risks deriving from treatment from those inherent in the disease process.

Analysis of data from the British Society for Rheumatology biologics registry is now beginning to clarify these concerns, as cancer incidence among 9,999 first-exposure anti-TNF–treated patients was compared with that of 1,877 biologic-naive rheumatoid arthritis patients taking traditional disease-modifying antirheumatic drugs (DMARDs), according to Dr. Watson of the Arthritis Research Campaign's epidemiology unit, University of Manchester, England.

Participants were followed from the date of their registration through September 2005, and reports on cancer cases were obtained from the Office for National Statistics or from 6-monthly physician questionnaires. Incidence rate ratios were adjusted for age, gender, disease severity, and smoking history.

The incidence of new malignancies among the anti-TNF–treated patients overall was not elevated, compared with that of the DMARD-treated group, with a relative risk of 0.7, Dr. Watson said.

But patients treated with biologics who had previous malignancies had an increased risk of developing a further malignancy after commencing therapy, with an incidence rate ratio of 2.5. This increased risk was higher than that for DMARD-treated patients who had had previous cancers. (See box.) ■

Previous Malignancy and Incident Cancer Rates

	DMARD		Anti-TNF	
	Previous Ca	No Previous Ca	Previous Ca	No Previous Ca
No. of patients	58	1,819	154	9,844
No. of new cancers	1	27	6	158
Incidence/1,000 patient-years	18.2	14.1	20.5	8.4
Adjusted incidence/rate ratio	1.2	Referent	2.5	Referent

Source: Dr. Watson

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