Ασθενής με Ψωριασική Αρθρίτιδα και δυσανεξία στη Μεθοτρεξάτη

Σπύρος Ν Νίκας

Ρευματολόγος

Ιωάννινα

Σύγκρουση συμφερόντων

Τιμητική αμοιβή από την Pfizer για τη συγκεκριμένη ομιλία

«Η Pfizer έχει ελέγξει το περιεχόμενο ώστε να ανταποκρίνεται στις ειδικές προδιαγραφές της αλλά δεν έχει επιβεβαιώσει ότι οι βιβλιογραφικές παραπομπές έχουν παρατεθεί ορθά».

«Για όλα τα φαρμακευτικά προϊόντα που αναφέρονται παρακαλείσθε να συμβουλεύεστε/συμβουλευτείτε τις εγκεκριμένες Περιλήψεις Χαρακτηριστικών των Προϊόντων»

Περιστατικό

Τζένη Π., ετών 34

Υπέρβαρη (BMI 29) έγγαμος

ΗΠΙΑ Ψωρίαση από 5ετιας (κατά πλάκας, αγκώνες, γόνατα)

Ολιγοαρθρίτιδα προ 2ετιας (γόνατο ΔΕ, 2 ΜΚΦ ΑΡ)

DAS28 5,6

Έλαβε MTX (12,5 mg/w) & Medrol (tapering σε 3 μήνες)

6m μετά: Λόγω ενεργότητας νόσου (DAS28 5,3)-> MTX -> 17,5 mg/w

2m: Αύξηση ηπατικών (alt 87/40)

DAS28 5,2

?

Νέα γυναίκα με ενεργό ΨΑ

και MTX-αποτυχία :

Σε αποτελεσματικότητα

Και σε ασφάλεια

Θερ. επιλογές

Αγνοούμε τα ηπατικά και μένουμε όπως είμαστε

ενεργότητα

τα ηπατικά θα ανέβουν κι άλλο (ΣΒ)

Μειώνουμε την MTX

ενεργότητα

Μειώνουμε ή κόβουμε MTX και προσθήκη άλλου DMARDs

Λεφλουνομίδη κυκλοσπορίνη

Ηπατικά / ΝΕΑ γυναίκα

Βιολογικός

(TNFi/IL17/ 12-23/ ABA)

Etanercept

Την **πιο δόκιμη** επιλογή

Jak αναστολέας / TsDMARDs

ΠΑΛΙ κορτιζόνη + ?

Recommendation

OPEN ACCESS

EULAR recomm psoriatic arthri 2019 update

	Recommendations
1	Treatment should be aimed at reaching the target of remission or, alternatively, low disease activity, by regular disease activity assessment and appropriate adjustment of therapy.
2	Non-steroidal anti-inflammatory drugs may be used to relieve musculoskeletal signs and symptoms.
3	Local injections of glucocorticoids should be considered as adjunctive therapy in psoriatic arthritis*; systemic glucocorticoids may be used with caution at the lowest effective dose†.
4	In patients with polyarthritis, a csDMARD should be initiated* rapidly†, with methotrexate preferred in those with relevant skin involvement*.
5	In patients with monoarthritis or oligoarthritis, particularly with poor prognostic factors such as structural
6	In patients with peripheral arthritis and an inadequate response to at least one csDMARD, therapy with a bDMARD should be commenced; when there is relevant skin involvement, an IL-17 inhibitor or IL-12/23 inhibitor may be preferred.
7	In patients with peripheral arthritis and an inadequate response to at least one csDMARD and a bDMARD, or when a bDMARD is not appropriate, a JAK inhibitor may be considered.
11	In patients who fail to respond adequately to, or are intolerant of a bDMARD, switching to ar tsDMARD should be considered*, including one switch within a class†.
12	In patients in sustained remission, cautious tapering of DMARDs may be considered.

Γιατί όχι έναν JAKi ?

EULAR SLR :> **tofacitinib** may have
similar efficacy as the TNFi adalimumab for joint involvement, but
numerically lower efficacy in skin psoriasis

Gossec L, Baraliakos X, Kerschbaumer A, et alEULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 updateAnnals of the Rheumatic Diseases 2020;79:700-712
*First published **May 20, 2020***

Κυκλοσπορίνη στην ΨΑ ?

Recommendation

OPEN ACCESS

EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update

tation. Other csDMARDs have shown efficacy in PsA as well and may also be considered at this stage (although with less efficacy in the skin): these include leflunomide and sulfasalazine.[50] Ciclosporin is not recommended for PsA.

Anti-IL-17A / -IL-12/23 στη ΨΑ ? (Τζένη Π.)

Η Τζένη Μ

JAK inhibitors

Three Janus kinase (JAK) inhibitors (baricitinib, tofacitinib, and upadacitinib) are approved i the United States for the treatment of patients with RA. Pregnant and lactating women should avoid use of JAK inhibitors.[53, 54] Pregnancy-related risks and recommendations fo these agents include the following:

International Guidelines

The EULAR recommendations considered the continuation of infliximab, adalimumab, and golimumab in the first part of pregnancy and certolizumab and etanercept till the end of pregnancy (Götestam Skorpen et al., 2016). In the same year, BSR-BHPR guidelines recommended safe continuation of infliximab till the 16th week, adalimumab and etanercept till the end of the second trimester, and certolizumab throughout pregnancy (Flint et al., 2016). The latest recommendations issued by the American College of Rheumatology (ACR) strongly considered the continuation of certolizumab at conception and during pregnancy. In the case of infliximab, golimumab, adalimumab, and etanercept, the ACR recommendations considered their continuation during first and second trimesters and discontinuation in the third trimester if the disease is well controlled. If the disease is active, the conditional continuation of these biological agents can be considered (Sammaritano et al., 2020).

Whereas nea monoclonal outcomes of pregnancy, s among the 2 Puchner et a is still recommended 2018; European Medicines Agency, 201

and IL-23 cytokines (Ben- eatment of moderate to nimal studies have Lund and Thomsen, 2017; stekinumab was used has and eighth weeks. without any anomalies der ustekinumab et al., 2019). Maternal- w safety information was

8–12 weeks prior to parturition (Gisbert and Chaparro, 2020). According to both the EULAR and ACR statements, ustekinumab should be stopped before attempting conception and during pregnancy (Götestam Skorpen et al., 2016; Sammaritano et al., 2020).

e final application be discontinued

Τζένη Π:
TNFi => Την **πιο δόκιμη** επιλογή

ΜΤΧ στην ΨΑ ?

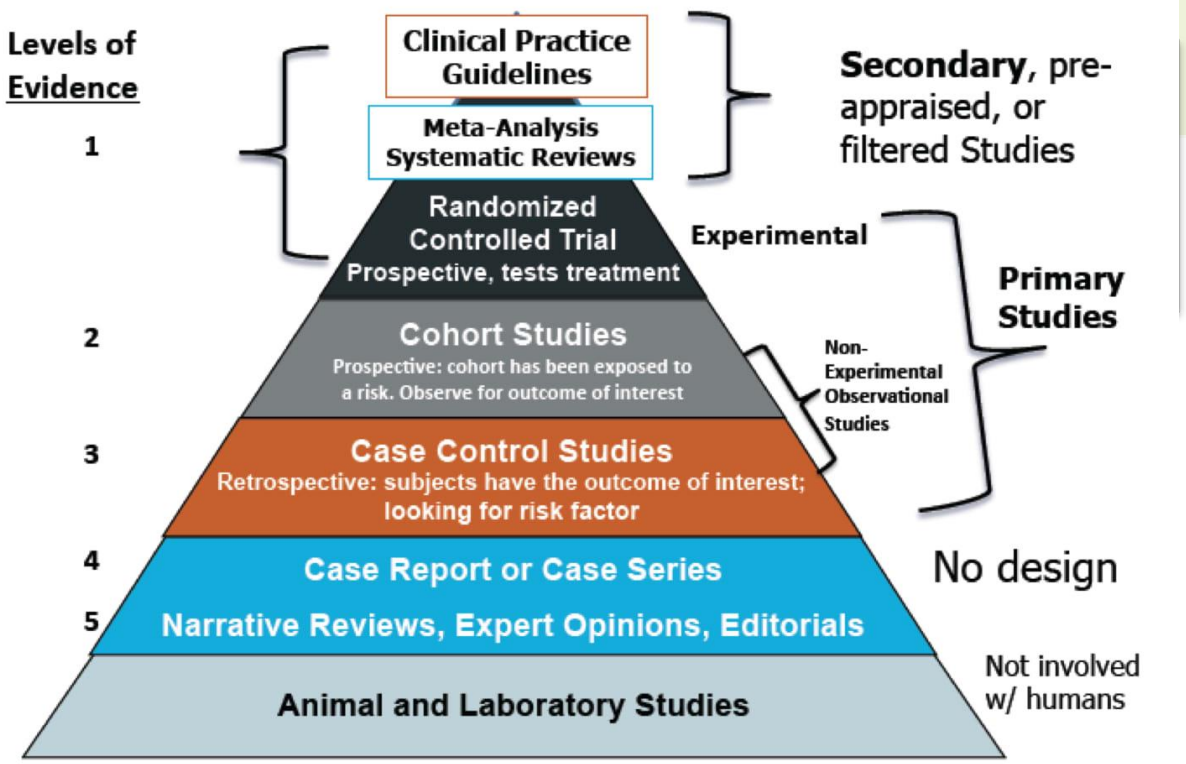

Είναι δόκιμο ?
Με την έναρξη του βιολογικού -> **συγχορήγηση**
Έναρξη αγωγής με ΜΤΧ

ΜΤΧ στην ΨΑ ?

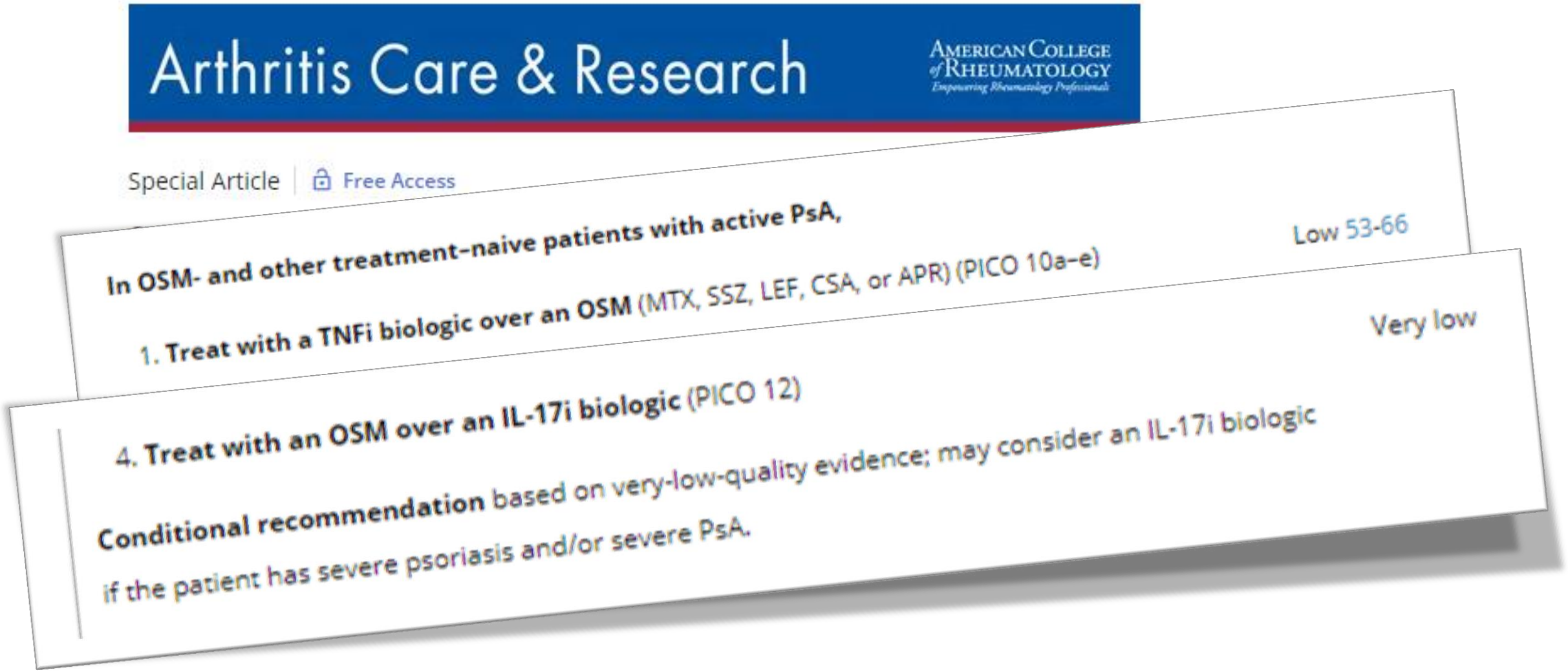

Είναι δόκιμο ?
Με την έναρξη του βιολογικού -> συγχορήγηση
Έναρξη αγωγής με ΜΤΧ

ULAR recommendations for the management of soriatic arthritis with pharmacological therapies: 019 update

	Recommendations
1	Treatment should be aimed at reaching the target of remission or, alternatively, low disease activity, by regular disease activity assessment and appropriate adjustment of therapy.
2	Non-steroidal anti-inflammatory drugs may be used to relieve musculoskeletal signs and symptoms.
3	Local injections of glucocorticoids should be considered as adjunctive therapy in psoriatic arthritis*; systemic
4	In patients with polyarthritis, a csDMARD should be initiated* rapidly†, with methotrexate preferred in those with relevant skin involvement*.
5	In patients with monoarthritis or oligoarthritis, p[illegible] damage, high erythrocyte sedimentation rate/C [illegible]
7	The continuous prioritisation of csDMARDs reflects consensu[illegible] balance of csDMARDs and in particular MTX over biologicals, a[illegible] scarce and include only small or inconclusive clinical trials,[37] a[illegible] evidence from observational studies.[38–41] However, the SEAM[illegible]
8	[illegible] bDMARD nor a JAK inhibitor is appropriate*, a PDE4 inhibitor may be considere
9	In patients with unequivocal enthesitis and insufficient response to NSAIDs or lo therapy with a bDMARD should be considered.
10	In patients with predominantly axial disease which is active and has insufficient with a bDMARD should be considered, which according to current practice is a T relevant skin involvement, IL-17 inhibitor may be preferred.
11	In patients who fail to respond adequately to, or are intolerant of a bDMARD, sw tsDMARD should be considered*, including one switch within a class†.
12	In patients in sustained remission, cautious tapering of DMARDs may be conside



MTX στη ΨΑ ?


Arthritis Care & Research
American College of Rheumatology
Empowering Rheumatology Professionals
Special Article
Free Access
In OSM- and other treatment-naive patients with active PsA,
1. Treat with a TNFi biologic over an OSM (MTX, SSZ, LEF, CSA, or APR) (PICO 10a–e)
Low 53-66
4. Treat with an OSM over an IL-17i biologic (PICO 12)
Very low
Conditional recommendation based on very-low-quality evidence; may consider an IL-17i biologic
if the patient has severe psoriasis and/or severe PsA.

MTX στη ΨΑ
ειδικά για την ασθενή

Με την έναρξη του βιολογικού

-> έχει νόημα η **συγχορήγηση** MTX ?

Arthritis Care & Research

American College of Rheumatology

Special Article

In adu

1. Sv

Biologic monotherapy is recommended over biologic combination therapy with MTX (the most commonly used OSM in combination therapy). When switching to biologic monotherapy, stopping the OSM or tapering of the OSM are both reasonable options and depend on patient and health care provider preferences. A biologic agent in combination with MTX may be used instead of biologic monotherapy if the patient has severe psoriasis, has had a partial response to current MTX therapy, or has concomitant uveitis (since uveitis may respond to MTX therapy), or in patients receiving treatment with a monoclonal antibody TNFi biologic, especially infliximab and adalimumab, to potentially delay or prevent the formation of antidrug antibodies.

Etanercept

ΔΕΝ χρειάζεται MTX

ΟΥΤΕ Η ΑΣΘΕΝΗΣ ΜΑΣ

MTX στη ΨΑ
ειδικά στη Τζένη

Με την έναρξη του **βιολογικού**

-> έχει νόημα η **συγχορήγηση** MTX ?

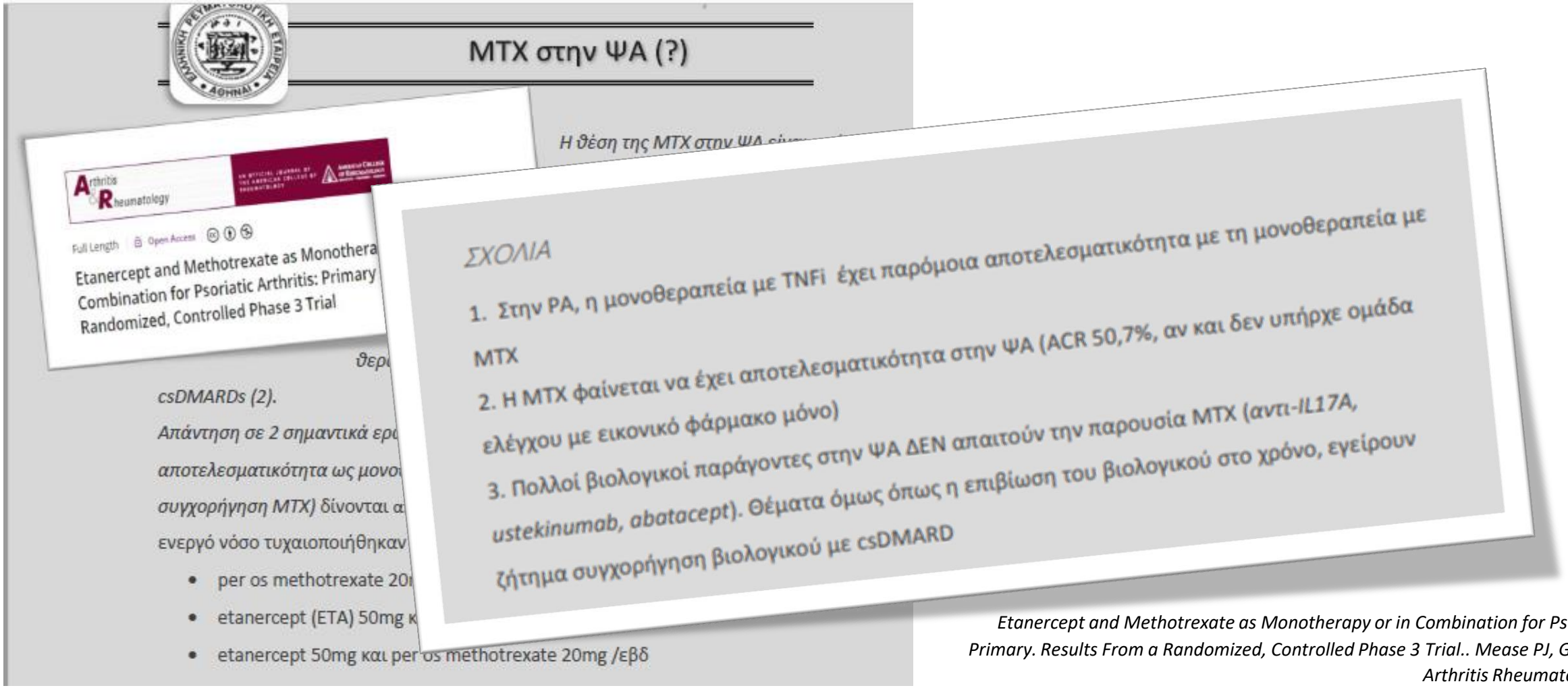
Recommendation

OPEN ACCESS

EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update

The issue of monotherapy with bDMARDs versus combination therapy with a csDMARD was discussed.[69 70] The current recommendation is to continue MTX with a bDMARD (using the latter as an add-on strategy) in patients already taking this drug and tolerating it well, but the taskforce admitted that to date there is no clear evidence that combination therapy is more efficacious than monotherapy, aside from a slight reduction of immunogenicity that is of doubtful clinical significance.[71] We suggest that MTX dose may be reduced in subjects showing a good biological drug response, especially when there are concerns about MTX toxicity. However, more data are needed and this point was put into the research agenda.

Από τις ελάχιστες μελέτες : MTX στη ΨΑ (?)



Etanercept and Methotrexate as Monotherapy or in Combination for Psoriatic Arthritis: Primary. Results From a Randomized, Controlled Phase 3 Trial.. Mease PJ, Gladman D et al. Arthritis Rheumatol. ***2019 Feb 12***.

Arthritis & Rheumatology
Vol. 71, No. 7, July 2019, pp 1112–1124
DOI 10.1002/art.40851

American College of Rheumatology
Empowering Rheumatology Professionals

Etanercept and Methotrexate as Monotherapy or in Combination for Psoriatic Arthritis: Primary Results From a Randomized, Controlled Phase III Trial

Philip J. Mease,[1] Dafna D. Gladman,[2] David H. Collier,[3] Christopher T. Ritchlin,[4] Philip S. Helliwell,[5] Lyrica Liu,[3] Gregory Kricorian,[3] and James B. Chung[3]

851 ασθενείς με ΨΑ

- oral **methotrexate** (20 mg) plus subcutaneous placebo (n = 284)
- subcutaneous **etanercept** (50 mg) plus oral placebo (n = 284)
- subcutaneous etanercept (50 mg) plus oral methotrexate (20 mg) weekly (**combination** therapy, n = 283)

Arthritis & Rheumatology
Vol. 71, No. 7, July 2019, pp 1112–1124
DOI 10.1002/art.40851

American College of Rheumatology
Empowering Rheumatology Professionals

Etanercept and Methotrexate as Monotherapy or in Combination for Psoriatic Arthritis: Primary Results From a Randomized, Controlled Phase III Trial

Philip J. Mease,[1] Dafna D. Gladman,[2] David H. Collier,[3] Christopher T. Ritchlin,[4] Philip S. Helliwell,[5] Lyrica Liu,[3] Gregory Kricorian,[3] and James B. Chung[3]

Στις 24 εβδομάδες :

1) ΟΧΙ ΣΤΗ ΡΑ !

η μονοθεραπεία με ΕΤΑ ήταν ανώτερη της μονοθεραπείας με MTX

(ACR20: 60.9% vs 50.7% [P=0.029])

Ο συνδυασμός επίσης MTX & ETA ήταν ανώτερος της μονοθεραπείας με MTX

(ACR20: 65.0% vs 50.7% [P=0.005])

MTX & ETA ή ETA > MTX στην ακτινολογική εξέλιξη

(48 εβδ)

2) MTX «ΔΟΥΛΕΥΕΙ» ΣΤΗ ΨΑ

eular
fighting rheumatic & musculoskeletal diseases together

- Μονοθ. ETA => 61%
- ETA + MTX => 65%

3) Η MTX ΔΕΝ προσφέρει κάτι στο ETA (ίσως δέρμα)

ACR American College of Rheumatology

Ή ΜΗΠΩΣ ΟΧΙ !

MTX

TNFi στη ΨΑ: με ή χωρίς

Annals of the
Rheumatic Diseases

Latest content Current issue Archive

Home / Archive / Volume 74, Issue 6

Article Text

Article info

Citation Tools

Clinical and epidemiological research
Extended report

The effect of comedication with conventional synthetic disease modifying antirheumatic drugs on TNF inhibitor drug survival in patients with ankylosing spondylitis and undifferentiated spondyloarthritis: results from a nationwide prospective study FREE

Elisabeth Lie [1, 2], Lars Erik Kristensen [3, 4], Helena Forsblad-d'Elia [1], Tatiana Zverkova-Sandström [1], Johan Askling [5], Iacobsson [1], for the ARTIS Study Group

φαίνεται όμως να σχετίζεται με καλύτερη επιβίωση του TNFi

θέματα μεταβολών στο DAS28, ενώ η προσθήκη δεδομένων από το Βρετανικό αρχείο δεν ανέδειξε διαφορές στο HAQ

Advanced Search

Matthew
Lenka Sz
The Journ

rel Pavelka,
ngale

MTX στη ΨΑ?

Psoriatic arthritis

Effectiveness and treatment retention of TNF inhibitors when used as monotherapy versus comedication with csDMARDs in 15 332 patients with psoriatic arthritis. Data from the EuroSpA collaboration

OR 1.25 (1.12–1.41). Methotrexate comedication was associated with improved remission for adalimumab (OR 1.45 (1.23–1.72)) and infliximab (OR 1.55 (1.21–1.98)) and improved retention for infliximab. No effect of comedication was demonstrated for etanercept.

Η ασθενής μας ΔΕΝ χρειάζεται να εκτεθεί σε MTX -> ηπατικά

Lindström U, Di Giuseppe D, Delcoigne B, et alEffectiveness and treatment retention of TNF inhibitors when used as monotherapy versus comedication with csDMARDs in 15 332 patients with psoriatic arthritis. Data from the EuroSpA collaboration. Annals of the Rheumatic Diseases Published Online First: ***03 June 2021***

Περιστατικό

Τζένη Π., ετών 34

Υπέρβαρη (BMI 29) έγγαμος

ΗΠΙΑ Ψωρίαση από 5ετιας (κατά πλάκας, αγκώνες, γόνατα)

Ολιγοαρθρίτιδα προ 2ετιας (γόνατο ΔΕ, 2 ΜΚΦ ΑΡ)

DAS28 5,6

Ελαφε MTX (12,5 mg/w) & Medrol (tapering σε 3 μήνες)

6m μετά: Λ ενεργότητας νόσου (DAS28 5,3)-> MTX -> 17,5 mg/w

2m: Αύξηση ηπατικών (alt 87/40)

DAS28 5,2

?

Νέα γυναίκα με ενεργό ΨΑ

και MTX-αποτυχία

Σε αποτελεσματικότητα

Και σε ασφάλεια

Etanercept

ΧΩΡΙΣ MTX

(αποτελεσματικότητα & επιβίωση)

Ευχαριστω