Ασθενής με χρόνια, αδιαφοροποίητη μονοαρθρίτιδα

at_kout@yahoo.com

Σύγκρουση συμφερόντων

Καμία για την παρουσίαση αυτή

Την διετία 2020-22 τιμητική αμοιβή από τις εταιρείες AbbVie, Genesis Pharma, Pfizer, UCB

Τα έξοδα της συμμετοχής και διαμονής στο συνέδριο καλύπτονται από την εταιρεία MSD

Γυναίκα
49 ετών
Εργασία γραφείου
Πρώην ερασιτέχνης αθλήτρια, σε υψηλό επίπεδο
Καπνίστρια

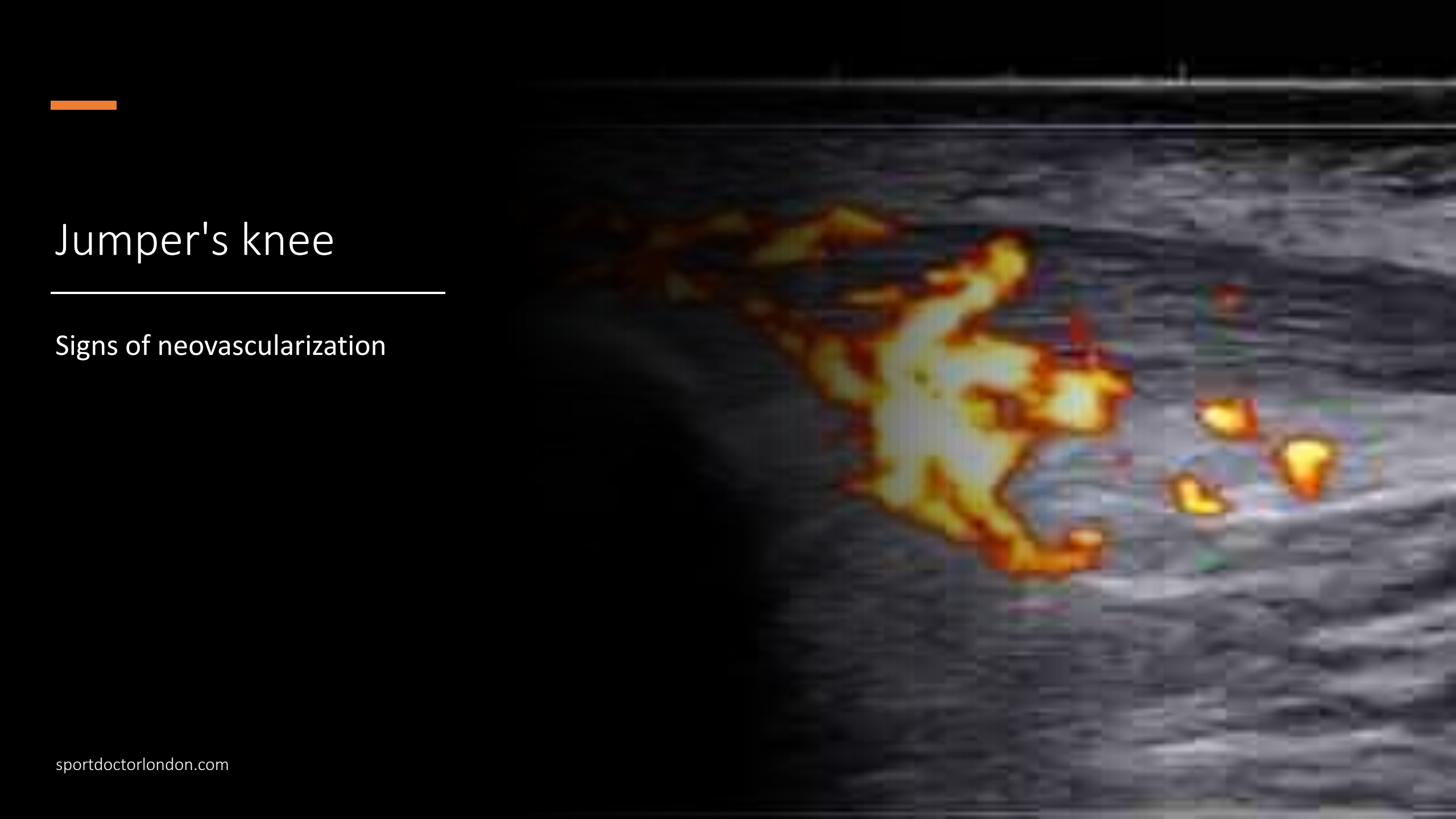
Πόνος
1. στον θύλακο του μείζονος τροχαντήρα ΑΡ (εδώ και 1 ½ έτος, με διακυμάνσεις)
2. Στο ΔΕ γόνατο (εδώ και 3 εβδομάδες)

MRI ΟΜΣΣ (?)
MRI γόνατος

Θυλακίτιδα μείζονος τροχαντήρα
Τενοντίτιδα επιγονατιδικού τένοντα

Jumper's knee

Signs of neovascularization



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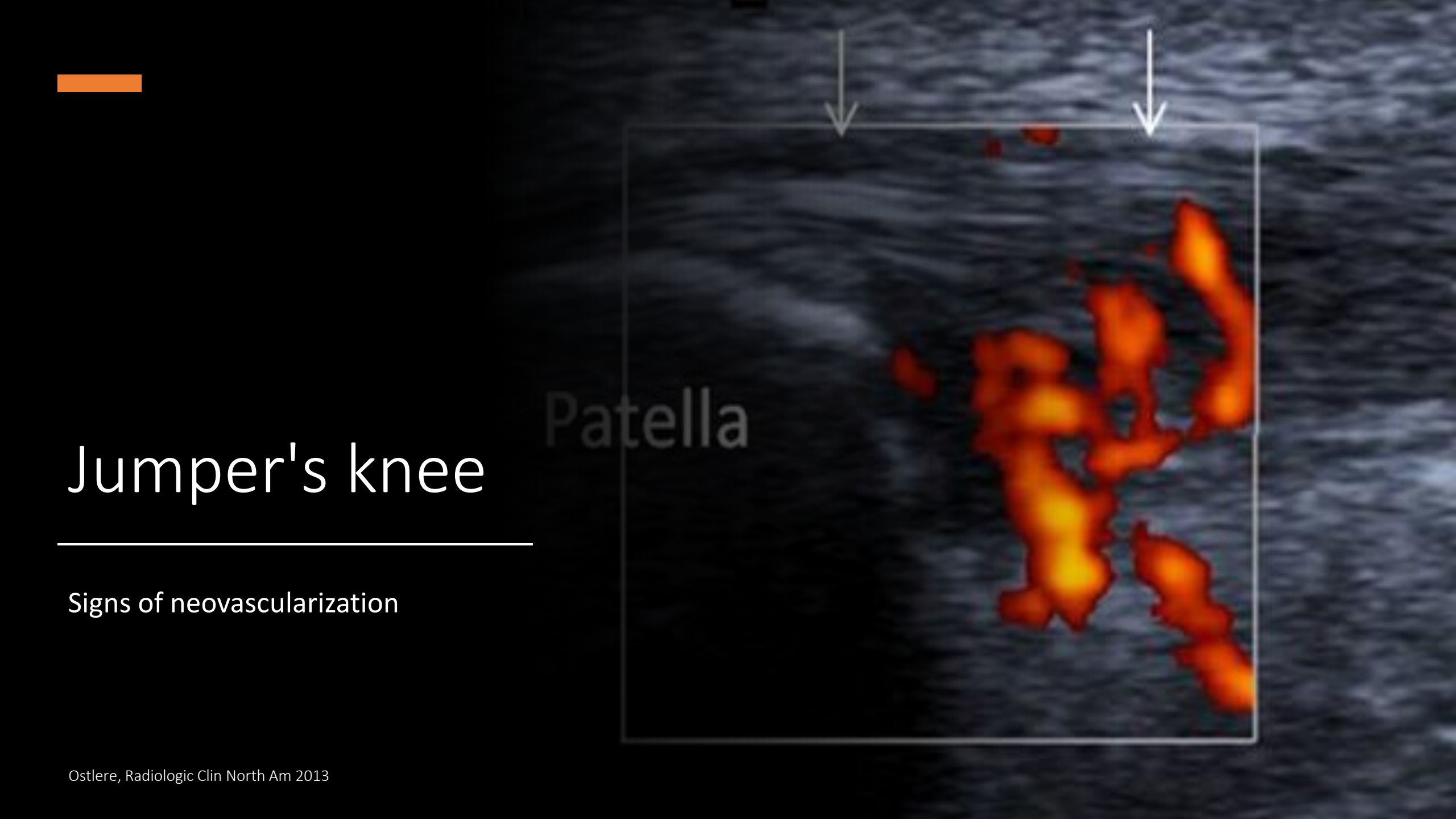


Ostlere, Radiologic Clin North Am 2013

ΤΚΕ=42 mm/1η ώρα
CRP=1,8 mg/dl

Φλεγμονώδης ενθεσίτιδα
Τραυματική ενθεσοπάθεια
Εκφυλιστική τενοντοπαθεια

Τί να σκεφτώ;

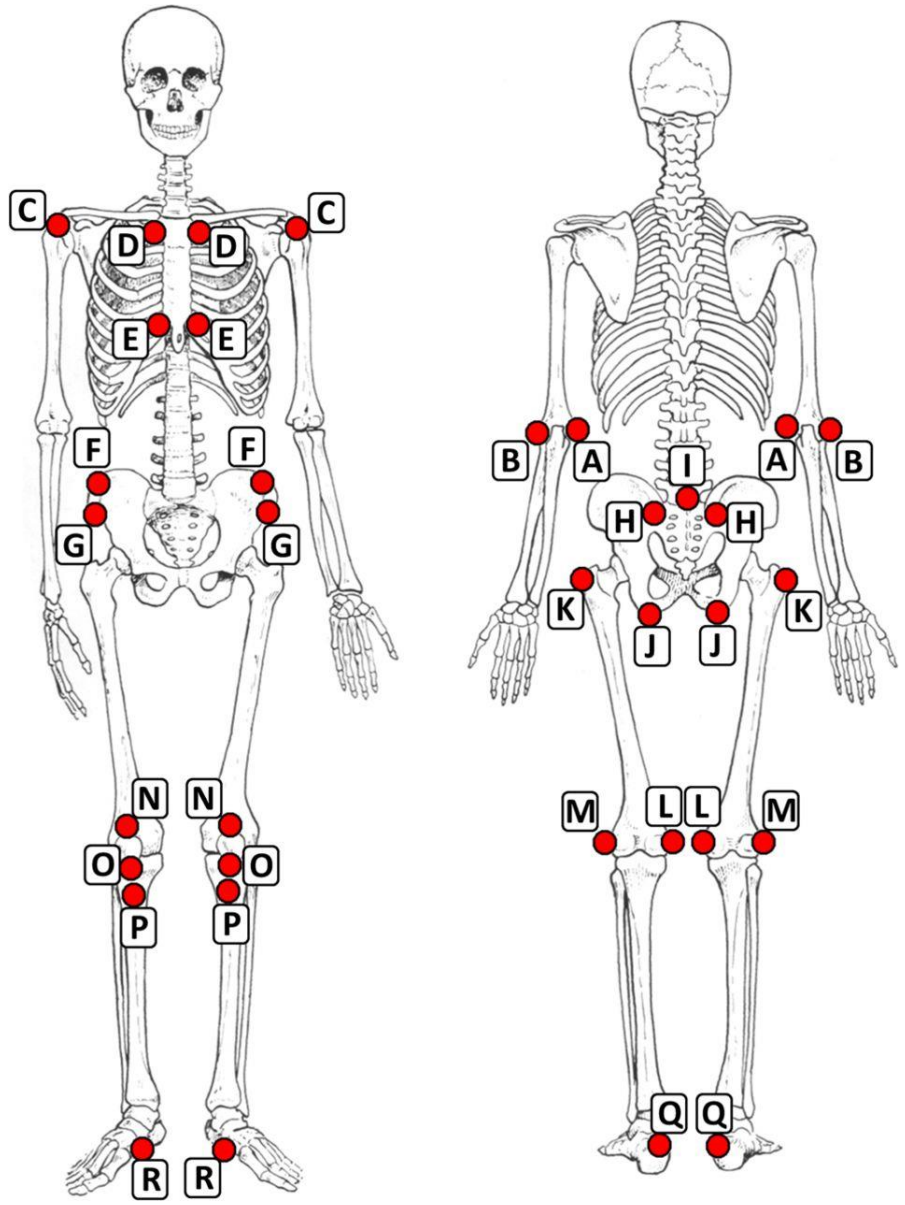
Ενθεσοπάθεια: διαφορική διάγνωση

Table 1 Various Medical Disorders Manifesting with Enthesopathy

Rheumatic Disorders	Metabolic and Endocrine Disorders	Drug-Induced
Spondyloarthropathies	Hyperparathyroidism	Fluoride and fluoroquinolones
Rheumatoid arthritis	Hypoparathyroidism	Glucocorticosteroids
Chondrocalcinosis	X-linked hypophosphatemia	Retinoids
Osteoarthritis	Hypothyroidism	
DISH	Acromegaly	
SAPHO	Hemochromatosis	
	Ochronosis	
	Familial hypercholesterolemia	
	Diabetes mellitus	
	Chronic renal failure	

Slobodin, Semin Arthritis Rheum 2007

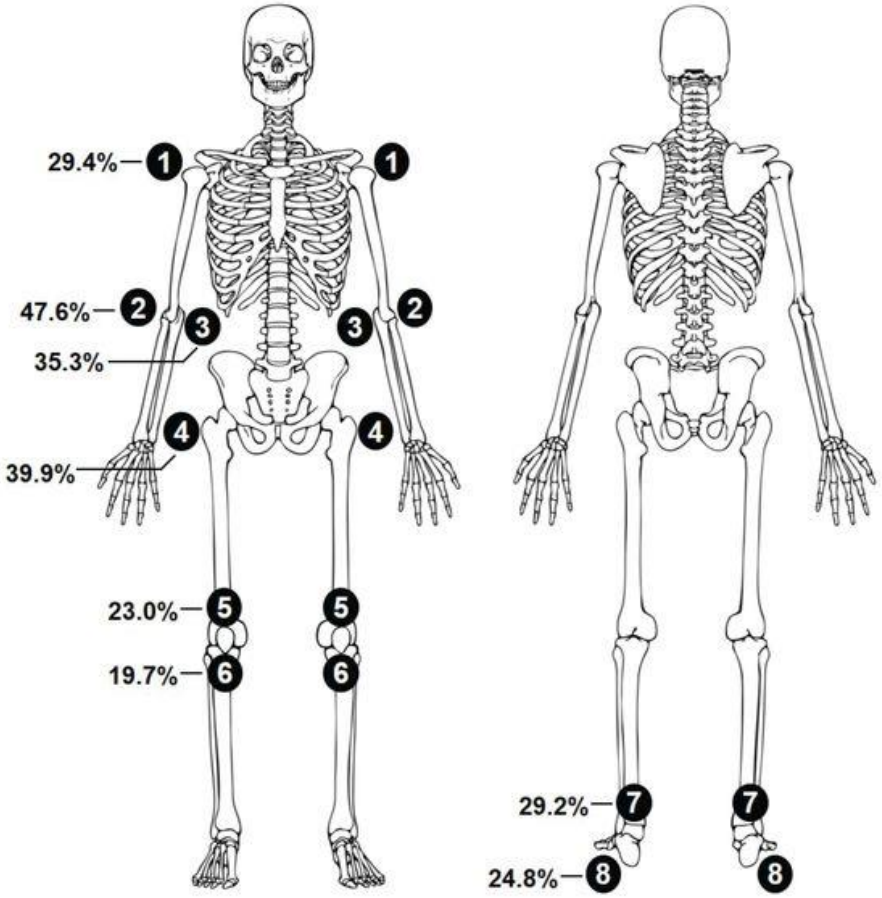
Εντοπίσεις ενθεσίτιδας

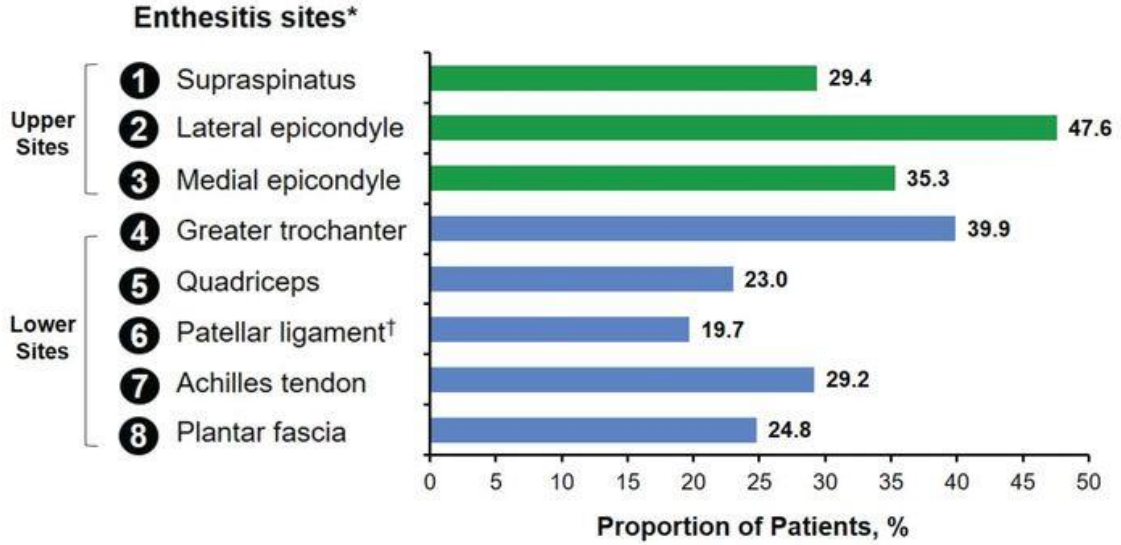


Poggenborg, Ann Rheum Dis 2015

Prevalence of enthesitis by site

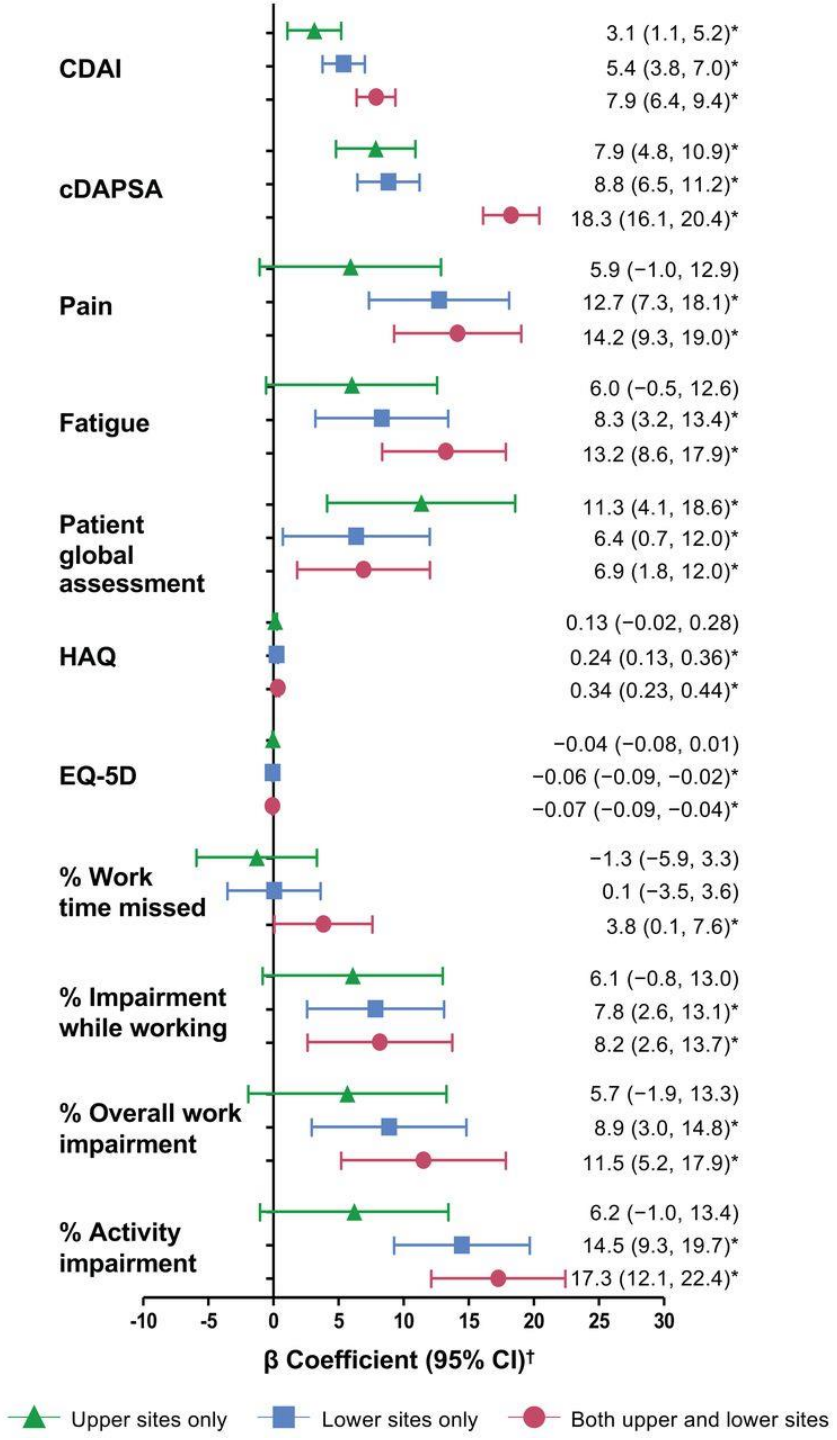
Data from the US Corona registry





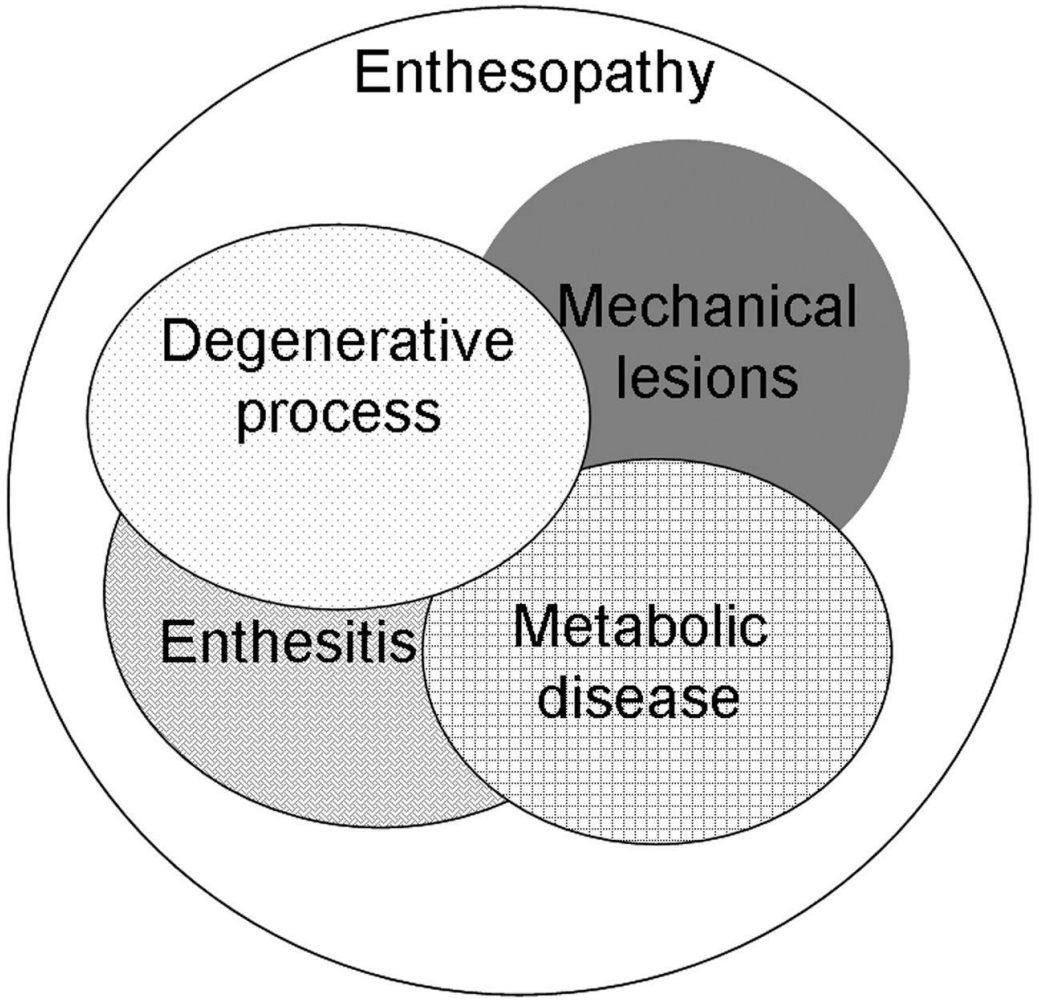
Mease, J Rheumatol 2021

Enthesitis adversely affects disease activity and pain scores



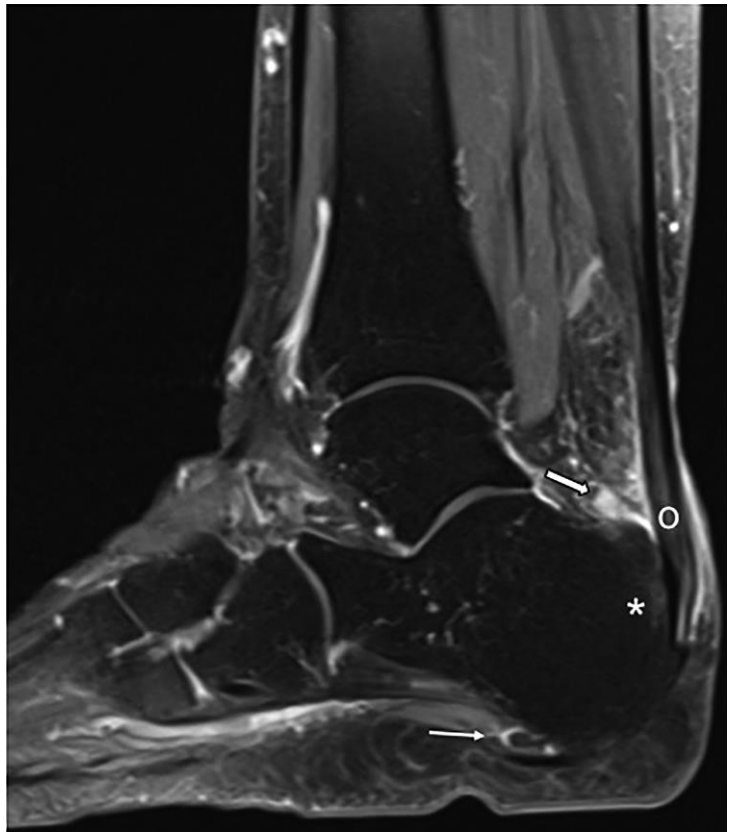
Mease, J Rheumatol 2021

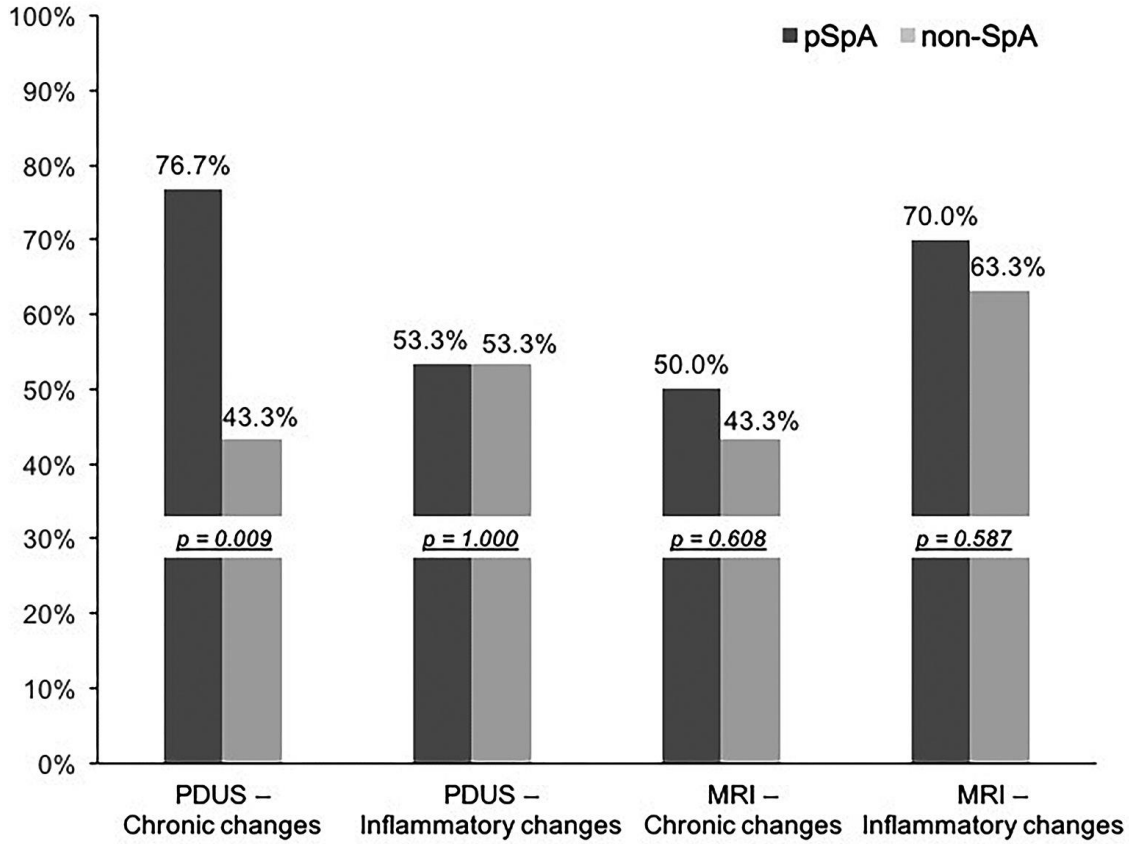
Aetiological classification of enthesopathy



Mandl, Ann Rheum Dis 2011

Ενθεσίτιδα: μηχανική ή φλεγμονώδης;





Baraliakos, RMD Open 2017

Prevalence of any pathological finding for inflammation (intratendinous or peritendinous inflammatory signal, bone marrow oedema at the painful sites) or chronic (thickness of painful tendon, pathological finding of fibrous structure including rupture of the painful tendon, bone erosion or calcification/enthesophyte formation at the site of examination) changes in the lower limbs (heel and knee) between patients with SpA and no SpA

ΤΚΕ=42 mm/1η ώρα
CRP=1,8 mg/dl
HLA B27 (-)

Ναπροξένη 500 mg x2 για 2 εβδομάδες
Ελάχιστη ανταπόκριση

Ετορικοξίμπη 90 mg x 1, για 2 εβδομάδες
Ικανοποιητική ανταπόκριση

...Μετά δύο μήνες...

Πόνος
1. στον θύλακο του μείζονος τροχαντήρα ΑΡ
2. Στο ΔΕ γόνατο
3. Στον ΔΕ αγκώνα (μετά απο αγροτικές εργασίες)

Θυλακίτιδα μείζονος τροχαντήρα
Τενοντίτιδα επιγονατιδικού τένοντα
Εξω επικονδυλίτιδα

Τοπική έγχυση κορτικοειδούς
Ικανοποιητική ανταπόκριση αλλά μετά δύο εβδομάδες υποτροπή.
Ετορικοξίμπη: μέτρια ανταπόκριση, αλλά 2 εβδομάδες μετά την διακοπή, υποτροπή.

Steroid injections for SpA

EULAR recommendations, 2019

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†.	3b* 4†	C	9.5 (1.1)

Systematic review, 2006

- NSAID, physiotherapy, and corticosteroid injections improve entheseal symptoms (level 4, grade D)

Gossec, Ann Rheum Dis 2020, Ritchlin, J Rheumatol 2006

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Gossec, Ann Rheum Dis 2020, Ritchlin, J Rheumatol 2006

Φλεγμονώδης οσφυαλγία
Α/α ιερολαγονίων: ΚΦ
MRI ιερολαγονίων: Non-criteria ευρήματα

Βλάβη στο νύχι
Δερματολόγος: ψωρίαση ή μύκητας;

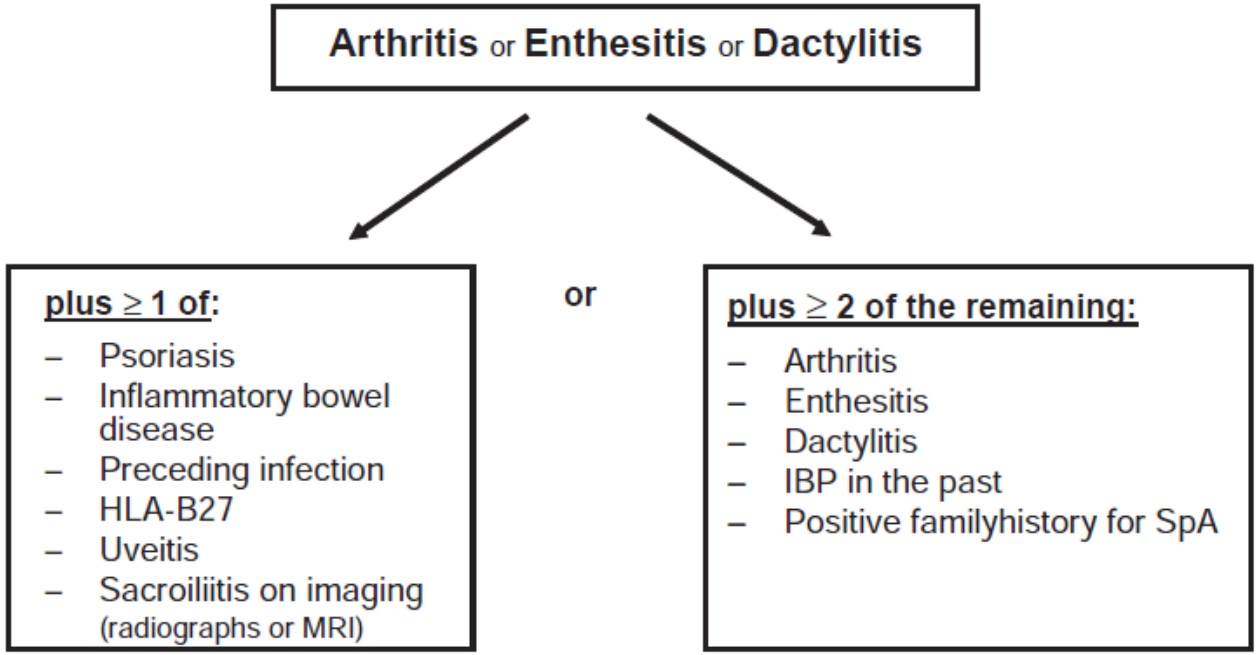
Βλάβη στο νύχι
Δερματολόγος: ψωρίαση ή μύκητας;
Ξύσμα για ανίχνευση μυκήτων: δεν έγινε
Τοπική θεραπεία: αναποτελεσματική

Ταυτόχρονα: υμενίτιδα ΔΕ γόνατος


Homework

Το φάσμα των Σπονδυλαρθρίτιδων ΣπΑ

Peripheral SpA



Rudwaleit, Ann Rheum Dis 2011

Κριτήρια ταξινόμησης ASAS για Αξονική Σπονδυλαρθρίτιδα (ΣπΑ)

Σε ασθενείς με ≥3 μήνες πόνο στη σπονδυλική στήλη και ηλικία έναρξης <45 ετών

Ιερολαγονίτιδα απεικονιστικά * **και** **≥1 χαρακτηριστικό ΣπΑ**	**ή**	**HLA-B27** **και** **≥2 άλλα χαρακτηριστικά ΣπΑ**

***Ιερολαγονίτιδα απεικονιστικά**

- **ενεργός (οξεία) φλεγμονή σε MRI πολύ ύποπτη για ιερολαγονίτιδα σχετιζόμενη με ΣπΑ**
- **Βέβαιη ακτινολογικά ιερολαγονίτιδα με βάση τα τροποποιημένα κριτήρια Νέας Υόρκης**

Χαρακτηριστικά ΣπΑ:

- Φλεγμονώδης πόνος ΣΣ
- Αρθρίτιδα
- Ενθεσίτιδα (πτέρνα)
- Ραγοειδίτιδα
- Δακτυλίτιδα
- Ψωρίαση
- Crohn/ελκώδης κολίτιδα
- Καλή απάντηση σε ΜΣΑΦ
- Οικογενειακό ιστορικό ΣπΑ
- HLA-B27
- Αυξημένη CRP

n=649 ασθενείς με πόνο στη σπονδυλική στήλη

Συνολικά
Ευαισθησία: 82.9%, Ειδικότητα: 84.4%
Μόνο απεικονιστικά
Ευαισθησία: 66.2%, Ειδικότητα: 97.3%
Μόνο κλινικά
Ευαισθησία: 56.6%, Ειδικότητα: 83.3%

Rudwaleit M et al. Ann Rheum Dis 2009;68:777-783 (with permission)

Ψωριασική αρθρίτιδα κριτήρια CASPAR

Classification of Psoriatic-Arthritis: CASPAR Criteria

To meet the CASPAR criteria for PsA, a patient must have inflammatory articular disease (joint, spine, or entheseal) and score ≥3 points based on these categories.

	POINTS
1. Evidence of psoriasis	
Current psoriasis	2 or
Personal history of psoriasis	1 or
Family history of psoriasis	1
2. Psoriatic nail dystrophy	
Pitting, onycholysis, hyperkeratosis	1
3. Negative test result for rheumatoid factor	1
4. Dactylitis	
Current swelling of an entire digit	1 or
History of dactylitis	1
5. Radiologic evidence of juxta-articular new bone formation	
Ill-defined ossification near joint margins on plain x-rays of hand and foot	1

CASPAR, **C**l**AS**sification Criteria for **P**soriatic **AR**thritis
Taylor W. et al. Arthritis Rheum 2006;54:2665-2673

ΣΣΖ 2 γρ ημερησίως

ΣΣΖ 2 γρ ημερησίως
Σε 6 μήνες χωρίς πόνο (& χωρίς ΜΣΑΦ)

ΣΣΖ για την αρθρίτιδα/ ενθεσίτιδα;

Table 3 Efficacy data at baseline, week 24 and at week 48 in the etanercept versus sulfasalazine treatment group

Parameters assessed	Time	Etanercept group (n=40)	Sulfasalazine group (n=36)	p Value*
BASDAI (0–10), mean (±SD)	Baseline†	5.5 (1.3)	6.0 (1.2)	
	Week 24	2.6 (2.3)	4.4 (2.2)	0.002
	Week 48	2.5 (2.0)	4.4 (2.4)	0.001
BASFI (0–10), mean (±SD)	Baseline†	4.3 (2.3)	4.3 (1.8)	
	Week 24	1.9 (2.2)	3.1 (2.2)	0.005
	Week 48	2.0 (2.1)	3.3 (2.2)	0.001
Patient global (0–10), mean (±SD)	Baseline†	6.7 (2.1)	7.1 (1.6)	
	Week 24	2.6 (2.6)	5.1 (2.5)	<0.001
	Week 48	2.6 (2.2)	4.9 (3.0)	<0.001
Physician global (0–10), mean (±SD)	Baseline†	6.4 (1.2)	6.1 (1.5)	
	Week 24	1.8 (1.9)	3.8 (2.5)	<0.001
	Week 48	1.8 (1.8)	4.1 (2.9)	<0.001
Joint count (0–64), mean (±SD)	Baseline†	2.3 (5.8)	1.3 (1.7)	
	Week 24	0.3 (1.3)	0.4 (2.0)	0.70
	Week 48	0.2 (0.7)	0.3 (1.5)	0.48
Enthesitis score (0–17), mean (±SD)	Baseline†	4.4 (4.6)	3.4 (3.4)	
	Week 24	1.6 (4.1)	2.6 (3.6)	0.01
	Week 48	1.8 (4.2)	1.4 (2.9)	0.70
BASMI (0–10), mean (±SD)	Baseline†	1.9 (1.7)	1.7 (1.4)	
	Week 24	1.7 (1.6)	1.9 (1.6)	0.28
	Week 48	1.6 (1.8)	1.9 (1.7)	0.32
EQ-5D (0–1), mean (±SD)	Baseline†	0.6 (0.3)	0.6 (0.3)	
	Week 24	0.9 (0.2)	0.7 (0.2)	0.01
	Week 48	0.8 (0.2)	0.7 (0.3)	0.047
AS-QoL (0–18), mean (±SD)	Baseline†	9.7 (4.5)	9.3 (3.6)	
	Week 24	4.1 (4.3)	7.4 (5.0)	<0.001
	Week 48	4.4 (4.8)	7.5 (5.4)	<0.001
CRP (ref 5 mg/l), mean (±SD)	Baseline†	11.9 (13.2)	10.6 (14.9)	
	Week 24	4.2 (3.5)	8.5 (11.8)	0.07
	Week 48	4.3 (3.7)	8.7 (12.5)	0.13

*p Values for comparison of changes in the parameters between both groups by analysis of covariance.
†No significant differences at baseline between etanercept and sulfasalazine. Every mean value refers to the complete intention-to-treat population (etanercept, n=40; sulfasalazine, n=36).
ASQoL, ankylosing spondylitis quality of life questionnaire; BASDAI, Bath ankylosing spondylitis disease activity index; BASFI, Bath ankylosing spondylitis disease functional index; BASMI, Bath ankylosing spondylitis metrology index; CRP, C-reactive protein (reference range <5mg/l); EQ-5D, EuroQoL index.

The ESTHER trial

Song, Ann Rheum Dis 2011

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The ESTHER trial

Song, Ann Rheum Dis 2011

SSZ for inflammatory back pain?

PsA

Axial disease

Compared to AS:

Can be asymptomatic

Asymmetrical sacroiliitis

More common and worse peripheral arthritis

Spondylitis w or w/o sacroiliitis

Poddubnyy. Semin Arthritis Rheum 2021.
Philip Mease, @RheumNow 2022

...12 μήνες μετά...

Υποτροπή της συμπτωματολογίας από:
1. Το ΔΕ γόνατο
2. Την επικονδυλιτιδα ΔΕ αγκώνα

και επιπλέον δακτυλίτιδα 2ου δακτύλου ΑΡ ποδός

Συνδυασμός:
Υμενιτιδας
Ενθεσίτιδας
Δακτυλίτιδας

Συνδυασμός:
Υμενιτιδας
Ενθεσίτιδας
Δακτυλίτιδας

Βιολογική θεραπεία με etanercept

Ενθεσίτιδα- δακτυλίτιδα

Ποιά η καλύτερη αγωγή;

PRESTO Trial

Etanercept

50 mg/week

Vs

50 mg x2/week

in PsA

	Etanercept 50 mg BIW/QW (n=379)	Etanercept 50 mg QW/QW (n=373)
Enthesitis		
Enthesitis at baseline	153 (40.4)	134 (35.9)
Improved week 12	109/148 (73.7, 65.8 to 80.5)	91/130 (70.0, 61.3 to 77.7)
Improved week 24	114/141 (80.9, 73.4 to 87.0)	100/123 (81.3, 73.3 to 87.8)

Sterry, BMJ 2010

Ενθεσίτιδα- δακτυλίτιδα

Ποιά η καλύτερη αγωγή;

PRESTO Trial

Etanercept

50 mg/week

Vs

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in PsA

	Etanercept 50 mg BIW/QW (n=379)	Etanercept 50 mg QW/QW (n=373)
Enthesitis		
Enthesitis at baseline	153 (40.4)	134 (35.9)
Improved week 12	109/148 (73.7, 65.8 to 80.5)	91/130 (70.0, 61.3 to 77.7)
Improved week 24	114/141 (80.9, 73.4 to 87.0)	100/123 (81.3, 73.3 to 87.8)
Dactylitis		
Dactylitis at baseline	158 (41.7)	160 (42.9)
Mean score at baseline	7.93	8.16
Week 12:		
Mean (SD) score	2.06 (5.51)	2.52 (7.69)
Mean % change from baseline	74.3	78.4
Week 24:		
Mean (SD) score	1.42 (5.12)	1.80 (7.15)
Mean % change from baseline	84.5	84.8

Sterry, BMJ 2010

Regarding bDMARDs, the taskforce now regards all bDMARDs as having efficacy of a similar magnitude for enthesitis and hence the preference for TNFi has been deleted.[1]

EULAR recommendations for the treatment of PsA- 2019 update

Gossec, Ann Rheum Dis 2020

Biologics for enthesitis

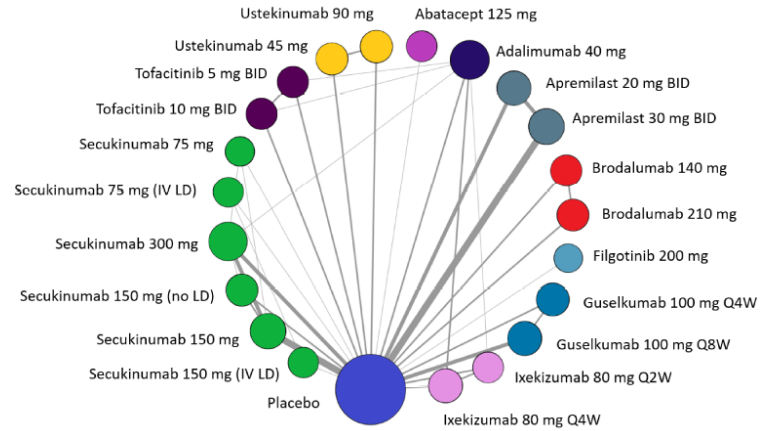
Study	Author	Year	Drug	Outcome	Time of outcome (weeks)	Result
IMPACT 2 (1)	Antoni	2005	IFX vs. PLB	Patients with enthesitis	14	22% vs. 34% ($p = 0.016$)
					24	20% vs. 37% ($p = 0.002$)
(13)	Genovese	2007	ADA vs. PLB	Reduction of enthesitis	12	−0.5 vs. −0.2 ($p > 0.05$)
GO-REVEAL (18)	Kavanaugh	2009	GOL 50 mg vs. PLB	Patients with enthesitis	14	55% vs. 71% ($p = 0.008$)
			GOL 100 mg vs. PLB			61% vs. 71% ($p = 0.10$)
			GOL 50 mg vs. PLB		24	49% vs. 69% ($p = 0.002$)
			GOL 100 mg vs. PLB			50% vs. 69% ($p = 0.003$)
GO-REVEAL (61)	Kavanaugh	2012	GOL 50 mg vs. PLB	Modified MASES index (change from baseline)	Week 52	56.3 ± 62.4 vs. 39.1 ± 76.1
			GOL100 mg vs. PLB			51.9 ± 64.2 vs. 39.1 ± 76.1
RESPOND (22)	Baranauskaite	2012	IFX+MTX vs. MTX	Reduction of enthesitis	16	2 vs. 1 ($p = 0.082$)
PSUMMIT 1 (24)	McInnes	2013	UST vs. PLB	Patients with enthesitis	24	64.6% vs. 81% ($p = 0.006$)
GO-REVEAL (64)	Kavanaugh	2014	GOL 50 mg vs. PLB	Modified MASES index	Week 256	1.9 ± 3.3 vs. 2.4 ± 4.0
			GOL100 mg vs. PLB			2.0 ± 3.4 vs. 2.4 ± 4.0
PSUMMIT 2 (28)	Ritchlin	2014	UST 45 mg vs. PLB	MASES	24	−33,33% vs. 0% ($p > 0.05$)
			UST 90 mg vs. PLB			−48.33% vs. 0% ($p<0.01$)
			UST 45 mg vs. PLB		52	−36.67% vs. −33.33% ($p > 0.05$)
			UST 90 mg vs. PLB			−60% vs. −33.33% ($p > 0.05$)
RAPID-PsA (26)	Mease	2014	CZP 200 mg Q2W vs. PLB	LEI	24	−2.0 vs. −1.1 ($p<0.001$)
			CZP 400 mg Q4W vs. PLB	LEI		−1.8 vs. −1.1 ($p = 0.003$)
(32)	Mease	2015	SEC (pooled data) vs. PLB	Resolution of enthesitis	24	47.5% vs. 12.8% ($p<0.05$)
FUTURE 2 (31)	McInnes	2015	SEC (pooled data) vs. PLB	Resolution of enthesitis	24	22% vs. 40% ($p = 0.919$)
SPIRIT-P1 (37)	Mease	2017	IXE Q2W vs. PLB vs. ADA	LEI (responders)	Week 12	47.4 vs. 28.1 vs. 35.2 ($p<0.05$)*
			IXE Q4W vs. PLB vs. ADA			27.9 vs. 28.1 vs. 35.2
			IXE Q2W vs. PLB vs. ADA		Week 24	38.6 vs. 19.3 vs. 33.3 ($p \leq 0.025$)*
			IXE Q4W vs. PLB vs. ADA			42.6 vs. 19.3 vs. 35.2 ($p \leq 0.01$)*
SPITIT-P2 (38)	Nash	2017	IXE Q2W vs. PLB	LEI (proportion of patients with a response)	Week 24	31% vs. 22% ($p = 0.27$)
			IXE Q4W vs. PLB			35% vs. 22% ($p = 0.08$)
FUTURE 5 (47)	Mease	2018	SEC 150 mg vs. PLB	Resolution of enthesitis	Week 16	54.6% vs. 35.4% ($p < 0.05$)
			SEC 300 mg vs. PLB			55.7% vs. 35.4% ($p < 0.05$)
ECLIPSA (50)	Araujo	2019	UST vs. TNFi	SPARCC = 0	Week 12	74% vs. 42% ($p = 0.018$)
				MASES = 0		82% vs. 50% ($p = 0.032$)
				LEI = 0		78% vs. 50% ($p = 0.005$)
SPIRIT H2H (51)	Mease	2020	IXE vs. ADA	SPARCC = 0	Week 24	45.0% vs. 56.6% ($p = 0.019$)
				LEI = 0		55.1% vs. 59.7% ($p = 0.432$)
EXCEED (55)	McInnes	2020	SEC vs. ADA	resolution of enthesitis	Week 52	53% vs. 50% ($p = 0.5117$)

*ADA, adalimumab; IFX, infliximab; GOL, golimumab; CZP, certolizumab; UST, ustekinumab; SEC, secukinumab; IXE, ixekizumab; BRD, brodalumab; MTX, methotrexate; PLB, placebo; MASES, Maastricht Ankylosing Spondylitis Enthesitis Score; LEI, Leeds Enthesitis Index; SPARCC, Spondyloarthritis Research Consortium of Canada Enthesitis Index; TNFi, tumor necrosis factor inhibitor; *IXE vs. placebo.*

Torres, Front Med Rheumatol 2021

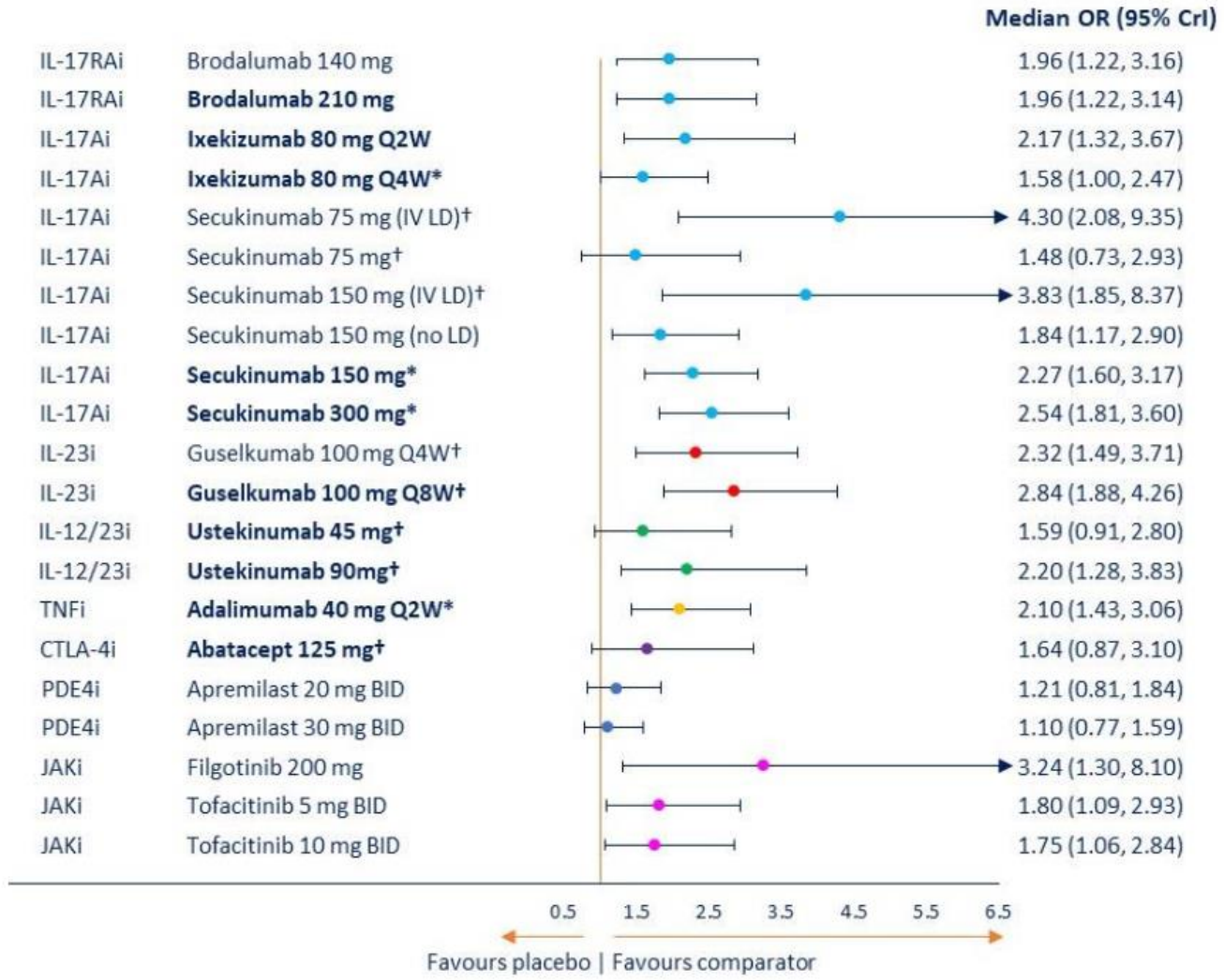
Biologics for enthesitis

Figure S 10 Network diagram for resolution of enthesitis



Node size denotes total number of patients on that treatment; line thickness denotes total number of studies informing that comparison.

Figure S 12 Forest plot for all interventions versus placebo on resolution of enthesitis



McInes, RMD Open 2022

Biologics for dactylitis

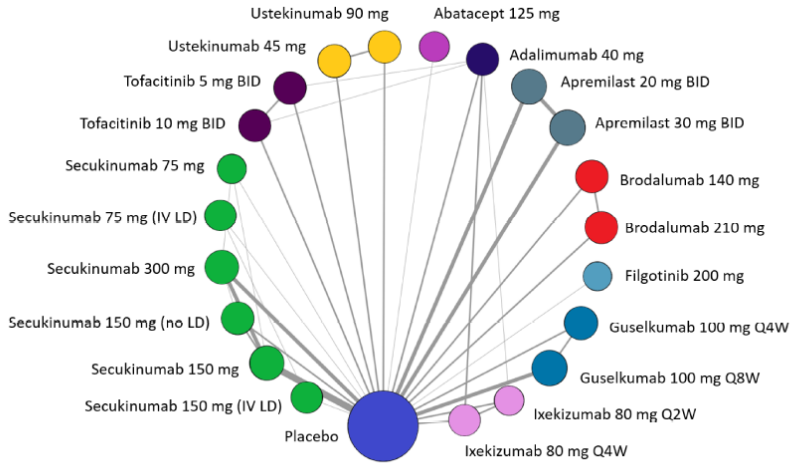
Study	Author	Year	Intervention	Outcome	Time of outcome	Result
IMPACT 2 (1)	Antoni	2005	IFX vs. placebo	At least 1 dactylitis digit	Week 14	22% vs. 34% ($p = 0.025$)
					Week 24	12% vs. 34% ($p<0.001$)
GO-REVEAL (18)	Kavanaugh	2009	GOL 50 mg vs. placebo	Patients with dactylitis	Week 14	22% vs. 26% ($p = 0.46$)
			GOL 100 mg vs. placebo			17% vs. 26% ($p = 0.10$)
			GOL 50 mg vs. placebo		Week 24	16% vs. 22% ($p = 0.21$)
			GOL 100 mg vs. placebo			14% vs. 22% ($p = 0.09$)
GO-REVEAL (61)	Kavanaugh	2012	GOL 50 mg vs. placebo	Dactylitis score change from baseline	Week 52	−4.20 ± 4.81 vs. −1.68 ± 2.79
			GOL 100 mg vs. placebo			−4.55 ± 6.60 vs. −1.68 ± 2.79
PSUMMIT 1 (24)	McInnes	2013	UST vs. placebo	Patients with dactylitis	Week 24	56.2% vs. 76.1% ($p = 0.0013$)
PSUMMIT 2 (28)	Ritchlin	2014	UST 45 mg vs. placebo	Percent change in dactylitis score	Week 24	0.0 vs. 0.0
			UST 90 mg vs. placebo			−64.58 vs. 0.0
			UST 45 mg vs. placebo		Week 52	−95.00 vs. −100
RAPID-PsA (26)	Mease	2014	CZP 200 mg Q2W vs. placebo	LDI change from baseline	Week 24	−40.7 vs. −22.0 ($p = 0.002$)
			CZP 400 mg Q4W vs. placebo			−53.5 vs. −22.0 ($p<0.001$)
GO-REVEAL (65)	Kavanaugh	2014	GOL 50 mg vs. placebo	Dactylitis score	Week 260	6.3 ± 6.1 vs. 3.1 ± 2.1
			GOL 100 mg vs. placebo			5.4 ± 6.7 vs. 3.1 ± 2.1
			UST 90 mg vs. placebo			−90.91 vs. −100
(30)	Mease	2015	SEC (pooled data) vs. placebo	Resolution of dactylitis	Week 24	52.4% vs. 15.5 ($p<0.05$)
FUTURE 2 (31)	McInnes	2015	SEC (pooled data) vs. placebo	Resolution of dactylitis	Week 24	47% vs. 15% ($p = 0.919$)
SPIRIT-P1 (37)	Mease	2017	IXE Q2W vs. placebo vs. ADA	LDI-B (change from baseline)	Week 12	−63.9 (10.6) vs. −36.3 (10.3) vs. −62.1 (11.9) ($p \leq 0.05$)*
			IXE Q4W vs. placebo vs. ADA			−72.8 (8.8) vs. −36.3 (10.3) −62.1 (11.9) ($p \leq 0.001$)*
			IXE Q2W vs. placebo vs. ADA		Week 24	−66.1 (9.8) vs. −33.7 (9.7) vs. −76.0 (10.9) ($p \leq 0.01$)*
			IXE Q4W vs. placebo vs. ADA			−75.4 (8.1) vs. −33.7 (9.7) −76.0 (10.9) ($p \leq 0.001$)*
SPIRIT-P2 (38)	Nash	2017	IXE Q2W vs. placebo	LDI-B (change from baseline)	Week 24	−32.1 (6.7) vs. −36.2 (8.4) $p = 0.65$
			IXE Q4W vs. placebo			−34.7 (6.7) VS. −36.2 (8.4) $p = 0.85$
FUTURE 5 (47)	Mease	2018	SEC 150 mg vs. placebo	Resolution of dactylitis	Week 16	57.5% vs. 32.3% ($p < 0.05$)
			SEC 300 mg vs. placebo			65.9% vs. 32.3% ($p < 0.05$)
SPIRIT H2H (51)	Mease	2020	IXE vs. ADA	LDI-B = 0	Week 24	88.1 vs. 93.1 ($p = 0.658$)
EXCEED (55)	McInnes	2020	SEC vs. ADA	Resolution of dactylitis	Week 52	75% vs. 70% ($p = 0.3560$)

*ADA, adalimumab; IFX, infliximab; GOL, golimumab; CZP, certolizumab; UST, ustekinumab; SEC, secukinumab; IXE, ixekizumab; BRD, brodalumab; PLB, placebo; LDI, Leeds Dactylitis Index; *IXE vs. placebo.*

Torres, Front Med Rheumatol 2021

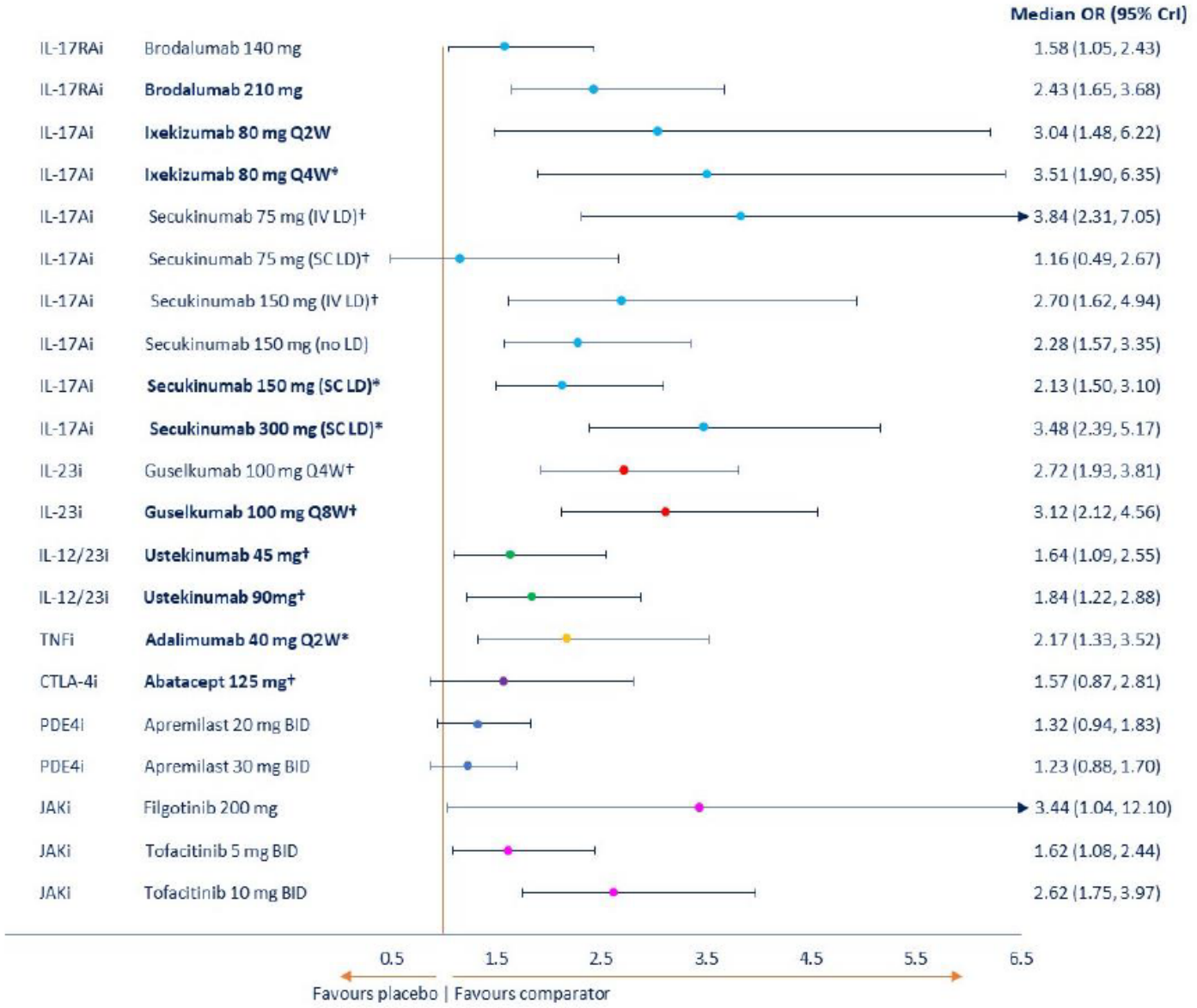
Biologics for dactylitis

Figure S 11 Network diagram for resolution of dactylitis



Node size denotes total number of patients on that treatment; line thickness denotes total number of studies informing that comparison.

Figure S 13 Forest plot of treatment effects for all interventions versus placebo on resolution of dactylitis



McInness, RMD Open 2022

...16μήνες μετά...

Υποτροπή της συμπτωματολογίας από:
Το ΔΕ γόνατο (υμενίτιδα με μεγάλη συλλογή υγρού)

Παρακέντηση:

Αφαίρεση 60 κ εκ αρθρικού κλάσσης ΙΙ

Μικροσκόπηση: όχι κρύσταλλοι

Κύτταρα: 3600/κκχ

(Πολυμορφοπύρηνα: 82%)

Καλλιέργεια: στείρα

Ενδοαρθρική έγχυση κορτικοειδούς
Μερική ανταπόκριση

Μονοαρθρίτιδα

Secukinumab

Αλλαγή βιολογικής θεραπείας: μετά τον aTNF;

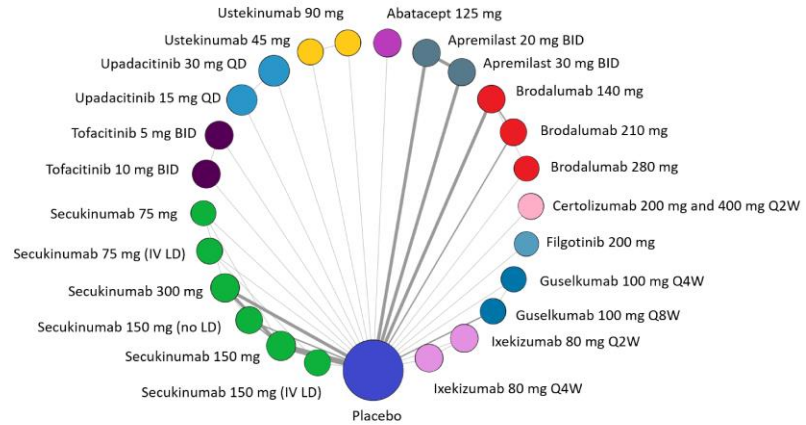
Οποιοσδήποτε βιολογικός παράγοντας.

EULAR 2019 guideline

Gossec, Ann Rheum Dis 2020

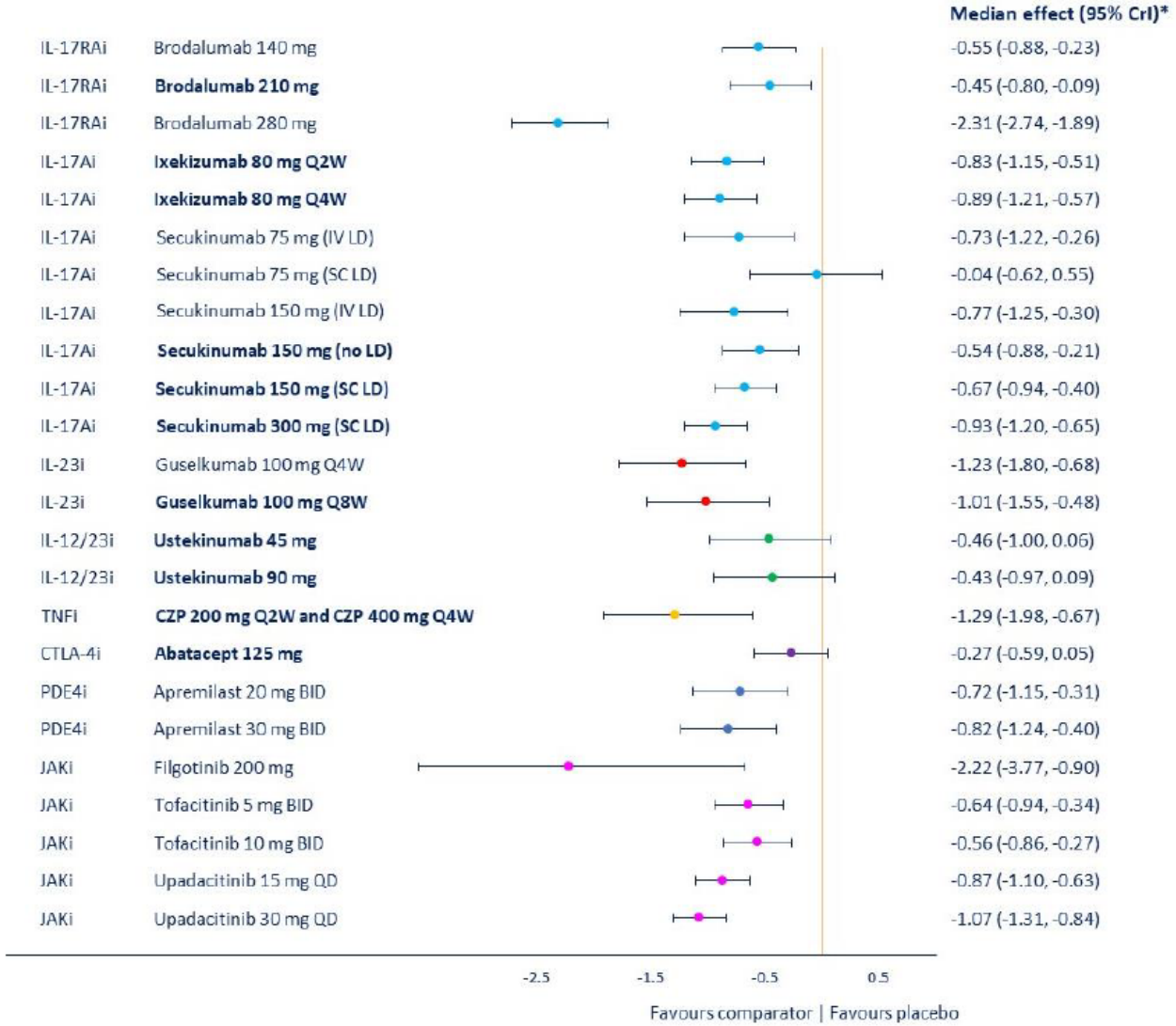
Biologics and targeted treatments in biologic-experienced patients

Figure S 4. Network diagram for ACR response in bDMARD-experienced subgroup



Node size denotes total number of patients on that treatment; line thickness denotes total number of studies informing that comparison.
Abbreviations: BID, twice daily; IV, intravenous; LD, loading dose; mg, milligram; QD, daily; Q2W, every 2 weeks; Q4W, every 4 weeks; Q8W, every 8 weeks.

Figure S 7 Forest plot of treatment effects for all interventions versus placebo on ACR response in bDMARD-experienced subgroup

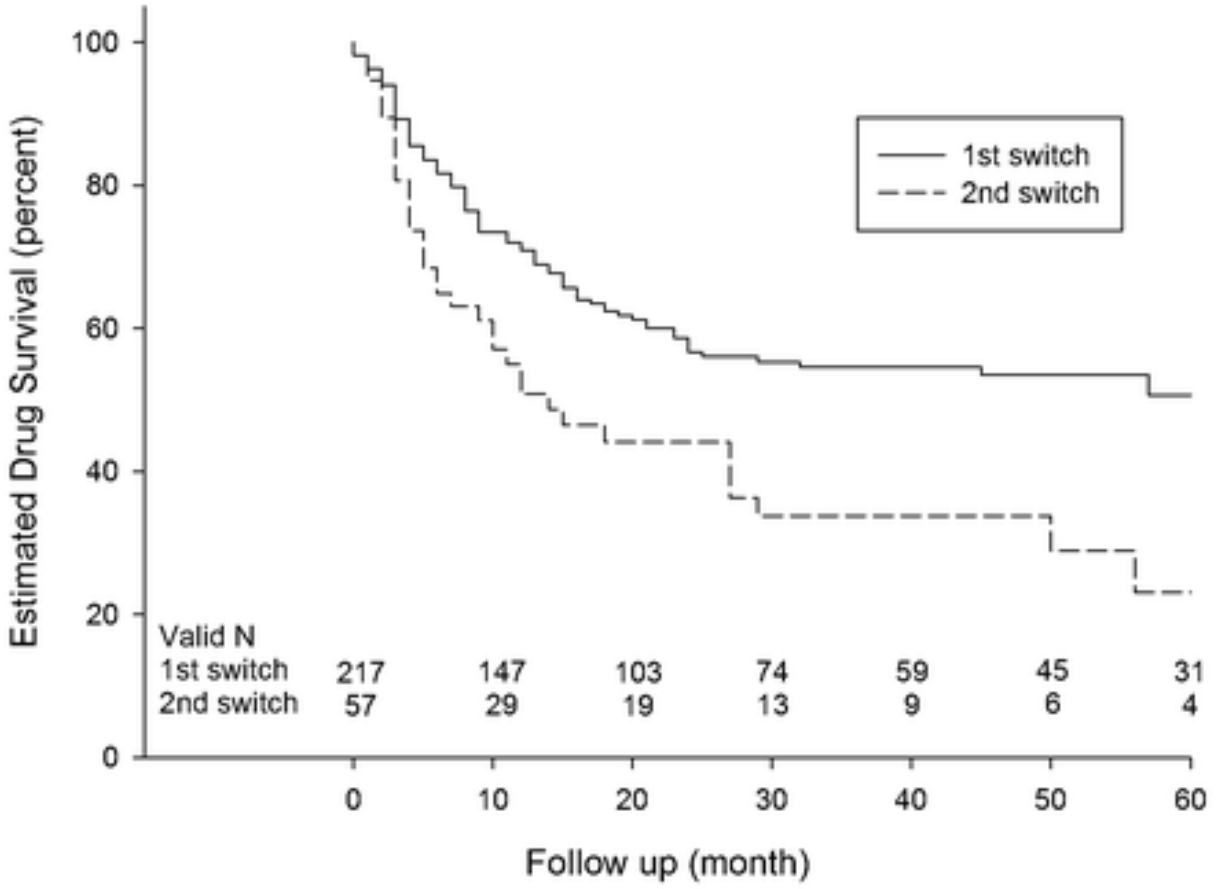


ACR treatment effect was based on a fixed-effects model with placebo adjustment. Key comparators are shown in bold.
Abbreviations: BID, twice daily; BIW, twice weekly; CrI, credible interval; CZP, certolizumab pegol; IV, intravenous; kg, kilogram; LD, loading dose; mg, milligram; MTX, methotrexate; QD, daily; QW, weekly; Q2W, every two weeks; Q4W, every four weeks; Q8W, every eight weeks; Q12W, every twelve weeks; SUCRA, surface under the cumulative ranking curve.

McInness, RMD Open 2022

Low effectiveness of a second TNF switch

Data from a Swedish registry



Kristensen, J Rheumatol 2016

BSR PsA treatment guideline (2022)

Primary TNF inh failure > biologic/targeted treatment with another MoA

Secondary TNF inh failure > another TNF inh

Tucker, Rheumatology 2022

ACR guideline 2018

Table 3. Recommendations for treatment of patients with active psoriatic arthritis despite treatment with a TNFi biologic, as monotherapy or in combination with MTX (PICOs 26–35; 70–75)*

	Level of evidence (evidence [refs.] reviewed)†
In adult patients with active PsA despite treatment with a TNFi biologic monotherapy,	
1. **Switch to a different TNFi biologic over switching to an IL-17i biologic** (PICO 28) **Conditional recommendation** based on low-quality evidence; may consider an IL-17i if the patient had a primary TNFi biologic efficacy failure or a TNFi biologic–associated serious adverse event or severe psoriasis.‡	Low (72, 73, 90–93, 95)
2. **Switch to a different TNFi biologic over switching to an IL-12/23i biologic** (PICO 27) **Conditional recommendation** based on low-quality evidence; may consider an IL-12/23i if the patient had a primary TNFi biologic efficacy failure or a TNFi biologic–associated serious adverse effect or prefers less frequent drug administration.	Low (72, 73, 99, 100)
3. **Switch to a different TNFi biologic over switching to abatacept** (PICO 70) **Conditional recommendation** based on low-quality evidence; may consider abatacept if the patient had a primary TNFi biologic efficacy failure or TNFi biologic–associated serious adverse effect.	Low (72, 73, 103, 104)
4. **Switch to a different TNFi biologic over switching to tofacitinib** (PICO 73) **Conditional recommendation** based on low-quality evidence; may consider tofacitinib if the patient prefers an oral therapy or had a primary TNFi biologic efficacy failure or a TNFi biologic–associated serious adverse effect.	Low (62–66, 72–78, 105)
5. **Switch to a different TNFi biologic (with or without MTX) over adding MTX to the**	Very low
patient prefers IV dosing or in patients with recurrent or serious infections.	
8. **Switch to an IL-17i biologic over tofacitinib** (PICO 75) **Conditional recommendation** based on low-quality evidence; may consider tofacitinib if the patient prefers an oral therapy or in patients with concomitant IBD or a history of recurrent *Candida* infections.	Low (90–93, 105)
9. **Switch to an IL-12/23i biologic over abatacept** (PICO 71) **Conditional recommendation** based on of low-quality evidence; may consider abatacept if the patient prefers IV dosing or in patients with recurrent or serious infections.	Low (99, 100, 103, 104)
10. **Switch to an IL-12/23i biologic over tofacitinib** (PICO 74) **Conditional recommendation** based on low-quality evidence; may consider tofacitinib if the patient prefers an oral therapy.	Low (98–100, 105)
11. **Switch to a different TNFi biologic monotherapy over switching to a different TNFi biologic and MTX combination therapy** (PICO 30) **Conditional recommendation** based on very-low-quality evidence; may consider switching to a TNFi biologic and MTX combination therapy if the current TNFi biologic is infliximab.	Very low
12. **Switch to an IL-17i biologic monotherapy over switching to an IL-17i biologic and MTX combination therapy** (PICO 32) **Conditional recommendation** based on very-low-quality evidence; may consider switching to an IL-17i biologic and MTX combination therapy in patients with concomitant uveitis, as uveitis may respond to MTX therapy.	Very low
13. **Switch to an IL-12/23i biologic monotherapy over switching to an IL-12/23i biologic and MTX combination therapy** (PICO 31) **Conditional recommendation** based on very-low-quality evidence; may consider switching to an IL-12/23i biologic and MTX combination therapy if the patient has severe psoriasis.	Very low

1. **Switch to a different TNFi biologic over switching to an IL-17i biologic** (PICO 28) Low (72, 73, 90–93, 95)

Conditional recommendation based on low-quality evidence; may consider an IL-17i if the patient had a primary TNFi biologic efficacy failure or a TNFi biologic–associated serious adverse event or severe psoriasis.‡

Singh, Arthritis Rheumatol 2019

ACR guideline 2018

Table 3. Recommendations for treatment of patients with active psoriatic arthritis despite treatment with a TNFi biologic, as monotherapy or in combination with MTX (PICOs 26–35; 70–75)*

	Level of evidence (evidence [refs.] reviewed)†
In adult patients with active PsA despite treatment with a TNFi biologic monotherapy,	
1. **Switch to a different TNFi biologic over switching to an IL-17i biologic** (PICO 28) **Conditional recommendation** based on low-quality evidence; may consider an IL-17i if the patient had a primary TNFi biologic efficacy failure or a TNFi biologic–associated serious adverse event or severe psoriasis.‡	Low (72, 73, 90–93, 95)
2. **Switch to a different TNFi biologic over switching to an IL-12/23i biologic** (PICO 27) **Conditional recommendation** based on low-quality evidence; may consider an IL-12/23i if the patient had a primary TNFi biologic efficacy failure or a TNFi biologic–associated serious adverse effect or prefers less frequent drug administration.	Low (72, 73, 99, 100)
3. **Switch to a different TNFi biologic over switching to abatacept** (PICO 70) **Conditional recommendation** based on low-quality evidence; may consider abatacept if the patient had a primary TNFi biologic efficacy failure or TNFi biologic–associated serious adverse effect.	Low (72, 73, 103, 104)
4. **Switch to a different TNFi biologic over switching to tofacitinib** (PICO 73) **Conditional recommendation** based on low-quality evidence; may consider tofacitinib if the patient prefers an oral therapy or had a primary TNFi biologic efficacy failure or a TNFi biologic–associated serious adverse effect.	Low (62–66, 72–78, 105)
5. **Switch to a different TNFi biologic (with or without MTX) over adding MTX to the same TNFi biologic monotherapy** (PICO 26 and 26A)	Very low
candida infections.	
9. **Switch to an IL-12/23i biologic over abatacept** (PICO 71) **Conditional recommendation** based on of low-quality evidence; may consider abatacept if the patient prefers IV dosing or in patients with recurrent or serious infections.	Low (99, 100, 103, 104)
10. **Switch to an IL-12/23i biologic over tofacitinib** (PICO 74) **Conditional recommendation** based on low-quality evidence; may consider tofacitinib if the patient prefers an oral therapy.	Low (98–100, 105)
11. **Switch to a different TNFi biologic monotherapy over switching to a different TNFi biologic and MTX combination therapy** (PICO 30) **Conditional recommendation** based on very-low-quality evidence; may consider switching to a TNFi biologic and MTX combination therapy if the current TNFi biologic is infliximab.	Very low
12. **Switch to an IL-17i biologic monotherapy over switching to an IL-17i biologic and MTX combination therapy** (PICO 32) **Conditional recommendation** based on very-low-quality evidence; may consider switching to an IL-17i biologic and MTX combination therapy in patients with concomitant uveitis, as uveitis may respond to MTX therapy.	Very low
13. **Switch to an IL-12/23i biologic monotherapy over switching to an IL-12/23i biologic and MTX combination therapy** (PICO 31) **Conditional recommendation** based on very-low-quality evidence; may consider switching to an IL-12/23i biologic and MTX combination therapy if the patient has severe psoriasis.	Very low

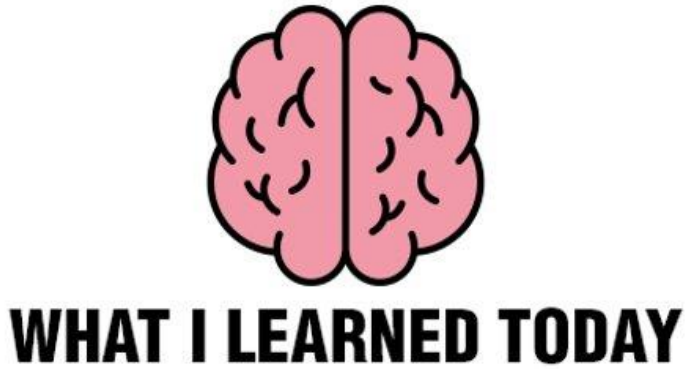
5. **Switch to a different TNFi biologic (with or without MTX) over adding MTX to the same TNFi biologic monotherapy** (PICO 26 and 26A) Very low

Conditional recommendation based on very-low-quality evidence; may consider adding MTX when patients have demonstrated partial response to the current TNFi biologic therapy, especially if the TNFi biologic is a monoclonal antibody.

Singh, Arthritis Rheumatol 2019

...12 μήνες μετά...

Σε κλινική ύφεση
Πολύ μικρή συλλογή υγρού στο γόνατο
Χωρίς ευαισθησία
Χωρίς λειτουργικό περιορισμό
Πλήρης κινητικότητα της άρθρωσης



Αδιαφοροποίητες εικόνες-
η διάγνωση μπορεί να αργήσει

Η πολυμορφία της νόσου μπορεί να απαιτεί προσαρμογές στην θεραπεία

Πολλές θεραπείες

Μία στρατηγική (T2T)

Η επιλογή μεταξύ των θεραπειών και η σωστή σειρά των επιλογών παραμένει θέμα προσωπικών προτιμήσεων και εμπειρίας