Letter to the Editor

Comment on: Efficacy and safety of anti-TNF therapies in psoriatic arthritis: an observational study from the British Society for Rheumatology Biologics Register

Sir, Saad et al. [1] report on predictors of treatment response and disease remission when using anti-TNF therapies in PsA. Analysis from the British Society for Rheumatology Biologics Register provides a large cohort to analyse and offers insight into treatment responses. However, we are concerned about the use of the disease activity score with 28-joint count (DAS-28) in patients with PsA. We recognize that retrospective analysis of interventional trial data sets has provided some evidence to support the use of DAS-28 as a response measure in polyarticular PsA [2]. However, the patients in these interventional trials had baseline swollen joint counts of around 20 rather than 9.

The use of DAS-28 in patients with typical psoriatic oligoarticular disease, particularly those who may have only three or four active joints, most commonly in the lower limb, may not be valid. However, these patients may still be eligible for anti-TNF therapy under current National Institute for Health and Clinical Excellence guidance, and may have been included in this data set. Of even greater concern is the calculation of those patients who achieve remission, defined as DAS-28 <2.6. There are three key issues with the use of this cut-off point. The first relates to the use of a 28-joint count to assess remission in PsA. Although reduction to a 28-joint count has been well validated in RA, the high prevalence of disease in the feet and lower limbs in PsA make a 28-joint count to assess disease activity inappropriate. The second issue is the use of the cut-off point of 2.6 defined in RA, without any validation of such a level in PsA. This cut-off point was carefully validated in RA against physician opinion, but this has not been validated in PsA. The individual components of the DAS-28 may have very significant implications in PsA. As stated previously, the 28-joint count may miss a significant amount of active disease. The patients’ assessment of global disease activity may not be related just to articular disease but also to skin, enthesal and axial disease activity. The use of acute-phase response markers may be unhelpful in PsA where there is a more tenuous relationship between disease activity and an elevated acute-phase response. A normal result contributing to a low DAS-28 score does not ensure that there is no active disease. Finally, the key issue of assessing psoriatic disease rather than arthritis is paramount. Defining patients as being in remission when they could have active skin, enthesal and axial disease is inappropriate.

Work on defining disease states in PsA is ongoing and work has been done with the collaboration of the members of the group for assessment of psoriasis and PsA (GRAPPA). Criteria for minimal disease activity (an OMERACT definition encompassing remission and low disease activity) in PsA have been developed [3] and validated [4, 5]. The survey data on which this study was based also asked members’ opinions of remission. The survey performed in 2008 using 40 real-life patient profiles found only four cases that >70% of the membership agreed to be in remission and all of these patients had no swollen joints, a psoriasis area and severity index of <0.3, no enthesitis and low patient-reported outcome measurements (data not shown). This highlights the stringent criteria that PsA experts apply to control disease activity in PsA and also underlines the need to consider all aspects of psoriatic disease.

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Comment on: Efficacy and safety of anti-TNF therapies in psoriatic arthropathy: an observational study from the British Society for Rheumatology Biologics Register: reply

Sir, We would like to thank Coates and Helliwell [1] for their interest in our recent publication [2]. We are pleased to note, in particular, how much we agree on one fundamental point—there is a need for reliable and valid measures of treatment response in PsA.

We also welcome the very recent publication by Coates et al. [3] proposing an operational definition for minimal disease activity in PsA and look forward to reviewing the associated validation studies once published. Unfortunately, this recent contribution was not available at the time we conducted our work (as recruitment to our study ceased in 2006).

As reported in our paper, the primary aim of the British Society for Rheumatology Biologics Register is to establish the long-term safety and efficacy of biologic therapies in patients with RA, but over time we have also benefited from the fact that the largest cohort of PsA patients receiving anti-TNF therapies in routine clinical practice has now also been studied. On the basis of what was available, we used the disease activity score-28 score as a measure of response to treatment, recognizing that this had previously been shown to perform better than psoriatic arthritis response criteria in randomized controlled trials of PsA [4] and to be discriminant and responsive in observational cohorts of PsA [5]. Nonetheless, we acknowledged in our paper possible limitations associated with this approach and called for further research to develop a full set of domains to assess improvements in PsA patients. With this in mind, readers may be interested in our recent paper examining improvements in quality of life (as captured by SF-36) in patients with PsA receiving anti-TNF therapies [6].

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