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EULAR updates rheumatoid arthritis guidelines

Patients with rheumatoid arthritis should start treatment with disease-modifying anti-rheumatic drugs as soon as they are diagnosed with the aim of reaching remission or low disease activity in every patient, recommend updated EULAR guidelines for the management of rheumatoid arthritis announced at the congress.

First-line treatment should start with methotrexate or combination therapy of methotrexate with other conventional synthetic disease-modifying anti-rheumatic drugs, the guidelines advise. Low-dose glucocorticoids should also be considered in combination with disease-modifying anti-rheumatic drugs for up to 6 months, but should be tapered as soon as clinically feasible.

Patients who do not respond to this treatment within 6 months or who have poor prognostic factors should be treated with biological disease-modifying anti-rheumatic drugs – either TNF inhibitors, abatacept or tocilizumab. This is a change to the previous guidelines, which recommended TNF inhibitors. 'Recent studies show that all biologics, including abatacept and tocilizumab, can be used in this setting,' said guideline taskforce member Professor Josef Smolen, from the Medical University of Vienna, Austria.

The updated guidelines are based on three systematic reviews of the efficacy and safety of biological and conventional disease-modifying anti-rheumatic drugs. Professor Smolen noted: 'They have less of a focus on the safety of and contraindications to biologics because they are based on a thorough review of the most recent literature showing the safety of biologics.'

Patients who fail to respond to an initial biologic disease-modifying anti-rheumatic drug should receive another biologic disease-modifying anti-rheumatic drug, according to the guidelines. They suggest that patients who have failed to respond to an initial TNF inhibitor may be given another TNF inhibitor, or a biologic with a different mode of action. If biologic treatment fails, tofacitinib may be considered where it is approved.

In a patient with persistent remission, clinicians should consider tapering the biological disease-modifying anti-rheumatic drug – after having tapered glucocorticoids – particularly if it is being used in combination with a conventional synthetic disease-modifying anti-rheumatic drug. In cases of sustained long-term remission, cautious dose-reduction of conventional synthetic disease-modifying anti-rheumatic drugs should be considered.

In addition to the latest treatment recommendations, the guidelines include some overarching principles for patient care. They recommend that the primary health-care provider to rheumatoid arthritis patients should be a rheumatologist. In addition, patients should undergo monitoring of disease activity every 1–3 months depending on their disease activity, and changes to therapy should be considered if no improvement occurs by 3 months post-treatment, or if the target has not been reached by 6 months.

Susan Mayor

Five-year data confirm efficacy and safety profile of golimumab

Data from phase 3 clinical studies show that once-monthly, subcutaneous injections of golimumab (Simponi) give sustained improvements in the signs and symptoms of patients with both active ankylosing spondylitis and moderate to severe, active rheumatoid arthritis over 5 years.

Additionally, new published data from the observational GO-MORE study (Combe et al, 2013) showed improved efficacy and comprehensive disease control when once-monthly, subcutaneous injections of golimumab 50 mg were added to conventional disease-modifying anti-rheumatic drugs for 6 months, as measured by clinical indices and patient reported outcomes. The open-label, multi-national, prospective study enrolled over 3000 adults with active rheumatoid arthritis.

Combe B, Dasgupta B, Louw I, et al (2013) Efficacy and safety of golimumab as add-on therapy to disease-modifying antirheumatic drugs: results of the GO-MORE study. *Ann Rheum Dis* 5 June (Epub ahead of print)

Rituximab better for maintenance in ANCA-associated vasculitis

A prospective, randomized, controlled trial compared rituximab to azathioprine to maintain remission of antineutrophil cytoplasmic antibodies (ANCA)-associated vasculitis (Terrier et al, 2013).

Once remission was obtained with a conventional regimen, patients were randomly assigned to receive a 500 mg rituximab infusion on days 1 and 15, 5.5 months later, then every 6 months for a total of five infusions over 18 months, or azathioprine for 22 months at the initial dose of 2 mg/kg/day. The primary end point was the major relapse rate at 28 months.

This study demonstrated that rituximab 500 mg every 6 months was superior to azathioprine to maintain ANCA-associated vasculitis remission during the 28-month follow-up, with a similar profile of tolerance.

Median duration of follow-up was 34.3 months (interquartile range 28.7–39.6 months). Six out of 56 (10.7%) rituximab patients and 24 out of 53 (45.3%) azathioprine patients had at least one major relapse.

Terrier B, Pagnoux C, Karras A et al (2013) Rituximab versus azathioprine for maintenance in antineutrophil cytoplasmic antibodies (ANCA)-associated vasculitis (mainritsan): follow up at 34 months. OP0213. *Ann Rheum Dis* **72**(Suppl 3): 124