European League Against Rheumatism
Conference Review

Making Education Easy

Annual European Congress of Rheumatology June 2008, Paris, France

In this issue:

Welcome to the EULAR Conference Review, a locally focused summary of some of the latest and most exciting developments in rheumatology research presented at the Annual European Congress of Rheumatology.

This Review has been created to allow those unable to attend, but with a keen professional interest in rheumatology research, to access a summary of significant clinical studies presented that are likely to affect current practice. Selection and review of the research is carried out independently by Dr Michelle Tellus, Consultant Rheumatologist in Kew, Victoria, who attended the EULAR Congress held in Paris, France. I hope you find the conference review stimulating and I look forward to your feedback.

Kind Regards,
Dr Shaun Holt
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Efficacy of abatacept in delaying the development of rheumatoid arthritis (RA) in adult patients with undifferentiated inflammatory arthritis at high risk of developing RA

Authors: Emery P et al

Summary: Study outcomes are reported for 50 evaluable patients with undifferentiated arthritis and who were anti-CCP positive, given abatacept (~10 mg/kg by weight range) or placebo, for 6 months. Non-steroidal anti-inflammatory drugs/stable low-dose oral corticosteroid (≤10 mg/day prednisone or equivalent) were permitted but no disease-modifying antirheumatic drugs. Patients who developed RA at any time were discontinued and could receive standard of care. The primary endpoint was the proportion of patients who developed rheumatoid arthritis (RA) by American College of Rheumatology criteria. By 12 months, 16/24 (67%) patients in the placebo arm had terminated treatment due to the development of RA, compared with 12/26 (46%) receiving abatacept.

Comment: In this session, it was noted that patients with undifferentiated inflammatory arthritis who have high anti-CCP antibodies are at high risk of developing RA. Abatacept, which is a T-cell co-stimulation modulator, has shown long-term efficacy in patients with RA. Through the prevention of activation of T-lymphocytes, abatacept has the potential to modify the course of early RA. Abatacept may in fact delay progression to definite RA in some patients with undifferentiated arthritis who are at high risk of developing RA. The disease-modifying effects of abatacept persisted for 6 months after cessation of treatment. In Australia, we could consider abatacept as a first-line agent in undifferentiated inflammatory arthritis in patients at high risk of developing RA, as this could delay the onset of disease and have significant impact on arresting disease progression in early disease. Instead of giving abatacept following a failed TNF in established RA, it may have a place in the first-line prevention of this potentially serious disease.

Reference: Ann Rheum Dis 2008;67(Suppl II):89
http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0130

The relationship between erosions and osteoporosis in patients with psoriatic arthritis

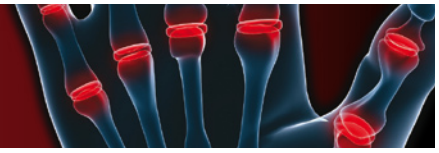
Authors: Anandarajah AP et al

Summary: Data from 1456 patients with psoriatic arthritis (PsA) identified in the Consortium of Rheumatology Researchers of North America (CORRONA) database were assessed for a possible association between generalised bone loss (osteoporosis) and focal bone loss (erosions). Erosions were present in 567 patients (40%) and not present in 889 (60%). The mean age of patients with erosions was 42 years, significantly younger than the patients who had no erosions (mean age 45 years). Erosions were significantly more common in men than in women (51.5% vs 48.5%; p=0.03). Adjusted multivariate analysis revealed significantly lower T-scores at the lumbar spine in patients with erosions compared with those without erosions (p=0.0006). An association was also detected between the erosion status and T-scores at the femoral neck of the hip, but this was not statistically significant. A significant association was detected, however, after adjusting for prednisone use (p=0.04). Steroid use was not significantly associated with the presence of erosions.

Comment: Several studies have found that bone erosions are nearly as common in psoriatic arthritis as in rheumatoid arthritis. Recent studies have found that patients with psoriatic arthritis also often have a low bone mass, and that patients with erosions are more likely to have low bone mass compared with those who do not have erosions.

This study examined associations between T-scores at the lumbar spine and the presence or absence of erosions, adjusting for steroid use, gender, methotrexate use, other disease modifying anti rheumatic drug use, and the use of biologics, as well as for weight, age, body mass index and disease index. It is concluded that the association between the presence of bone erosions and lower T-scores of the lumbar spine is clinically significant in the context of psoriatic arthritis.

Reference: Ann Rheum Dis. 2008;67(Suppl II):101
http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0168



Remission can be achieved in 50% of early rheumatoid arthritis patients after 25 weeks in daily clinical practice

Authors: Kuper I et al

Summary: Outcomes are reported for 169 disease-modifying antirheumatic drug (DMARD)-naïve patients with recent-onset rheumatoid arthritis (RA) attending rheumatology clinics of 3 hospitals in The Netherlands. Upon RA diagnosis, patients commenced a tight step-up DMARD treatment scheme aiming at remission (defined as a Disease Activity Score in 28 joints [DAS28] of <2.6). The protocol started with 15mg weekly methotrexate, increasing to 25mg weekly at eight weeks if remission had not been achieved. Absence of remission at week 12 indicated addition of sulfasalazine 2 g/day, which could be increased to 3 g/day by week 20 if required. At week 24, if still no evidence of remission was noted, adalimumab (Humira) was added to the methotrexate and other DMARDs and if at three months post addition of Humira no remission was achieved, a change to an alternative TNF inhibitor was made, based on DAS28 criteria. Treatment was adjusted every three months to provide sustained remission, as determined by the DAS28. Additions to treatment included non-steroidal anti-inflammatory drugs, intra-articular corticosteroid injections and prednisolone ≤10 mg/day. The mean age of the study patients was 57.3 years, 64% were female and the mean disease duration at diagnosis was 16 weeks. By study week 8, 15.5% of the patients had achieved remission. This number increased to 22.2% at week 12, 30.7% at week 20, 38.8% at week 24, 52.1% at week 36 and 51% between weeks 48 and 52. Based on Kaplan Meier survival curves, the estimated median time to first remission was 25 weeks.

Comment: Multiple randomised control trials have shown that remission in early RA is a realistic treatment goal, but trying to reproduce this in clinical practice is questioned in this session. This study demonstrates the possibility of achieving high remission rates in patients with recent-onset RA in routine clinical practice, utilising a step-up DMARD regime with tight control. This tight control regime has been proven effective in randomised control trials, but this evidence is the first to show that results can be attained in routine clinical practice.

Reference: Ann Rheum Dis 2008;67(Suppl II):48

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0003

About the Reviewer - Dr Michelle Tellus

M.B.B.S, F.R.A.C.P

Michelle Tellus is currently a Consultant Rheumatologist in Kew, Victoria. She undertook Rheumatology training in Melbourne and was involved with research at both the Royal Melbourne Hospital, Bone and Mineral Unit, and the Royal Children's Hospital. Her interests lie within the inflammatory diseases of the joints and muscles and in the field of osteoporosis.

Fatigue, discomfort & health-related quality of life in primary Sjögren's Syndrome (PSS) patients in the USA

Authors: Bowman SJ et al

Summary: This study aimed to measure fatigue, discomfort and health-related quality of life in US patients with primary Sjögren's syndrome (PSS) and to validate the use of the Profile of Fatigue and Discomfort – Sicca Symptoms Inventory (PROFAD-SSI) questionnaire in this population. Surveys were mailed to all active members of the Sjögren's Syndrome Foundation (SSF) USA, half of whom were asked to find a friend without PSS to complete it, and to PSS patients referred through physicians' offices (Phy-Ref). The survey also included other validated measures of Sjögren's related symptoms and quality of life including the medical outcome study 36–item Short Form health survey (SF–36), the functional assessment of chronic illness therapy fatigue scale (FACIT-F), the Center for Epidemiologic Studies Depression Scale (CES-D), and the modified Brief Pain Inventory (BPI). Analyses were based on 1225 SSF PSS patients, 281 Phy-Ref PSS patients and 606 non-PSS 'controls'. The two PSS groups demonstrated similar mean scores on the PROFAD-SSI, FACIT-F and SF-36; scores for both PSS groups were significantly different from those of the controls who did not have PSS.

Comment: In this session, Dr. Simon Bowman presented results of the first large-scale evaluation of fatigue in health-related quality of life in patients with PSS in the US. There have been several studies in Europe that have shown that chronic variable fatigue is a common disabling symptom reported in about 75% of patients with PSS. The European data also support that PSS patients have a substantially reduced health-related quality of life. Dr. Bowman, a clinical rheumatologist at the University Hospital, Birmingham, England, developed and validated the PROFAD-SSI with his colleagues in the UK. The PROFAD-SSI is a patient-completed questionnaire that measures physical and mental fatigue, joint pain, Raynaud's symptoms along with dryness symptoms. It was specifically designed for use in patients with Sjögren's but the fatigue component can certainly be relevant to other rheumatic diseases, such as lupus and rheumatoid arthritis. The PROFAD-SSI had been validated in the UK for nearly every component under study. The only exception was the 'cold hands' domain. In contrast, the US population correlated 'cold hands' with a cutaneous dryness domain of the SSI, suggesting that North American patients interpret the phrase differently than do the Europeans. It was felt prudent to omit the 'cold hands' domain when administering the PROFAD-SSI in the US as a result of this discrepancy.

The findings of this study supported an overall validity of the use of the PROFAD-SSI in North American patients with PSS and extend previous work with European patients demonstrating the severity of fatigue and discomfort in PSS. As the American and European populations are similarly affected, trials on new therapies for PSS could be carried out in both groups. Unfortunately, the relevance of this study is that Sjögren's outcome is quite poor in the United States and Europe from the point of view of treatment of fatigue and health-related quality of life measures.

Reference: Ann Rheum Dis 2008;67(Suppl II):48

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0004

The efficacy and safety of tocilizumab in the treatment of early and established rheumatoid arthritis

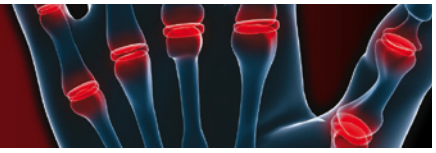
Authors: Genovese MC et al

Summary: These researchers evaluated the efficacy and safety of tocilizumab (TCZ) in combination with disease-modifying antirheumatic drugs (DMARDs) in patients with early (<2 years; n=326) and established (≥2 years from diagnosis; n=1298) rheumatoid arthritis (RA), using pooled data from two multinational, phase 3 clinical trials, OPTION and TOWARD. These trials involved patients with moderate-to-severe RA, who had experienced an inadequate response to prior DMARD therapy. Treatment consisted of TCZ (8 mg/kg) or placebo (control) via intravenous infusion every 4 weeks, in combination with DMARDs. American College of Rheumatology (ACR) remission criteria, Disease Activity Score in 28 joints (DAS28), and European League Against Rheumatism (EULAR) response were evaluated and safety parameters assessed over the 24-week treatment period. Among 202 patients with early RA treated with TCZ+DMARDs, 60%, 40% and 24% achieved a 20%, 50% and 70% reduction in the ACR criteria at Week 24, versus 27%, 11%, and 2%, respectively, in the control group (n=124) (all p<0.0001). In TCZ+DMARD-treated patients with established RA (n=805), similar ACR responses of 61%, 39%, and 20% were observed at Week 24, versus 25%, 9%, and 3%, respectively, in the control group (n=493) (all p<0.0001). Disease remission (DAS28 <2.6) was achieved in 38% of TCZ+DMARD-treated patients with early RA and 28% with established RA at Week 24, compared with 2% and 3%, respectively, in the control groups (both p<0.0001). At 24 weeks, moderate-to-good improvements in RA symptoms (EULAR response), were achieved in 81% of TCZ+DMARD-treated patients with early RA and 79% with established RA, compared with 38% and 36%, respectively, in the control groups (both p<0.0001). TCZ+DMARD combinations were well tolerated and showed a favourable safety profile. The rate of serious infections per 100 patient-years was 5.16 in TCZ+DMARD-treated patients with early RA and 6.13 with established RA, compared with 1.78 and 4.52, respectively, in the control groups.

Comment: In conclusion, tocilizumab is as good as other biologic agents in the treatment of early RA, as evidenced by the data presented in this session.

Reference: Ann Rheum Dis 2008;67(Suppl II):125

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0245



Dose-escalation of allopurinol versus benzbromarone in gout patients: A randomised controlled trial

Authors: Reinders MK et al

Summary: These researchers investigated the efficacy of titrating allopurinol dosage to attain serum urate (sUR) concentrations of ≤0.30 mmol/L, and compared the tolerability of allopurinol 300–600 mg/day with that of benzbromarone 100–200 mg/day. This open-label trial involved 55 patients with newly diagnosed gout who were randomised to receive allopurinol 300mg daily (n=30) or benzbromarone 100mg daily (stage 1). After two months of treatment, dosage could be increased to allopurinol 600mg daily or benzbromarone 200mg daily to attain the treatment target of stable sUr ≤0.30 mmol/L (stage 2). Patients were indicated for serum urate-lowering treatment if they had tophi or >2 gout attacks per year. Nol patients had any evidence of liver or renal disease and none had previously received any other medication for this condition. After two months, treatment target was reached by more patients treated with benzbromarone 100 mg/day than patients treated with allopurinol 300 mg/day (52% vs 27%; p=0.05). After increase of dosage, overall treatment target was reached by 78% of patients in each treatment group. Treatment was discontinued by two allopurinol recipients and three benzbromarone recipients, due to adverse drug reactions (ADRs). No additional ADRs were reported after increase of dosages.

Comment: In this very interesting session on the treatment of patients with gout it was shown that when using allopurinol or benzbromarone in slightly higher doses than normal, based on serum uric acid levels, patients with gout have equal rates of success in attaining a serum concentration of uric acid of 0.30 mmol/L. This value is thought to predict good control of flares and reduction of tophi. In this small study, tolerability was not affected by doubling the dose of the above medications in patients not reaching target levels of uric acid. The results of the study indicated no difference in efficacy between allopurinol and benzbromarone when given in adequate doses, despite their different mechanisms of action. Also, the allopurinol dosage was higher than is usual for clinical practice (300 mg/day to reach target serum levels). Gouty flares and tophi occur in body parts with the lowest temperature, particularly the extremities such as the ear and DIP joints. Uric acid concentration is a well accepted biomarker for the evaluation of gout treatment and must be lower than the solubility at 37 degrees (0.42 mmol/L) for good treatment to work. The solubility drops dramatically with lower temperature, so lower serum urate values are needed. A serum urate concentration of 0.30 mmol/L, although it has been shown to be adequate in previous studies. Evidence-based recommendations for gout advise hydrating the allopurinol dosage according to the level of serum urate that is attained. However, lack of information about this approach and the effects of higher doses of serum urate-lowering drugs will be required to decrease serum urate in patients who are not reaching target levels. As most clinicians prescribe a fixed dose of allopurinol (300mg daily), consideration for higher doses is proposed from the above data.

Reference: Ann Rheum Dis 2008;67(Suppl II):98

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0157

Incidence of pulmonary arterial hypertension related to systemic sclerosis: A 3-year nationwide longitudinal study

Authors: Hachulla E et al

Summary: In patients with systemic sclerosis the incidence of pulmonary arterial hypertension (PAH) is 0.61 per 100 patient-years, according to data on 384 patients in a longitudinal analysis of a study that was presented by Dr. Eric Hachulla. The prevalence of PAH in a cohort of patients from the ItinerAIR – HTAP registry, which is a three-year multicentre study of patients with systemic sclerosis, was found to be 7.85% (confidence interval range, 5.70–10.00), prompting the study to determine the incidence of pulmonary arterial hypertension over three years of follow-up. Patients underwent annual Doppler echocardiography screening for PAH, which was suspected in those with a peak velocity of tricuspid regurgitation (VTR) of 2.8–3 M-sec and unexplained dyspnoea, or with VTR >3 M-sec. Right heart catheterisation (RHC) was used to confirm pulmonary hypertension. The baseline characteristics of this population were: 87% female, mean age 53 years, mean duration of systemic sclerosis at study entry 8.7 years, and 24.0% with diffuse systemic sclerosis. Patients were followed for a mean of 41 months. PAH was found in 18 patients (incidence of 1.37 per 100 patient-years), 8 of whom had pre-capillary PAH identified by RHC, and a further 8 were found to have post-capillary pulmonary hypertension, despite the absence of left-heart dysfunction on echocardiography (incidence of 0.61 per 100 patient-years for both groups). The remaining two patients in the study had pulmonary hypertension documented as a result of severe interstitial lung disease.

Comment: These findings indicate that post-capillary pulmonary hypertension is common in systemic sclerosis, which indicates the need for RHC to confirm pre-capillary PAH. Clearly, detection will therefore allow patients accessibility to appropriate treatment.

Reference: Ann Rheum Dis 2008;67(Suppl II):122

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0235

Which subgroup of rheumatoid arthritis patients benefit most from switching to rituximab versus alternative anti-TNF agents after previous failure to anti-TNF agent?

Authors: Finckh A et al

Summary: This study aimed to determine the effectiveness of rituximab versus alternative anti-TNF agents on disease activity (DAS28) in rheumatoid arthritis (RA) patients with anti-TNF failure and examine potential effect modification by the type of prior anti-TNF failure or the type of anti-TNF switch, using data from 300 patients with RA who were originally enrolled in the Swiss clinical quality management of rheumatoid arthritis cohort. Overall, 65% had prior failure of an anti-TNF due to ineffectiveness and 35% due to an adverse event. These patients had switched either to rituximab in 101 cases or to another anti-TNF agent. There was no significant difference between the two groups in age, disease activity or duration, rheumatoid factor positivity, concomitant glucocorticoid use or disease-modifying agent use. The patients who failed anti-TNF treatment prior to the study due to ineffectiveness and who were taking rituximab at baseline had a significantly milder evolution of disease activity versus those patients who had failed an anti-TNF agent prior to the study and simply switched to another anti-TNF agent by baseline (i.e. mean decrease in DAS28 at 6 months, –1.55 versus –1.03, respectively).

Comment: In data presented by Dr. Axel Finckh, rituximab is shown to be more effective at reducing disease activity in RA patients who failed other TNF inhibitors than is simply switching to another anti-TNF. It may be reasonable to consider switching early to rituximab in RA patients who have persistent active disease despite treatment with anti-TNF agents.

This finding confirmed the results of prior observational studies. If the motive for switching was something other than ineffectiveness, such as an adverse event in association with a previous anti TNF, the evolution of disease activity between rituximab and alternative anti-TNF groups was similar (mean decrease in DAS28, –0.86 versus –0.77, respectively). This study indicated that rituximab worked effectively in patients with inadequate response to anti-TNF agents.

Reference: Ann Rheum Dis 2008;67 (Suppl II):127

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0249

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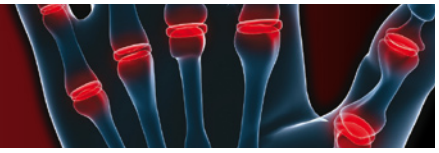


Overall effectiveness of MTX is similar in MTX naïve patients with psoriatic arthritis (PSA) and rheumatoid arthritis (RA): Data from the NOR-DMARD register

Authors: Lie E et al

Summary: In this presentation, Dr. Lie from Oslo in Norway assessed 430 methotrexate-naïve adults with psoriatic arthritis (PsA) who were enrolled in the Norwegian DMARD registry. Outcomes were compared with another 1222 patients with rheumatoid arthritis (RA). Clinicians and participants rated changes in inflammatory joint activity and health-related quality of life after being on methotrexate monotherapy for six months. At baseline, 71%/47% were female and 35%/26% had erosive disease in the RA and PsA groups, respectively. At six months, RA patients reported a mean 13 points improvement from baseline in global visual analogue scale (VAS) scores versus 12 among PsA patients; joint pain VAS scores improved by a mean 14 points in the RA group and by 11 in the PsA group. Fatigue VAS scores were improved by a significantly greater amount in the RA group compared with the PsA group (4 vs 0.01; p=0.014). Scores of physical functioning improved 9 points on the Short Form (SF)-36 instrument among patients with RA and 7 among PsA patients, while SF-36 body pain scores improved by 14 points in the RA group and by 10 in the PsA group (p=0.001). Assessor global VAS scores improved significantly more in the RA group (19 vs 14 for the PsA group; p<0.001). Other changes in favour of the RA group included reductions in ESR (–10.1 mm/hr vs –6.5 mm/hr, respectively; p<0.001) and C-reactive protein values (–10.5 mg/L and –5.7 mg/L, respectively; p<0.001). However, after adjusting for age, gender, methotrexate dose and baseline values, methotrexate was only significantly more effective for body pain and fatigue scores in the RA group.

Comment: Results indicated that methotrexate is by far the most widely used disease-modifying agent for psoriatic arthritis as indicated by the Norwegian DMARD register and also in Norway in general. Most patients with psoriatic arthritis are treated with methotrexate before introduction of a TNF inhibitor and a significant number of patients seem to achieve an important improvement in markers of inflammation as well as their health-related quality of life parameters. Methotrexate is an important DMARD in the treatment of rheumatoid arthritis and results from this study support that methotrexate is of similar importance in the treatment of patients with psoriatic arthritis. It is therefore considered to be a first-line DMARD for both conditions.

Reference: Ann Rheum Dis 2008;67(Suppl II):132

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0265

Golimumab, a new human anti-TNF-alpha monoclonal antibody, subcutaneously administered every 4 weeks in patients with active rheumatoid arthritis who were previously treated with anti-TNF-alpha agent(s): Results of the randomized, double-blind, placebo-controlled trial

Authors: Smolen J et al

Summary: This multicentre, double-blind study evaluated the efficacy and safety of golimumab (GLM) in 461 patients with active rheumatoid arthritis (RA) previously treated with anti-TNF-alpha agent(s), who were randomised to subcutaneous placebo (SC PBO) or golimumab (GLM) 50 or 100 mg every 4 weeks. Patients continued to receive stable doses of methotrexate (MTX), sulfasalazine (SSZ) and/or hydroxychloroquine (HCQ) if they were receiving them at baseline. Patients could have received ≥1 anti-TNF-alpha agent and may have discontinued them for any reason. The primary endpoint was the proportion of patients achieving at least 20% improvement according to criteria of the American College of Rheumatology (ACR20) at week 14. Improvement from baseline in HAQ at week 24 was assessed. Baseline characteristics were: mean disease duration 8.65 years to 9.80 years; 97% RF or anti-CCP positive, with 72% positive for both markers; 66% of patients were receiving MTX, and 5% and 7% were receiving SSZ and HCQ, respectively. All patients had received ≥1 anti-TNF-alpha agents. Prior anti-TNF-alpha agents had been discontinued due to lack of efficacy (58.4%), intolerance (16.5%) and other reasons (39.7%). Among patients who discontinued previous anti-TNF-alpha agents due to lack of efficacy, 35.7% and 42.7% of patients in the GLM 50mg and GLM 100mg groups, respectively, had an ACR20 response at week 14, compared with 17.7% in the PBO group. Through week 24, 72.3%, 66.4% and 78.3% of patients in the PBO, GLM 50mg and GLM 100mg groups, respectively, had ≥1 adverse events. No serious or severe reactions were reported and none led to discontinuation. Antibodies to GLM were detected in 3.7% of GLM recipients (50 and 100mg) and were observed in similar proportions of patients receiving GLM, irrespective of methotrexate use.

Comment: In conclusion, in patients with active RA who had received anti-TNF-alpha therapy and discontinued for any reason, GLM significantly reduced RA signs and symptoms and improved physical function. GLM was generally well tolerated.

Reference: Ann Rheum Dis 2008;67(Suppl II):50

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0010

MRI-inflammation of the vertebral unit (VU) only marginally contributes to new syndesmophyte formation in that unit: a multi-level analysis

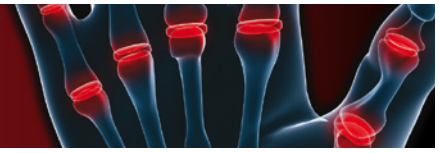
Authors: van der Heijde D et al

Summary: To gain insight into the process of underlying syndesmophyte development in ankylosing spondylitis, these researchers analysed a relationship between information visible on MRI and used syndesmophyte formation in vertebral units (VUs) in a subset of patients who participated in the ASSERT (ankylosing spondylitis study for the evaluation of recombinant infliximab therapy) trial. The patients who enrolled in the 24-week randomised control ASSERT trial and the 102-week open extension underwent MRI at baseline, at week 24 and at week 102 and spinal x-rays at baseline and at week 102. The MRI scans were scored by two independent radiologists using the AS spinal MRI activity (ASspiMRI-a) scoring system, which assesses 23 VUs of the entire spine. These x-rays were scored by two independent radiologists using the modified stoke ankylosing spondylitis spine score (mSASSS), which assesses 24 sites of the cervical and lumbar spine spanning 12 VUs. The investigators identified 2004 VUs in 182 patients that were assessed both by ASspiMRI-a and mSASSS. Using a multi-level approach to adjust for within-patient correlation by VU level and reader and by total ASspiMRI and total mSASSS at the patient level, they determined that more that 75% of new syndesmophytes incurred in VUs without MRI activity at baseline and fewer than 15% of VUs with MRI activity at baseline developed syndesmophytes. Analysis also showed the growth of existing syndesmophytes at the VU level was not associated with MRI activity and that at the patient level, MRI activity was not associated with change in mSASSS.

Comment: Most syndesmophytes develop without any sign of inflammation on MRI, even though the occurrence of inflammation and sites of syndesmophytes in patients with ankylosing spondylitis suggests that inflammatory processes may trigger the formation of bony spinal outgrowths. Despite the finding that MRI inflammation in a VU slightly increases the propensity to form a new syndesmophyte in the same VU, the observation that most syndesmophytes develop in VUs without any sign of MRI activity suggests that other, as yet unidentified, factors may trigger syndesmophyte formation.

Reference: Ann Rheum Dis 2008;67(Suppl II):130

http://www.abstracts2view.com/eular/view.php?nu=EULAR08L_OP-0259



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1. Schedule of Pharmaceutical Benefits, 1 March 2008. Available at: www.pbs.gov.au/html/healthpro/home (last accessed 17 May 2008)
2. ORENCIA (abatacept) Approved Product Information, 27 September 2007. Bristol-Myers Squibb Australia Pty Ltd.

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