ΠΑΝΕΠΙΣΤΗΜΙΑΚΟ ΓΕΝΙΚΟ ΝΟΣΟΚΟΜΕΙΟ ΛΑΡΙΣΑΣ /
ΓΕΝΙΚΟ ΝΟΣΟΚΟΜΕΙΟ ΛΑΡΙΣΑΣ «ΚΟΥΤΛΙΜΠΑΝΕΙΟ & ΤΡΙΑΝΤΑΦΥΛΛΕΙΟ»

Year in Review

ΣΠΟΝΔΥΛΑΡΘΡΙΤΙΔΕΣ

ΙΩΑΝΝΗΣ ΑΛΕΞΙΟΥ
Πανεπιστημιακή Κλινική
Ρευματολογίας & κλινικής Ανοσολογίας

Εαρινές Ημέρες Ρευματολογίας 2018

Σύγκρουση συμφερόντων
Conflict of interest

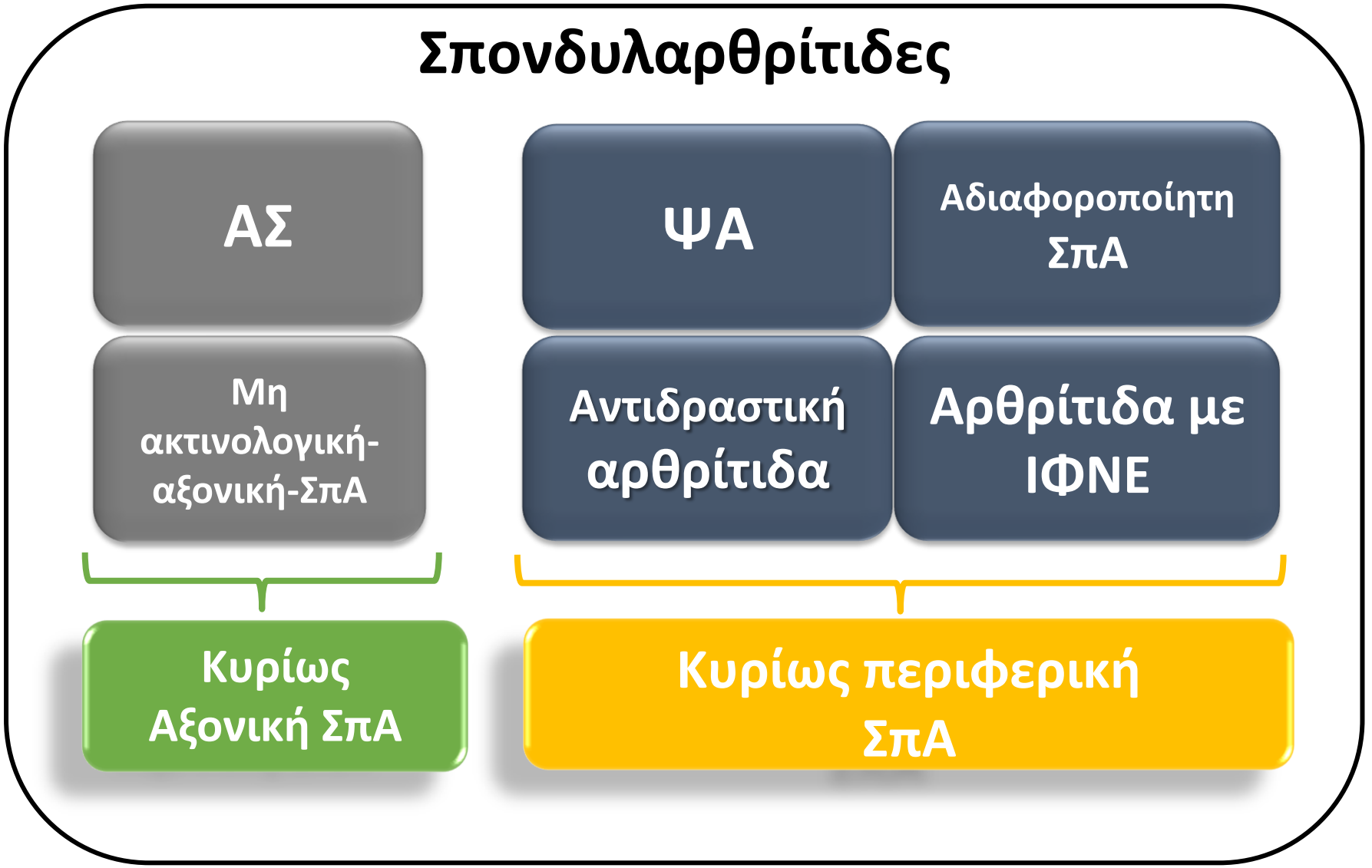
Καμία για αυτή την παρουσίαση

Εκπαιδευτικές- ερευνητικές- συμβουλευτικές επιχορηγήσεις την τελευταία διετία:

Actelion, Novartis, Abbvie, Genesis

Το φάσμα των σπονδυλαρθροπαθειών

Γενικά

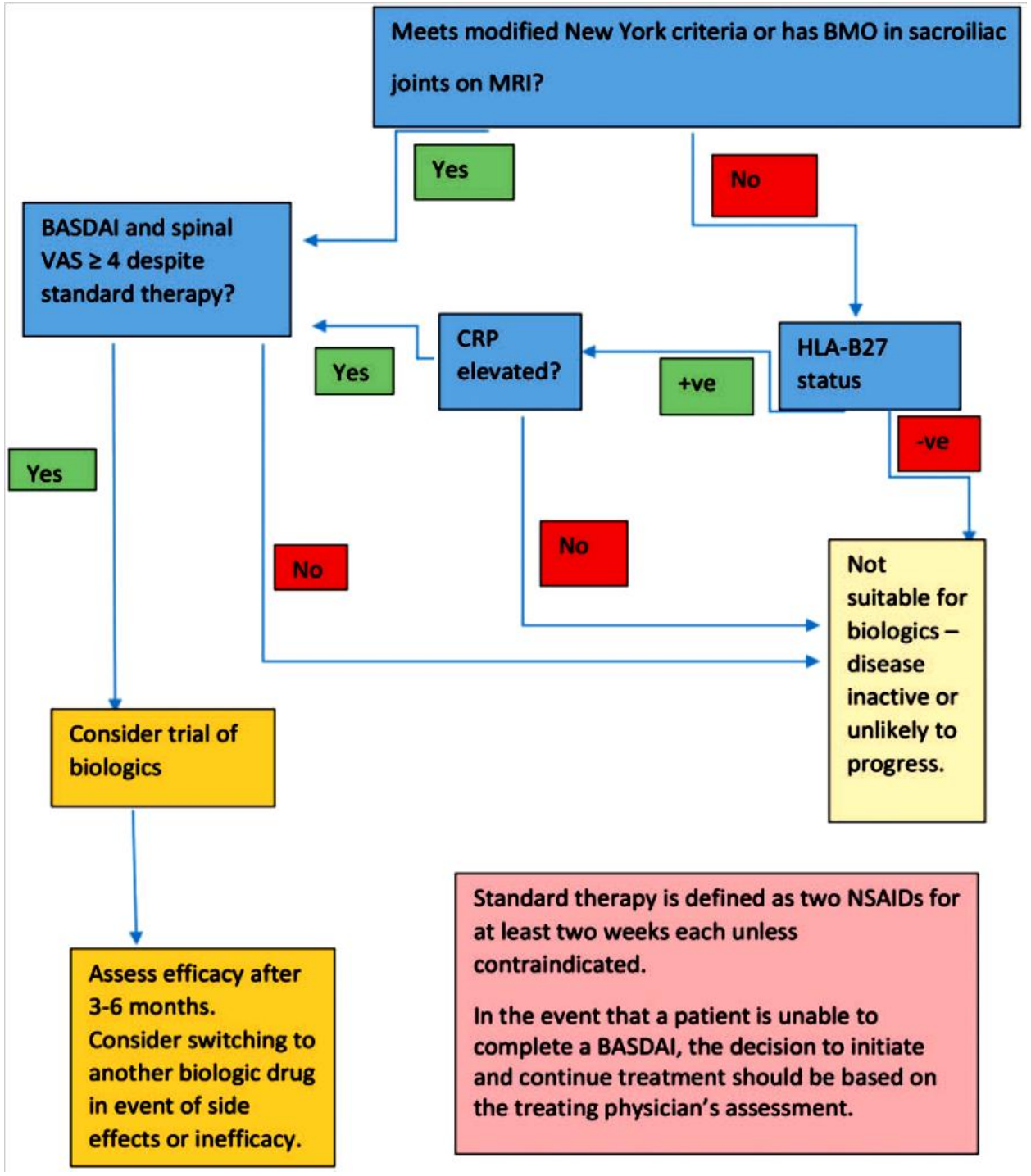

Σπονδυλαρθρίτιδες
ΑΣ
ΨΑ
Αδιαφοροποίητη ΣπΑ
Μη ακτινολογική-αξονική-ΣπΑ
Αντιδραστική αρθρίτιδα
Αρθρίτιδα με ΙΦΝΕ
Κυρίως Αξονική ΣπΑ
Κυρίως περιφερική ΣπΑ

AS

Search results

Items: 1 to 1124

Filters activated: Publication date from 2017/01/01 to 2017/12/31



BSR and BHPR guideline for the treatment of ax-SpA with biologics

Hamilton L et al. Rheumatology 2017;56:313-316

BSR and BHPR guideline

- While short-term MRI data support the efficacy of anti-TNF therapy in treating inflammatory SIJ and spinal lesions in axSpA, **evidence for anti-TNF therapy on radiographic disease progression is currently limited** [level of evidence (LOE) 1+; strength of recommendation A; consensus score 9.6]
- Active disease is defined as **a BASDAI and spinal pain** visual analogue scale (VAS) score ≥4 despite standard therapy

BSR and BHPR guideline

- The BASDAI should be measured on two occasions at least 4 weeks apart. Current National Institute for Health and Care Excellence guidelines require patients to have active spinal disease on two separate occasions 12 weeks apart, with the aim of avoiding the overtreatment of patients with a short-lived flare of disease
- Response is defined as a reduction in the BASDAI and spinal pain VAS of ≥2 U from baseline

BSR and BHPR guideline

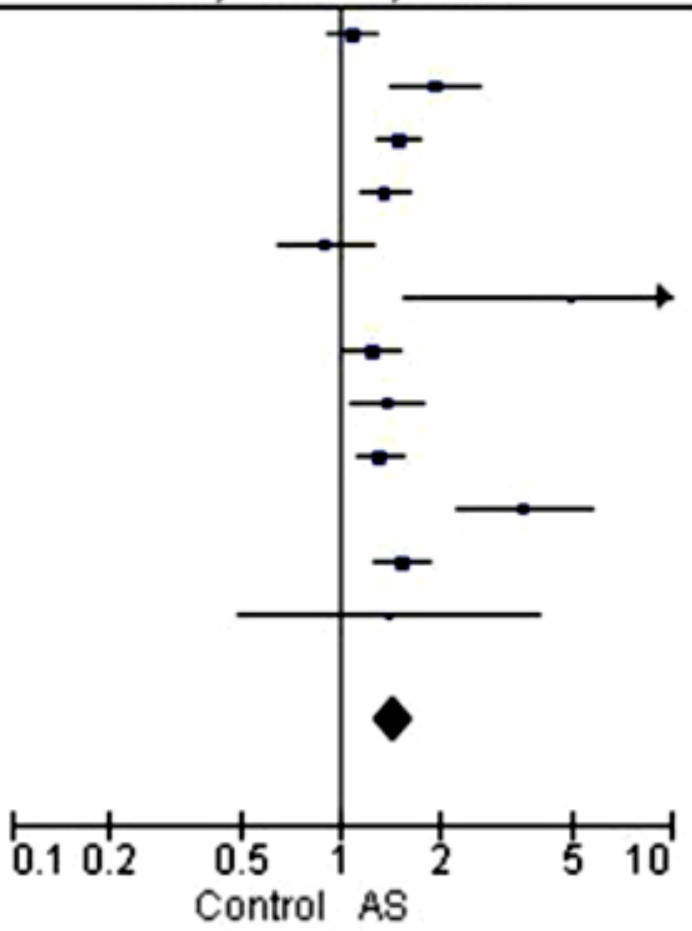
- In the absence of an initial clinical response by 6 months, or failure to maintain response at two consecutive assessments, withdrawal of that anti-TNF agent should be considered
- There is no evidence to support the withdrawal of anti-TNF therapy in treatment responders

Καρδιαγγειακά συμβάματα στην AS – MI

Study or Subgroup	AS Events	AS Total	Control Events	Control Total	Weight	Risk Ratio M-H, Random, 95% CI
Bengtsson 2017	143	6192	5480	257721	11.3%	1.09 [0.92, 1.28]
Brophy 2012	40	1686	14738	1206621	8.3%	1.94 [1.43, 2.64]
Chou 2013	221	6262	584	25048	11.5%	1.51 [1.30, 1.76]
Eriksson 2016	160	6813	540	31198	11.1%	1.36 [1.14, 1.62]
Essers 2016	38	3738	291	25843	7.7%	0.90 [0.64, 1.26]
Gaydukova Abs EULAR2016	28	278	3	150	1.4%	5.04 [1.56, 16.29]
Han 2006	122	1843	391	7372	10.6%	1.25 [1.03, 1.52]
Huang 2013	70	4794	253	23970	9.2%	1.38 [1.06, 1.80]
Keller 2013	171	2895	517	11580	11.2%	1.32 [1.12, 1.57]
Peters 2009	17	383	922	75333	5.5%	3.63 [2.27, 5.80]
So Abstract ACR 2017	115	7107	748	71033	10.7%	1.54 [1.26, 1.87]
Sukenik 1987	7	40	5	40	1.6%	1.40 [0.48, 4.04]
Total (95% CI)		**42031**		**1735909**	**100.0%**	**1.44 [1.25, 1.67]**
Total events	1132		24472			

Heterogeneity: $Tau^2 = 0.04$; $Chi^2 = 44.03$, $df = 11$ ($P < 0.00001$); $I^2 = 75\%$

Test for overall effect: $Z = 4.99$ ($P < 0.00001$)

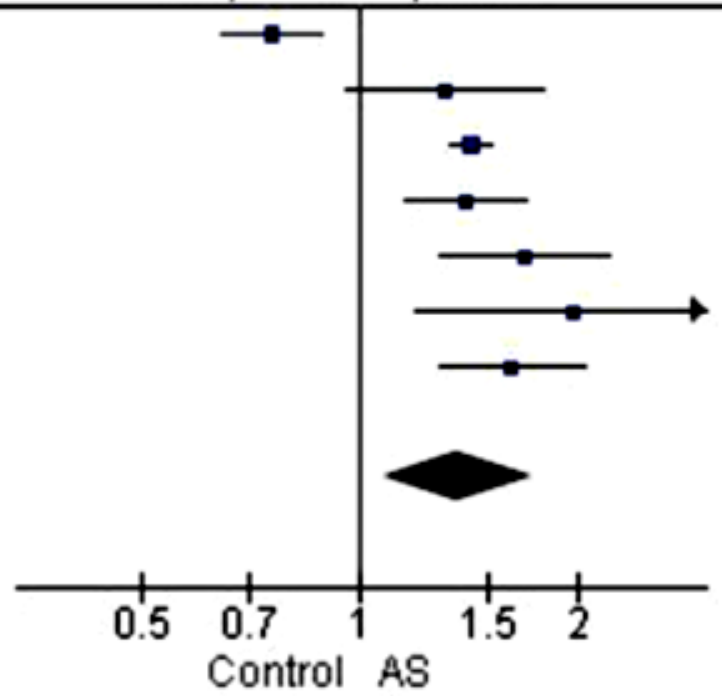


Καρδιαγγειακά συμβάματα στην AS – Stroke

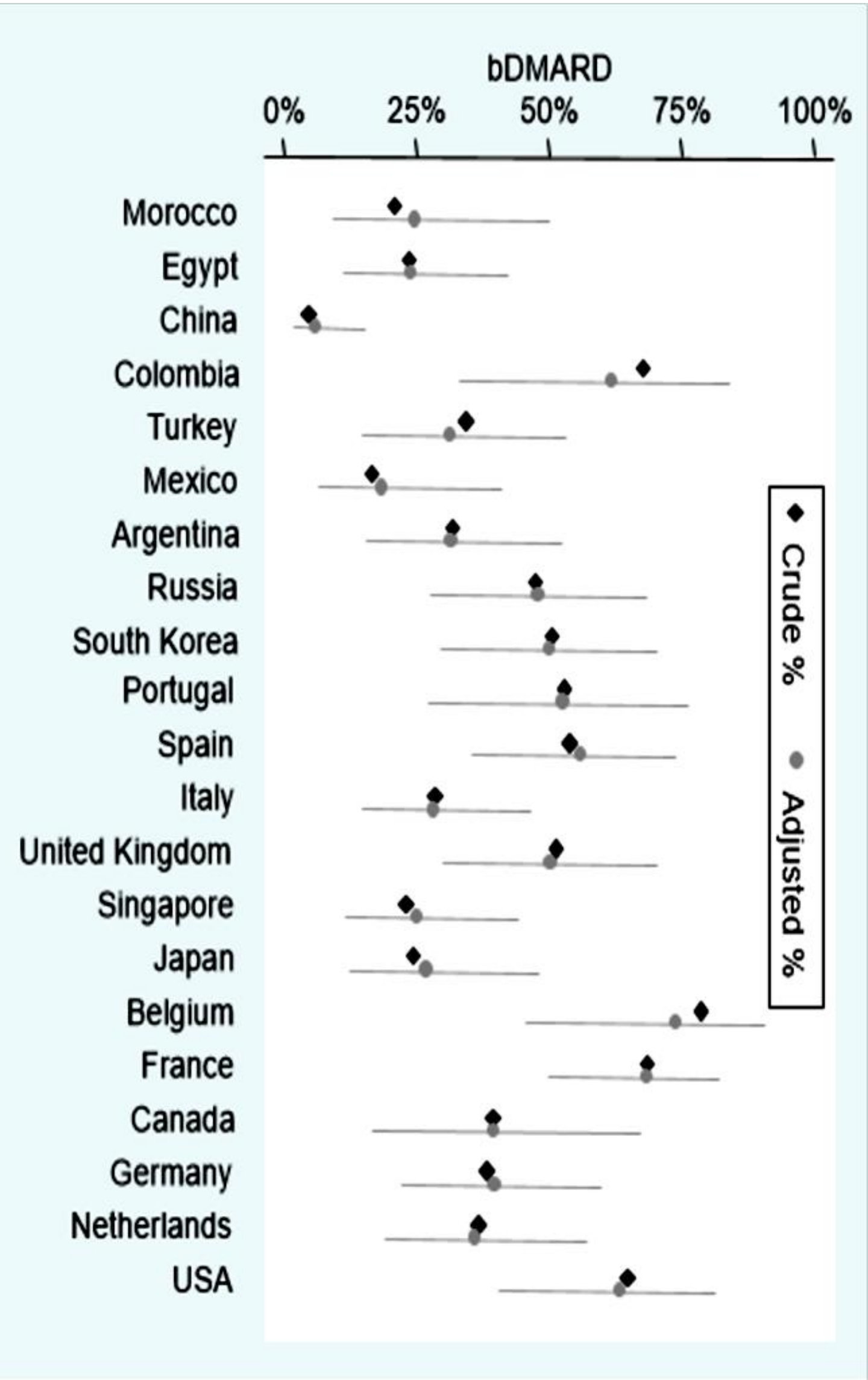
Study or Subgroup	AS Events	AS Total	Control Events	Control Total	Weight	Risk Ratio M-H, Random, 95% CI
Bengtsson 2017	147	6247	8001	257481	16.0%	0.76 [0.64, 0.89]
Brophy 2012	37	1686	20215	1206621	13.1%	1.31 [0.95, 1.80]
Chou 2013	895	6262	2514	25048	17.1%	1.42 [1.33, 1.53]
Eriksson 2016	128	7288	426	34023	15.5%	1.40 [1.15, 1.71]
Han 2006	72	1843	170	7372	14.1%	1.69 [1.29, 2.22]
Lin 2014	21	4562	53	22810	9.6%	1.98 [1.20, 3.28]
So Abstract ACR 2017	80	7148	492	71489	14.7%	1.63 [1.29, 2.06]
Total (95% CI)		**35036**		**1624844**	**100.0%**	**1.37 [1.08, 1.73]**
Total events	1380		31871			

Heterogeneity: $Tau^2 = 0.08$; $Chi^2 = 59.82$, $df = 6$ ($P < 0.00001$); $I^2 = 90\%$

Test for overall effect: $Z = 2.65$ ($P = 0.008$)



Ann Rheum Dis 2018;0:1–2.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Morocco
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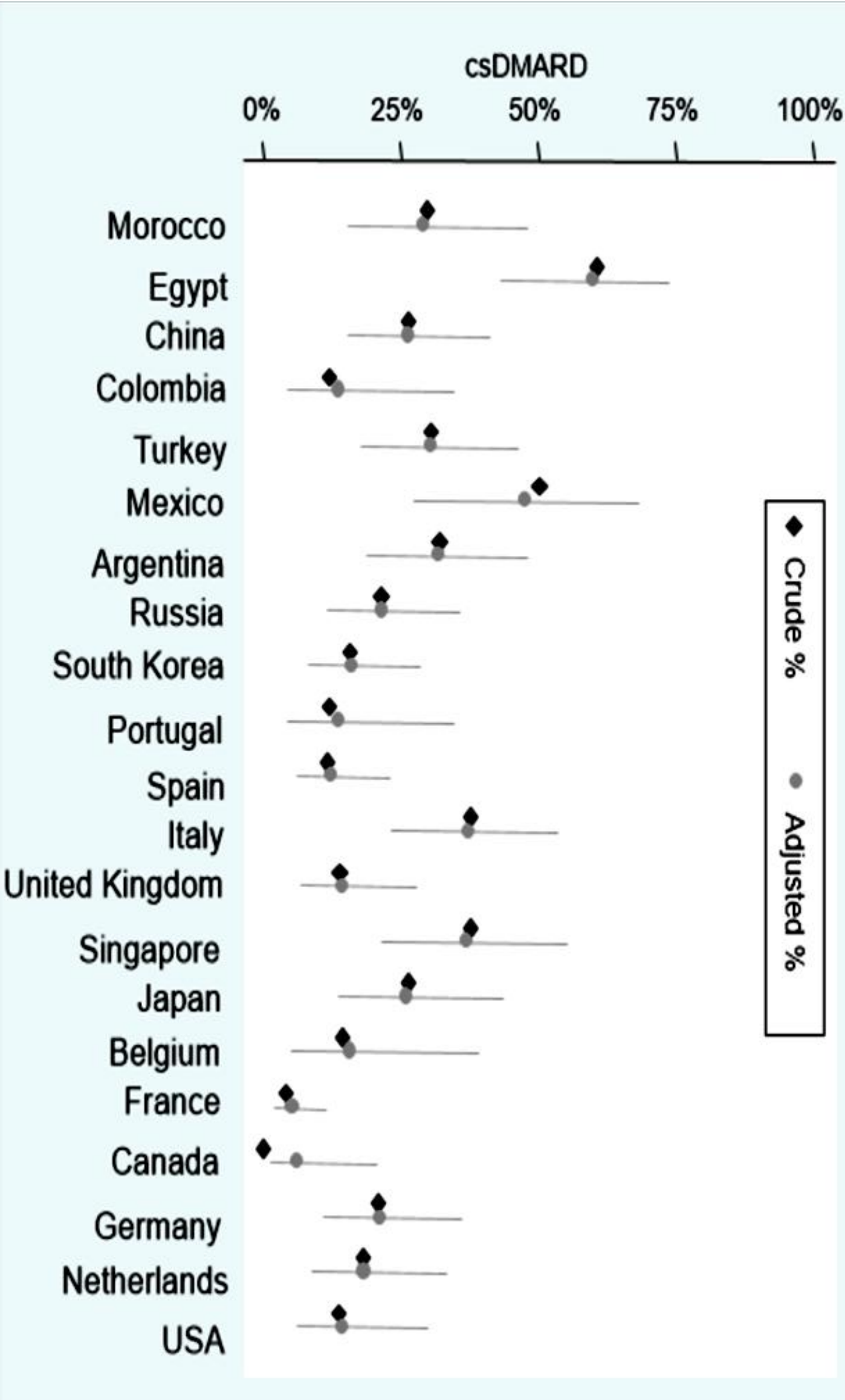
Singapore
Japan
Belgium
France
Canada
Germany
Netherlands
USA
Crude %
Adjusted %


csDMARD
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Portugal
Spain
Italy
United Kingdom
Singapore
Japan
Belgium
France
Canada
Germany
Netherlands
USA
Crude %
Adjusted %

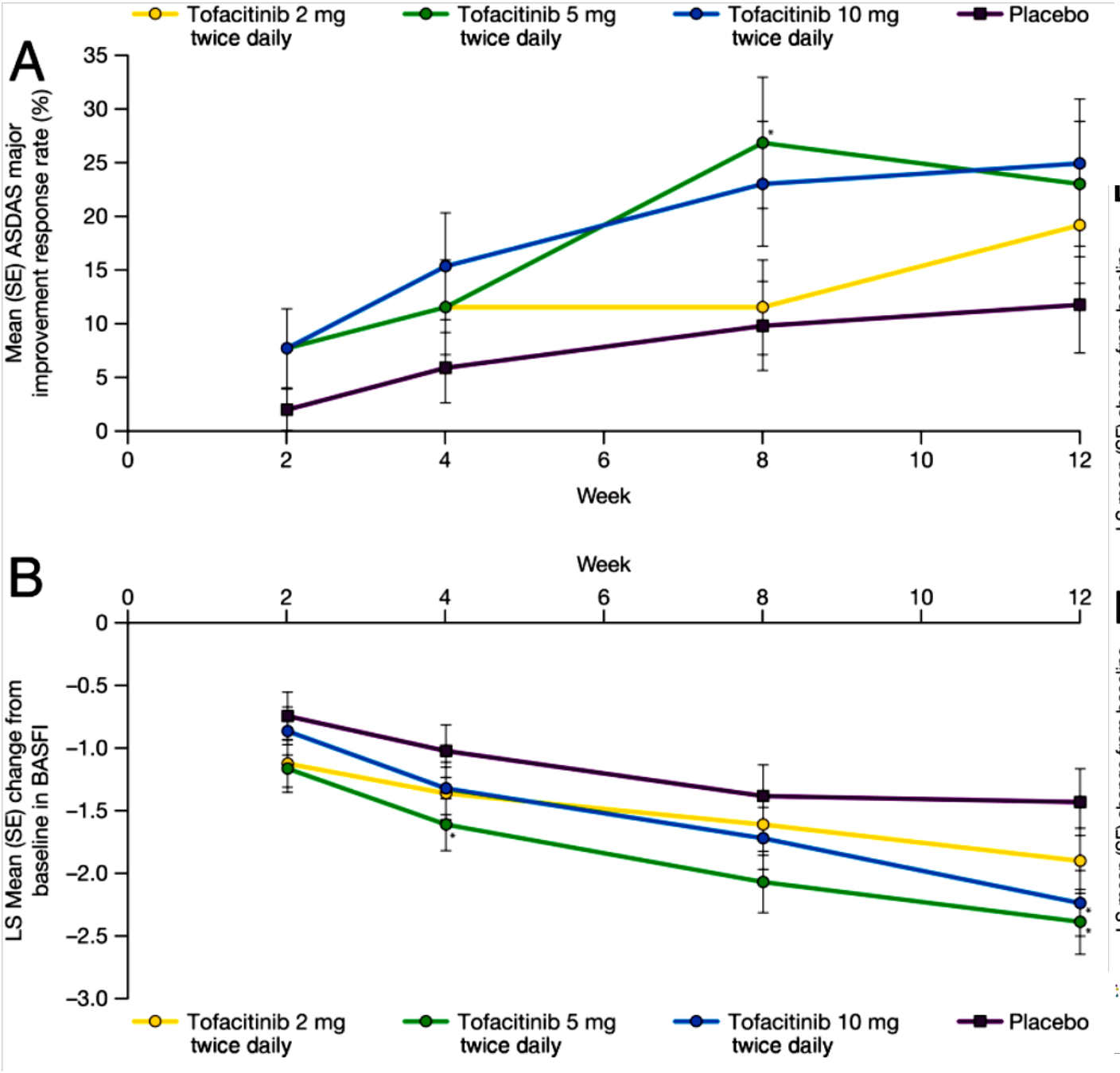
Apremilast στην AS - NCT01583374

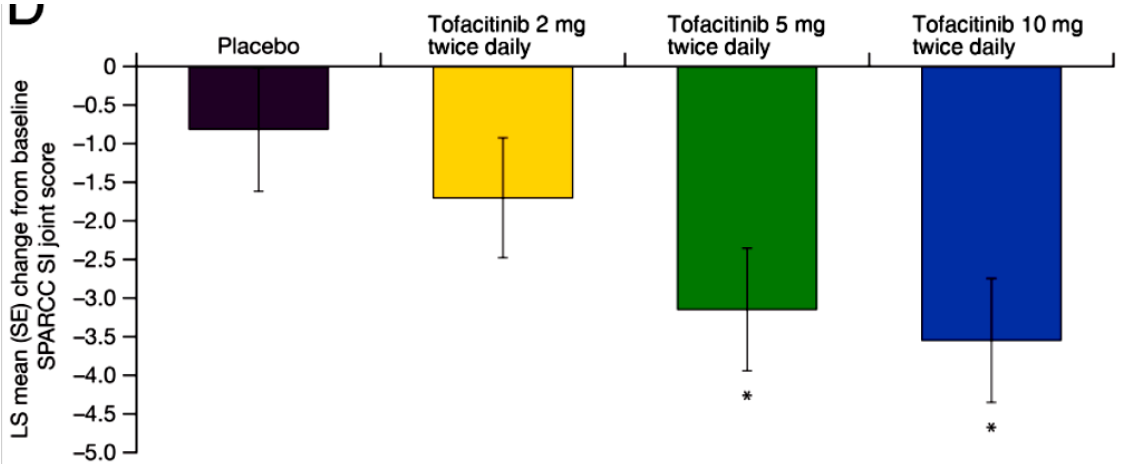
	Placebo	Apremilast 20 mg	Apremilast 30 mg
STARTED	164	163	163
Received Treatment	164	163	163
Completed Week 16	150	151	144
Early Escape at Week 16	51	49	49
COMPLETED	145	147	138
NOT COMPLETED	19	16	25
Adverse Event	6	7	12
Lack of Efficacy	3	2	5
Non-compliance with study drug	1	1	0
Withdrawal by Subject	8	3	5
Lost to Follow-up	1	2	0
Protocol Violation	0	0	3
Other	0	1	0

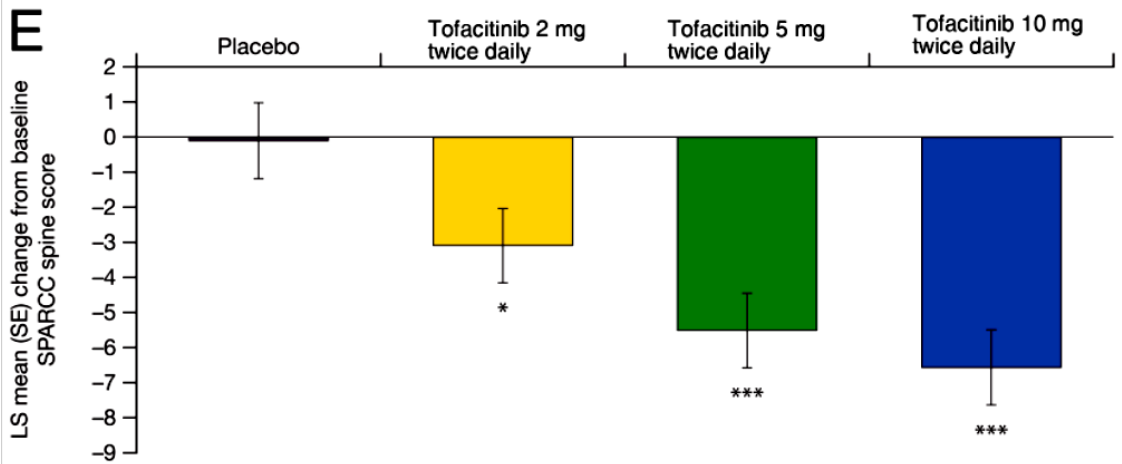
Apremilast στην AS - NCT01583374

	Placebo	Apremilast 30mg BID
Participants	**164**	**163**
ASAS 20 at week 16	**36.6%**	**32.5%**

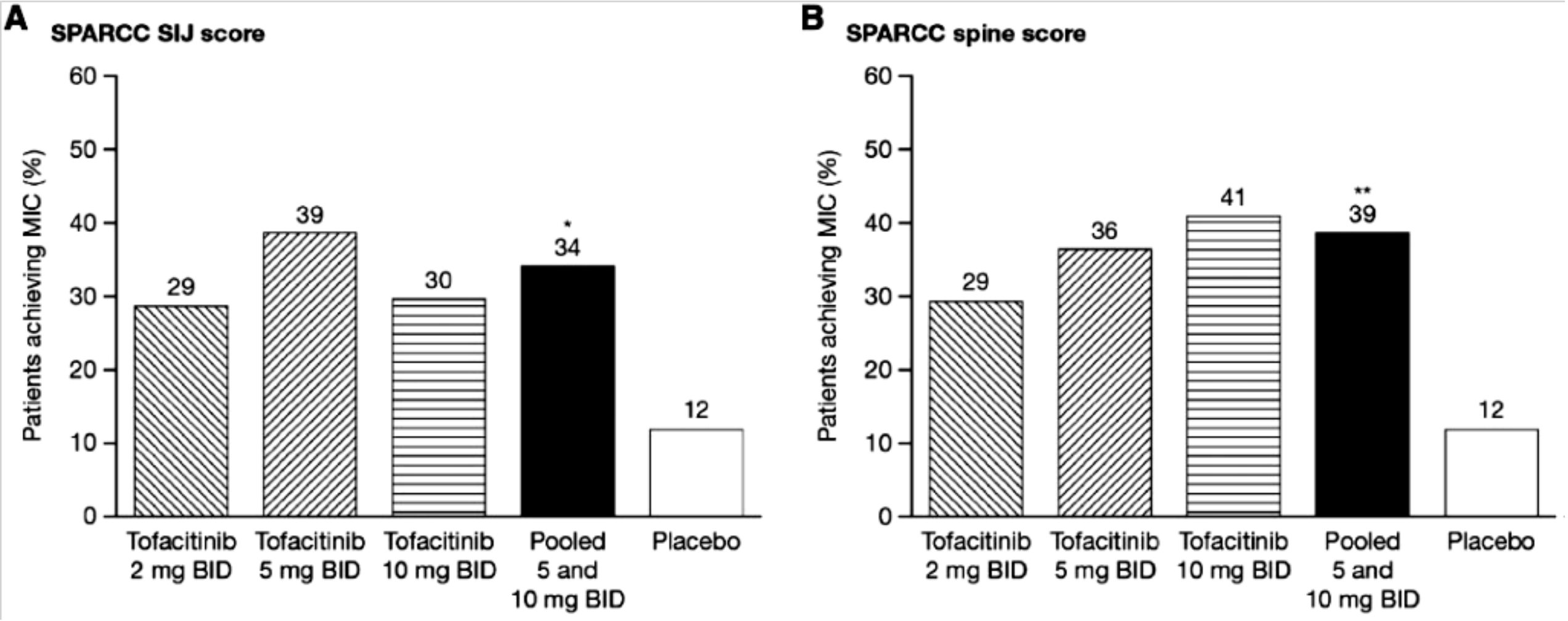
Tofacitinib στην AS







Tofacitinib στην AS

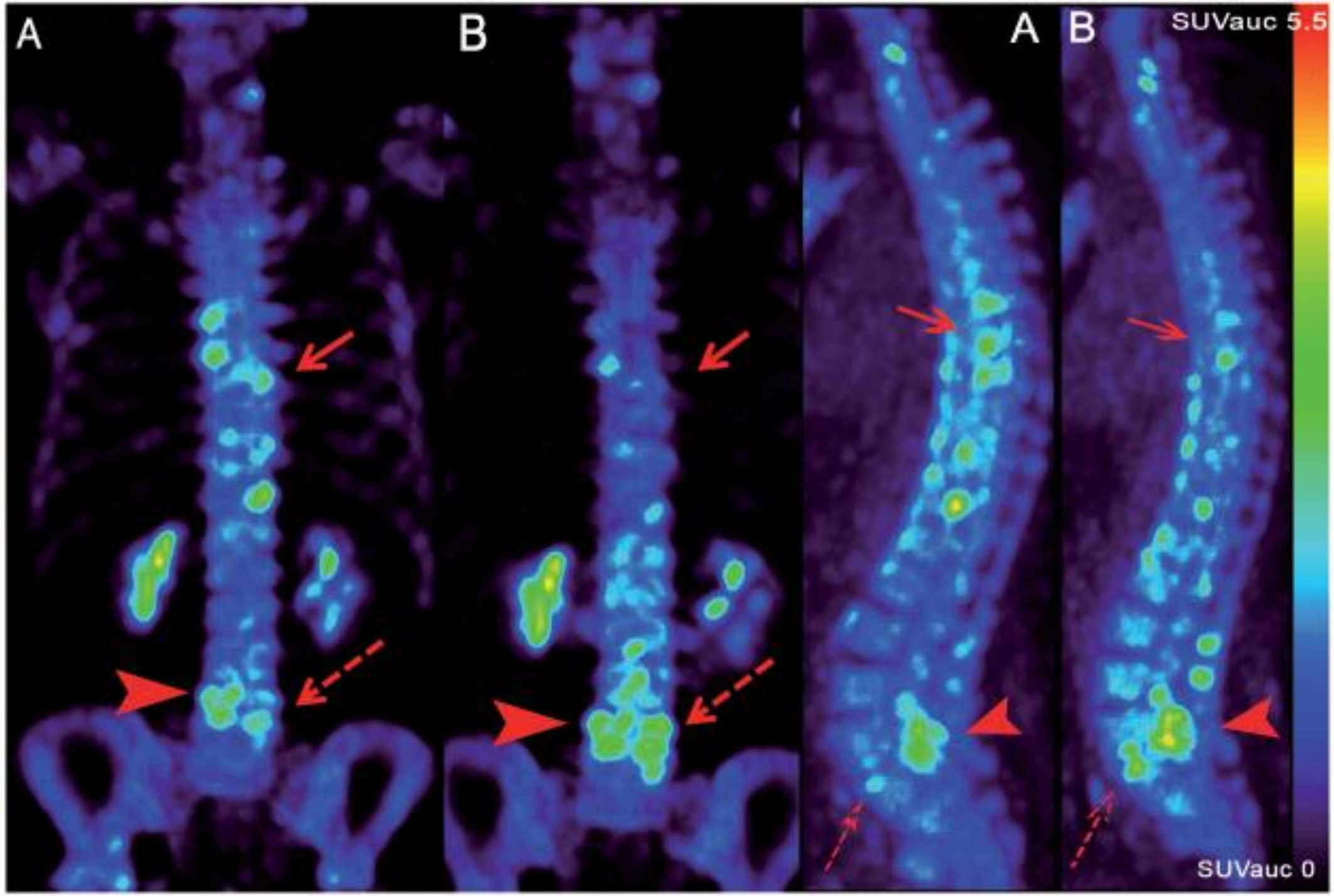


Απεικόνιση

- Whole – body MRI (wbMRI). Απεικονίζει την φλεγμονή και εκτιμά όλες τις περιφερικές αρθρώσεις και τον αξονικό σκελετό.
- Difusion – weighted MRI (DWI). Η αντίθεση της εικόνας παράγεται από την τυχαία κίνηση του νερού στους ιστούς εντός και εκτός κυττάρου, παρέχοντας ποσοτική [apparent diffusion coefficient (ADC)] και ποιοτική πληροφορία. Διαφοροποιεί την ενεργή από την μη ενεργή ιερολαγονίτιδα με τις ποσοτικές ADC μετρήσεις

Απεικόνιση

- Positron Emission Tomography (PET). Συνδυασμοί PET – CT και PET – MRI.
  PET → πρώιμη ανάδειξη φλεγμονής
  PET – CT → ανάδειξη φλεγμονής και δομικών βλαβών
  PET – CT → δείχνει οστική παραγωγή παρά φλεγμονή
  PET – MRI → οστεοβλαστική δραστηριότητα
- Επιβεβαίωση της σχέσης: φλεγμονή στην MRI, αύξηση οστεοβλαστικής δραστηριότητας στο PET, επακόλουθη παραγωγή οστεοφύτων


A
B
A
B
SUVauc 5.5
SUVauc 0

PsA

Search results

Items: 1 to 1066

Filters activated: Publication date from 2017/01/01 to 2017/12/31

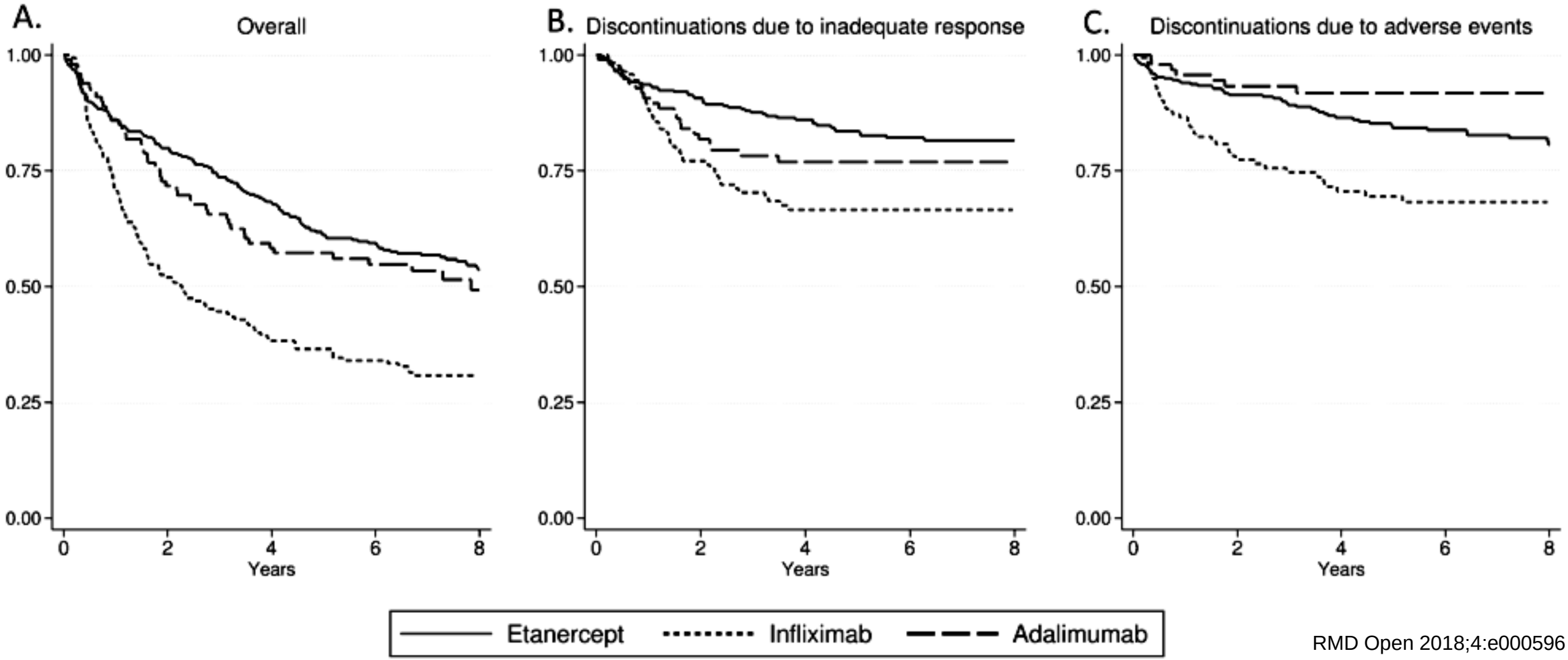
- Our aim was to study CD19(+)CD27(+)CD24(high) memory and CD19(+)CD24(high)CD38(high) transitional and IL-10+Breg cells, known to inhibit Th1 and Th17 cells in experimental arthritis, in psoriatic arthritis (PsA) and psoriasis (Ps). IL-10+Breg cells are decreased in PsA and Ps and inversely correlated with the severity of psoriasis and IL-17A+ and IFNγ+ T cells.

Mavropoulos A, Varna A, Zafiriou E, Liaskos C, Alexiou I, Roussaki-Schulze A, Vlychou M, Katsiari C, Bogdanos DP, Sakkas LI. Clin Immunol. 2017 Nov;184:33-41

Ερωτηματολόγια

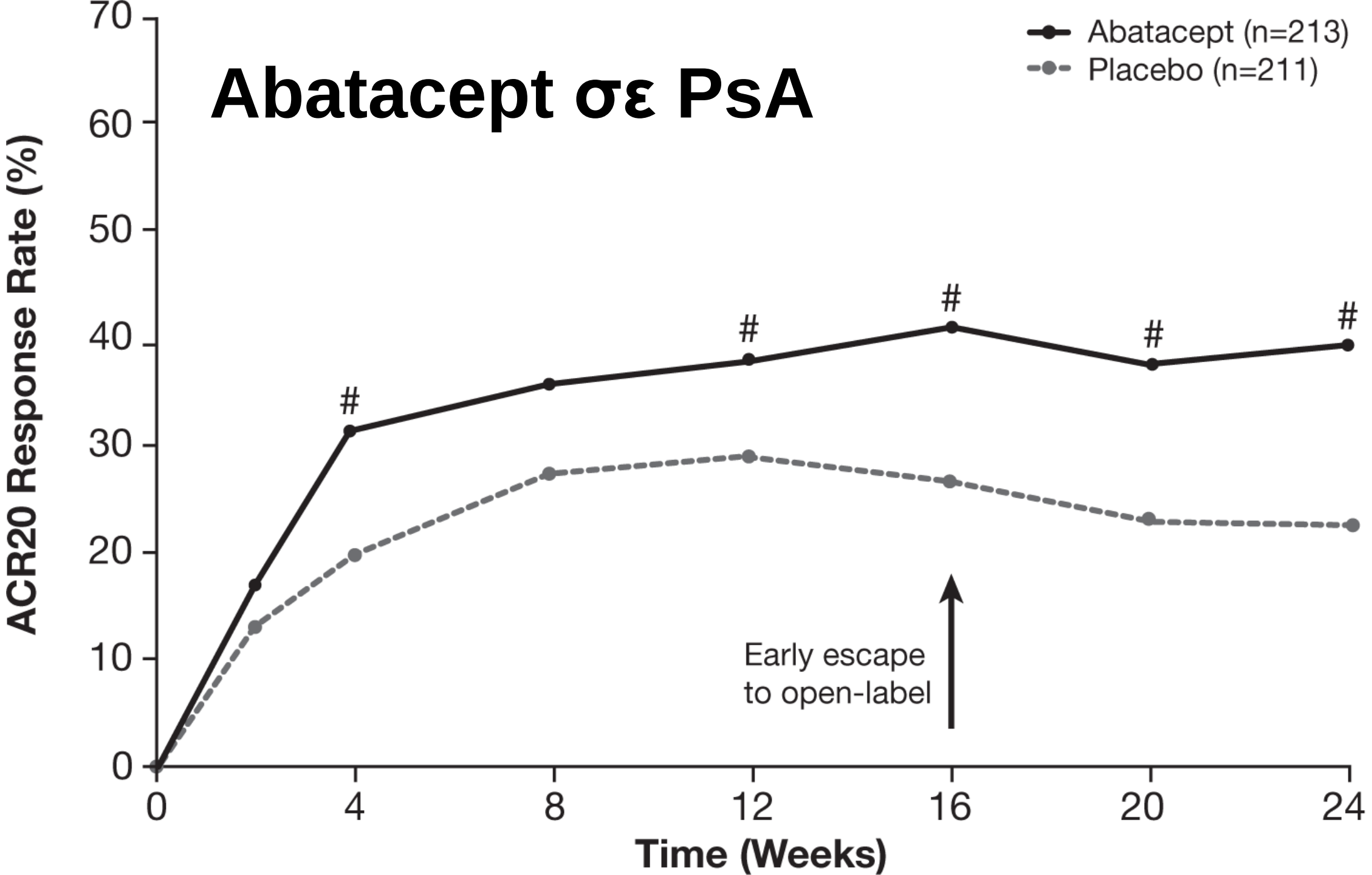
- The aim is to create an self-administered questionnaire, able to identify patients who need a rheumatologic consultation
- A group of dermatologists and rheumatologists developed a new questionnaire called Screening Tool for Rheumatologic Investigation in Psoriatic Patient (STRIPP). Two hundred and twelve patients with the diagnosis of psoriasis, were screened with STRIPP by dermatologists and sent to the rheumatologist.
- Statistical analysis showed a specificity of 93.3% and a sensibility of 91.5% taking a point of 3.5 as a cut-off.

Παραμονή α-TNFs στην PsA. British Registry

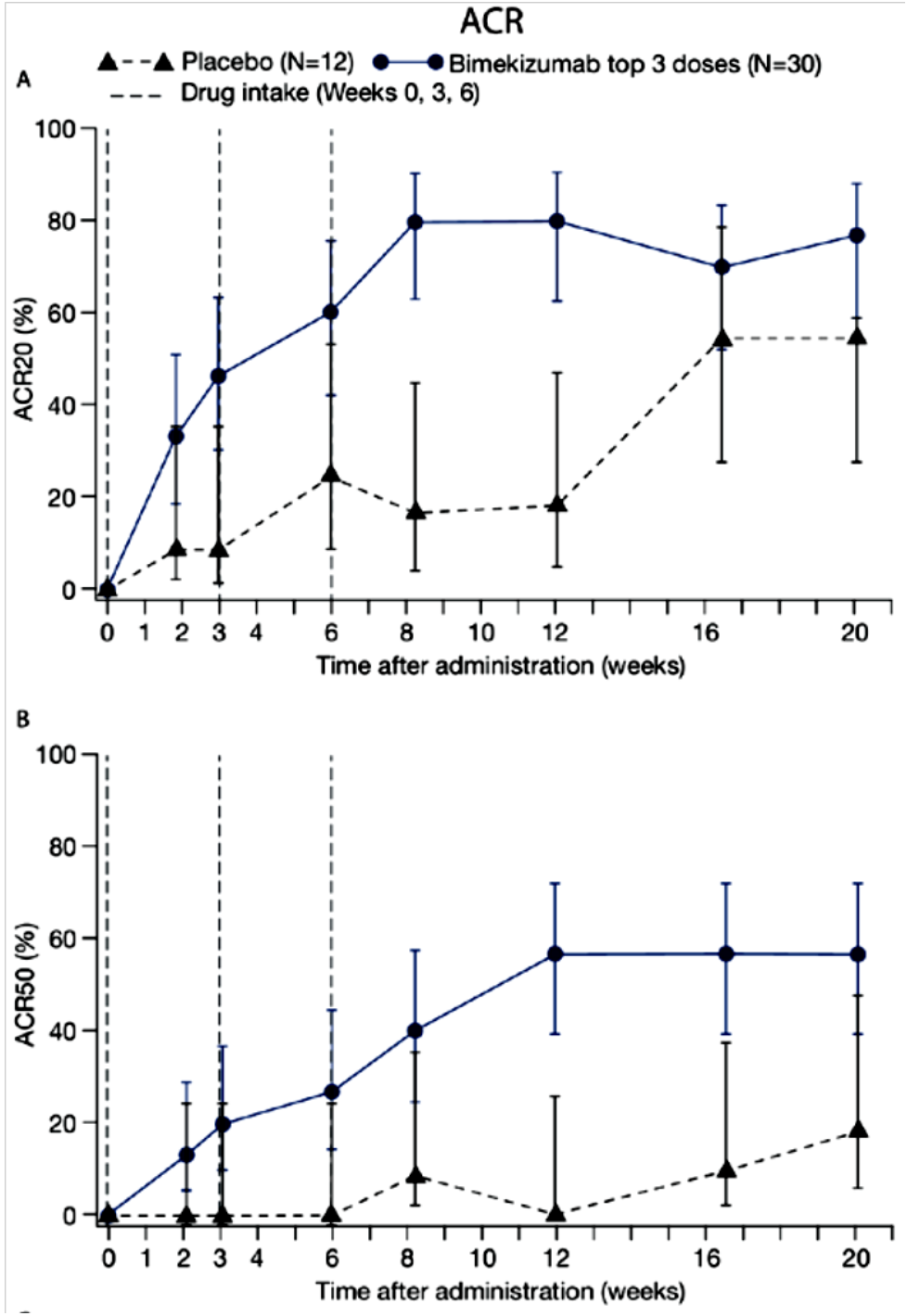


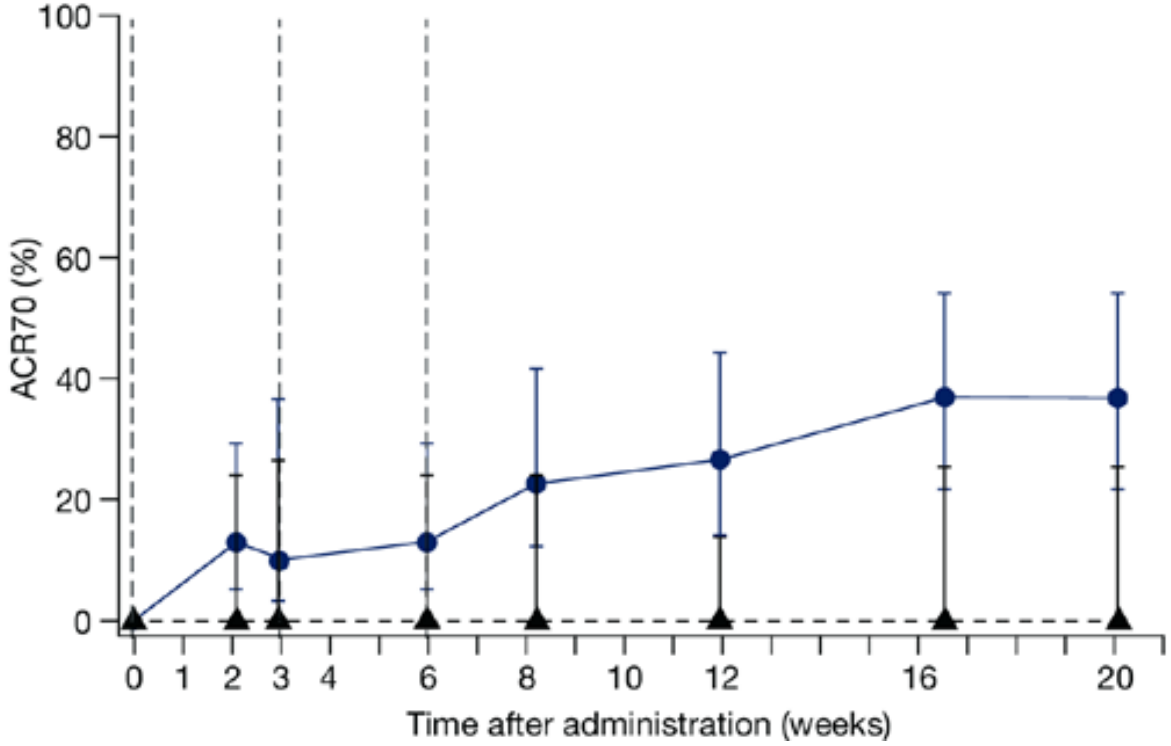
RMD Open 2018;4:e000596

Abatacept σε PsA

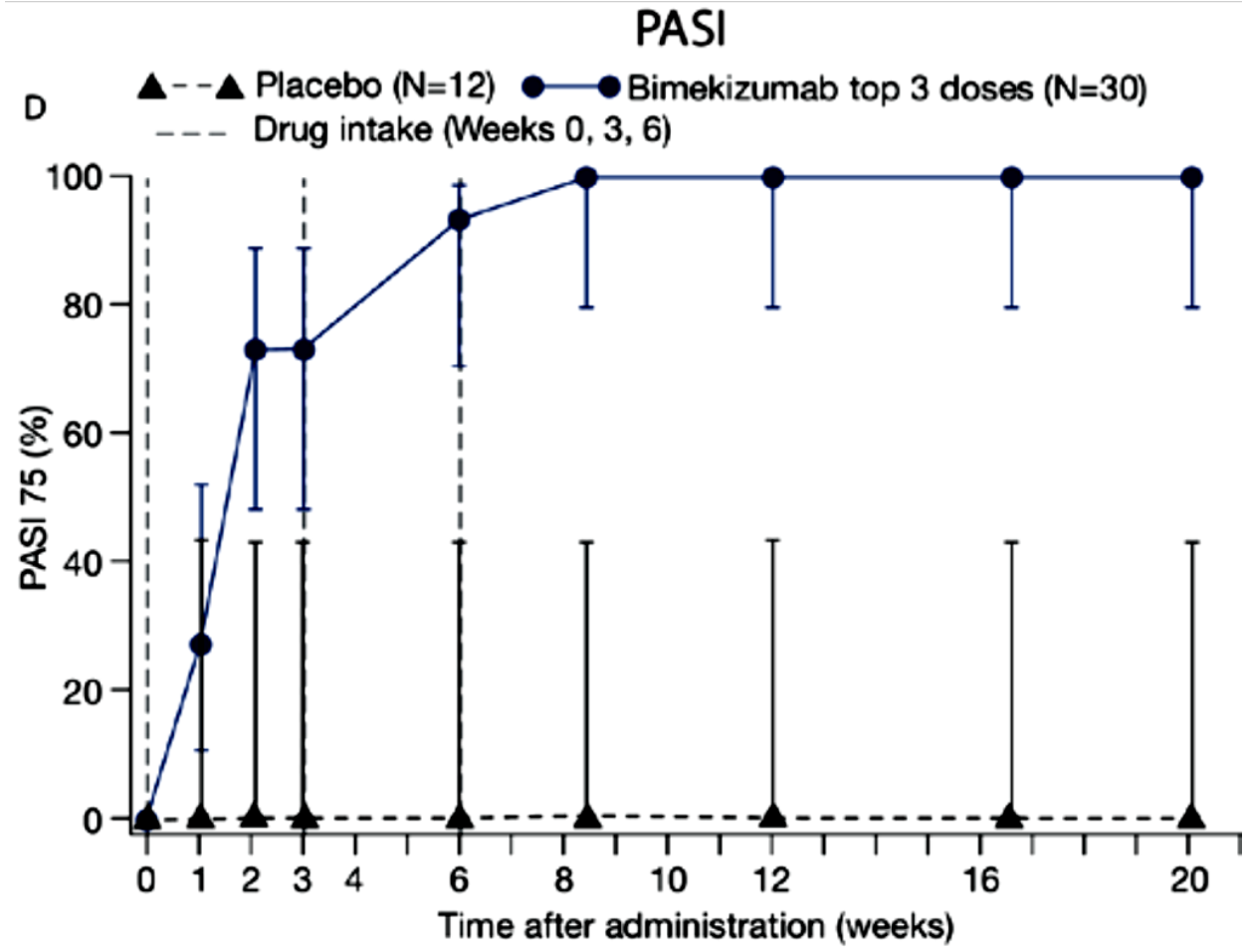


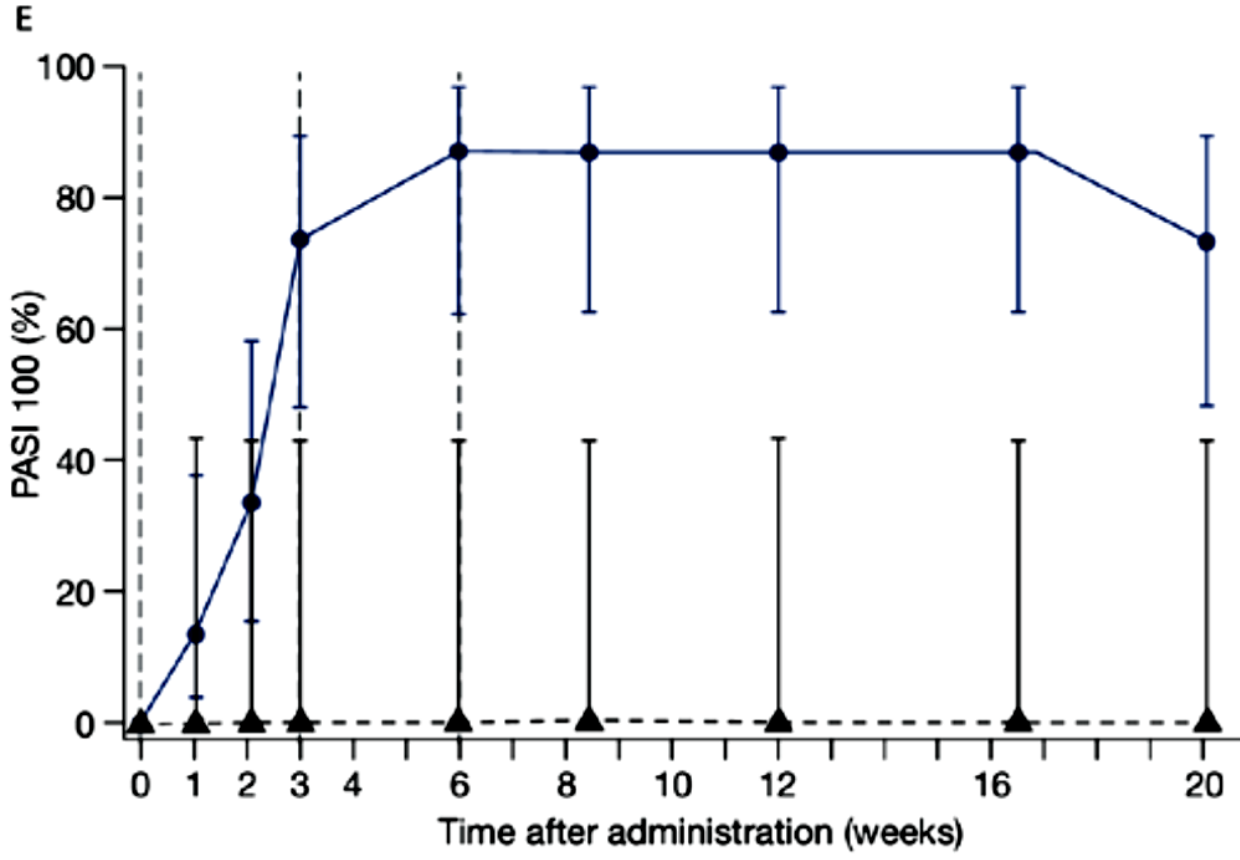
Bimekizumab σε PsA





PA0007, φάση Ib, διπλή τυφλή, ελεγχόμενη με placebo. Bimekizumab 160mg ή 240mg ή 560mg

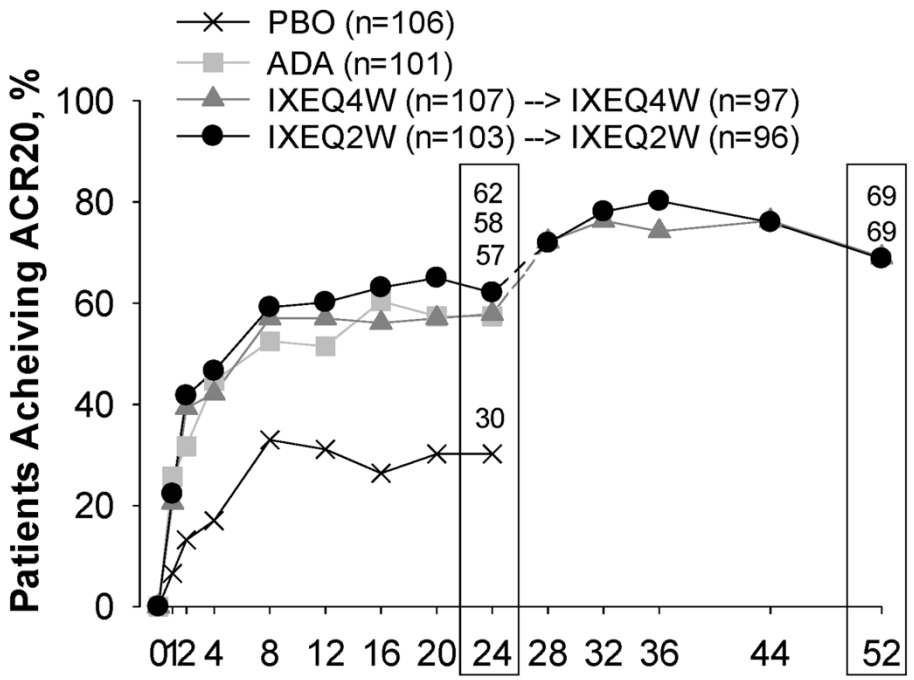


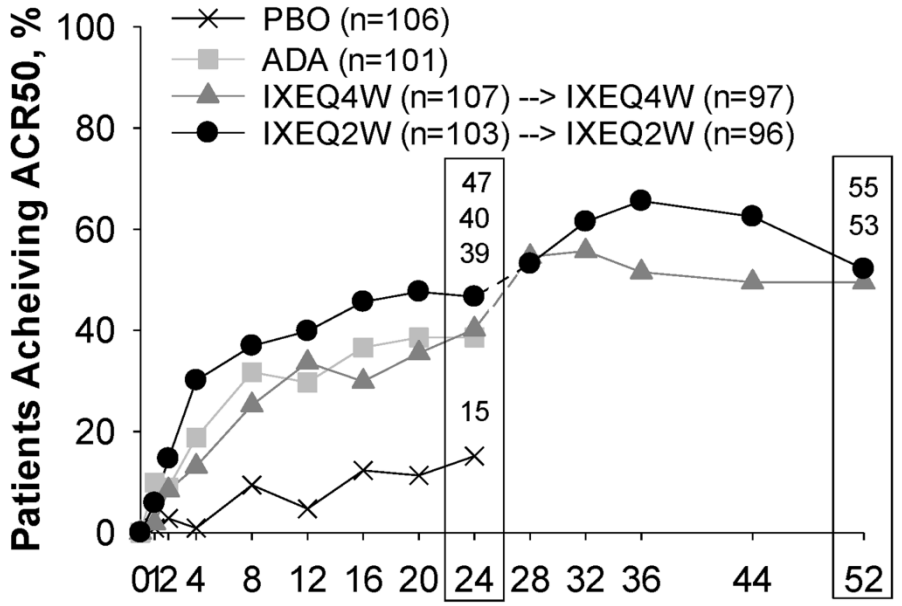


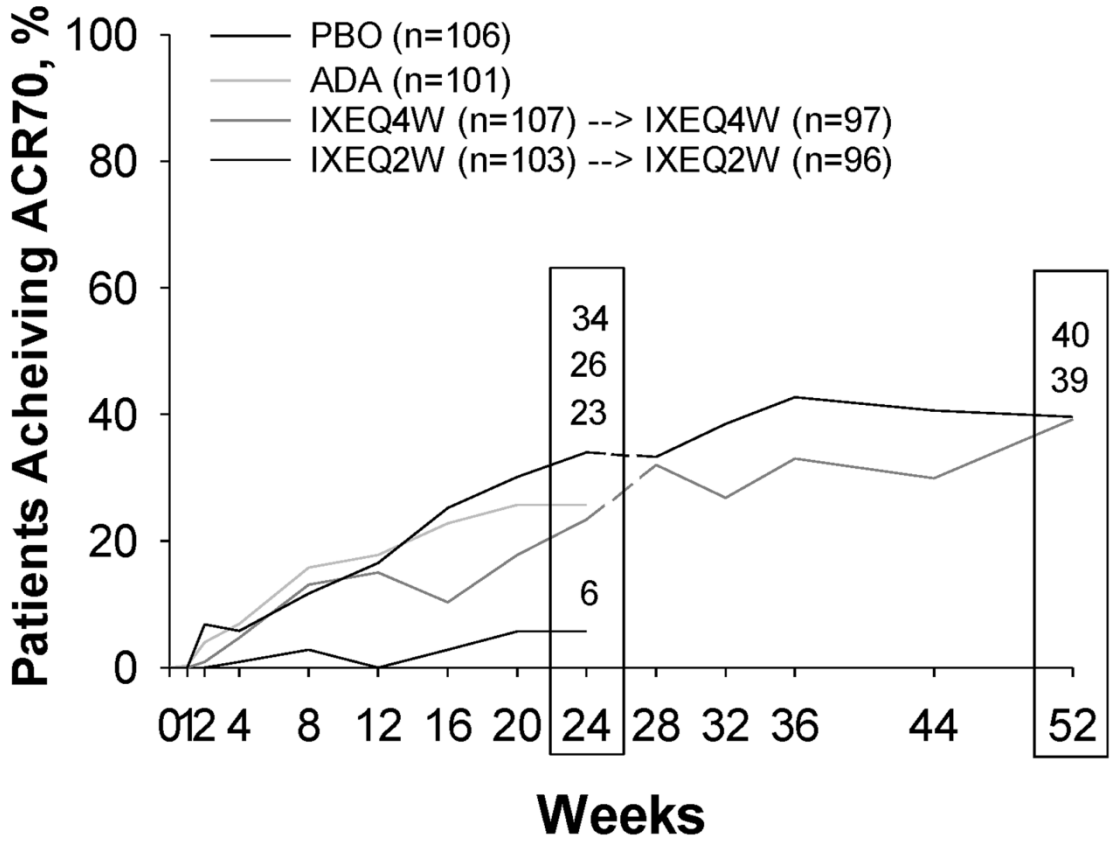
Bimekizumab σε Ps. PASI 75 στο 100% και PASI 100 στο 87% των ασθενών

Ann Rheum Dis 2018;77:523–532

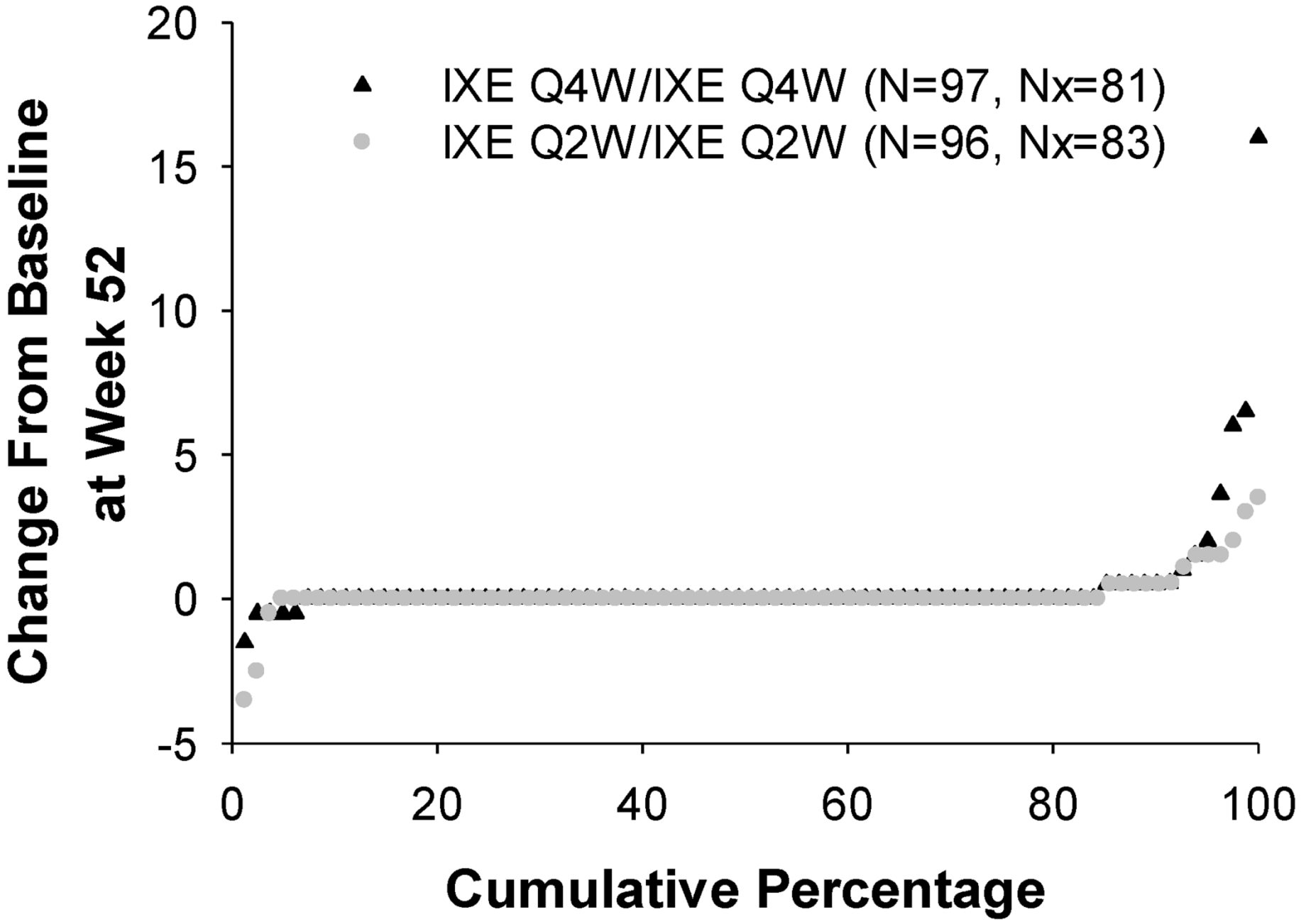
Ixekizumab σε PsA







J Rheumatol 2018;45:367–77



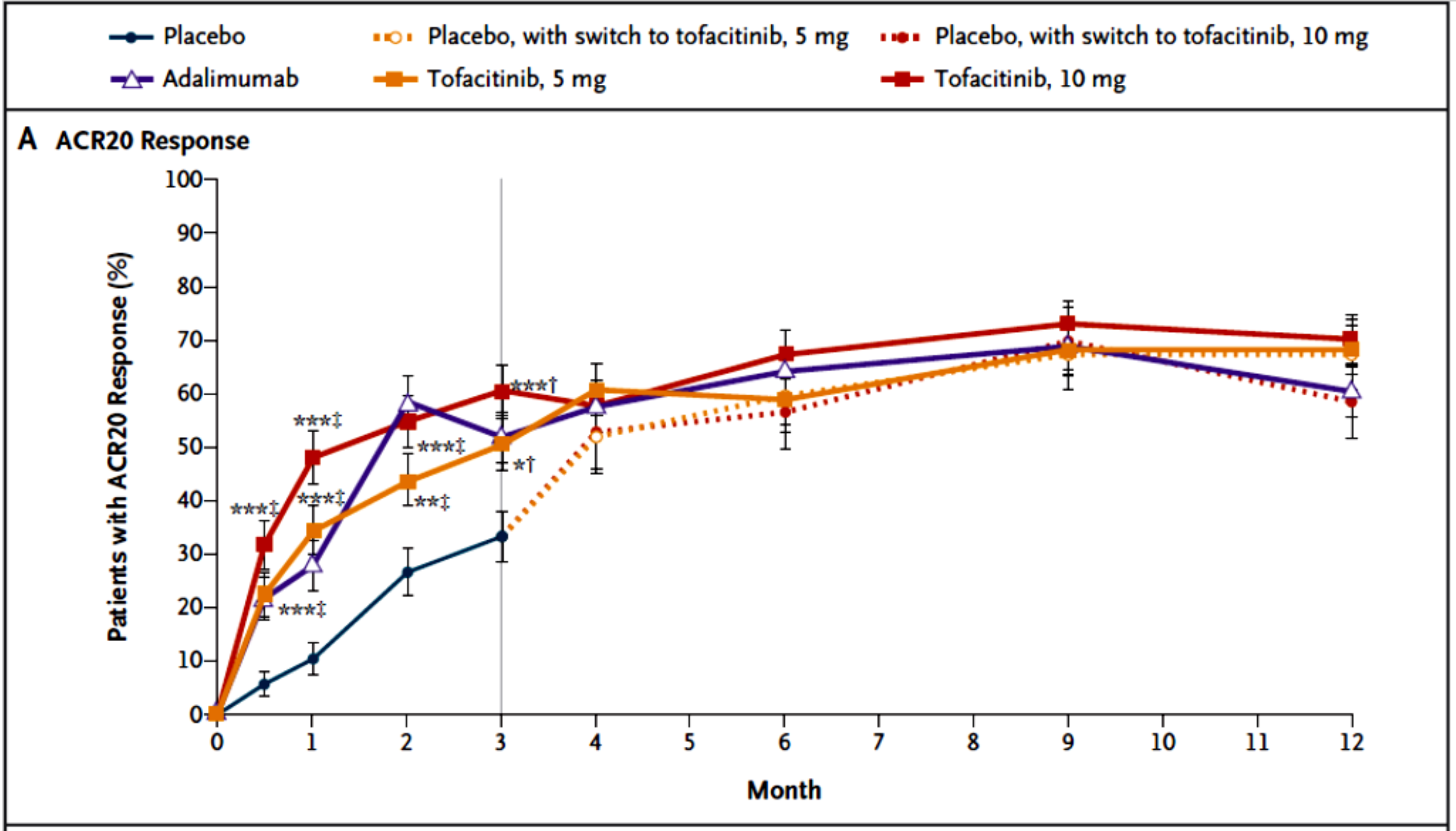
Radiographic progression (mTSS) was minimal in the Total IXEQ2W (0.18) and Total IXEQ4W group (0.36)

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Tofacitinib or Adalimumab versus Placebo for Psoriatic Arthritis

P. Mease, S. Hall, O. FitzGerald, D. van der Heijde, J.F. Merola, F. Avila-Zapata, D. Cieślak, D. Graham, C. Wang, S. Menon, T. Hendrikx, and K.S. Kanik


Placebo
Placebo, with switch to tofacitinib, 5 mg
Placebo, with switch to tofacitinib, 10 mg
Adalimumab
Tofacitinib, 5 mg
Tofacitinib, 10 mg
A ACR20 Response
Patients with ACR20 Response (%)
100
90
80
70
60
50
40
30
20
10
0
0
1
2
3
4
5
6
7
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9
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11
12
Month
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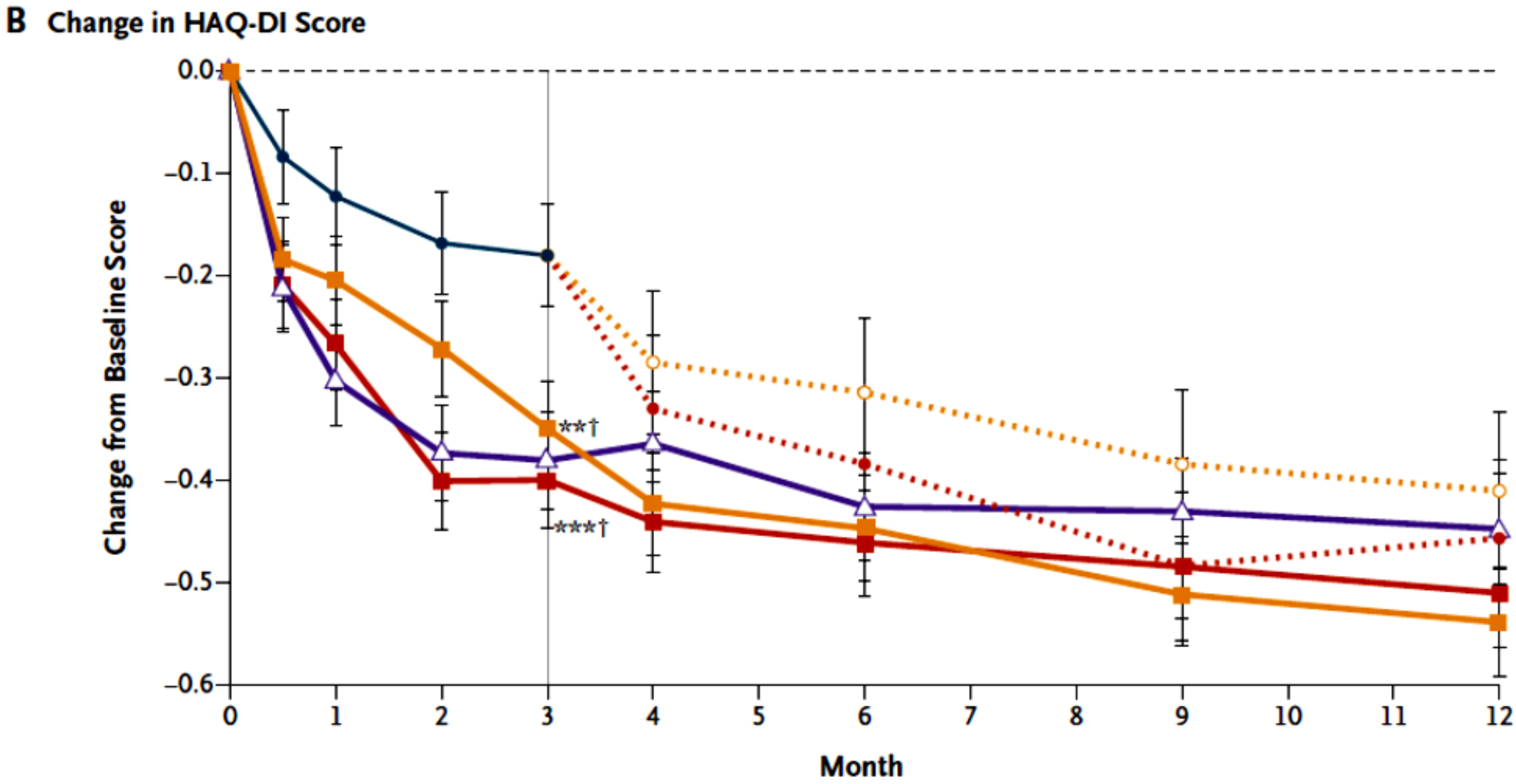


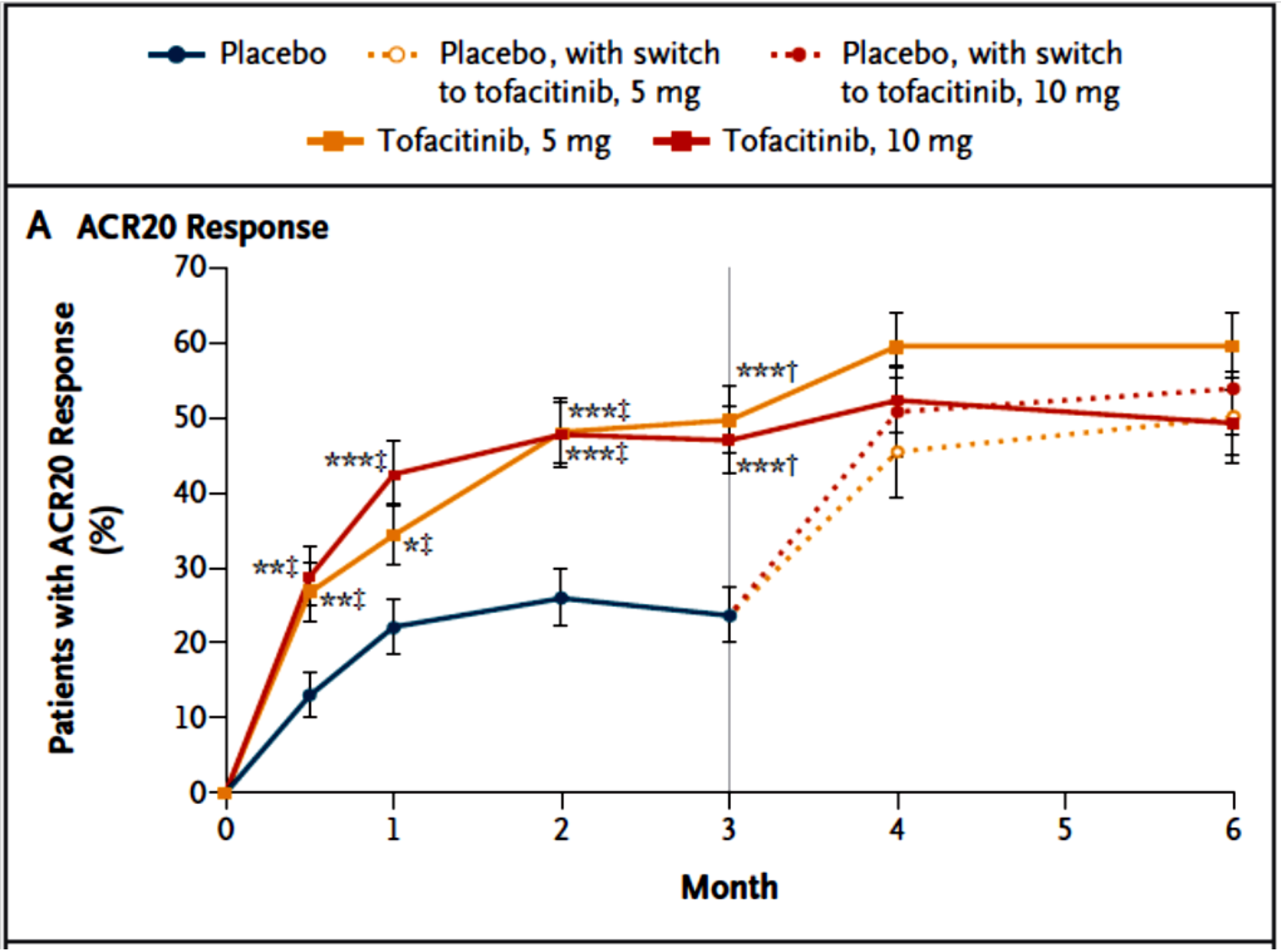
N Engl J Med 2017;377:1537-50

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Tofacitinib for Psoriatic Arthritis in Patients with an Inadequate Response to TNF Inhibitors

Dafna Gladman, M.D., William Rigby, M.D., Valderilio F. Azevedo, M.D., Ph.D., Frank Behrens, M.D., Ricardo Blanco, M.D., Andrzej Kaszuba, M.D., Ph.D., Elizabeth Kudlacz, Ph.D., Cunshan Wang, Ph.D., Sujatha Menon, Ph.D., Thijs Hendrikx, Ph.D., and Keith S. Kanik, M.D.


Placebo
Placebo, with switch to tofacitinib, 5 mg
Placebo, with switch to tofacitinib, 10 mg
Tofacitinib, 5 mg
Tofacitinib, 10 mg
A ACR20 Response
Patients with ACR20 Response (%)
70
60
50
40
30
20
10
0
0
1
2
3
4
5
6
Month
**‡
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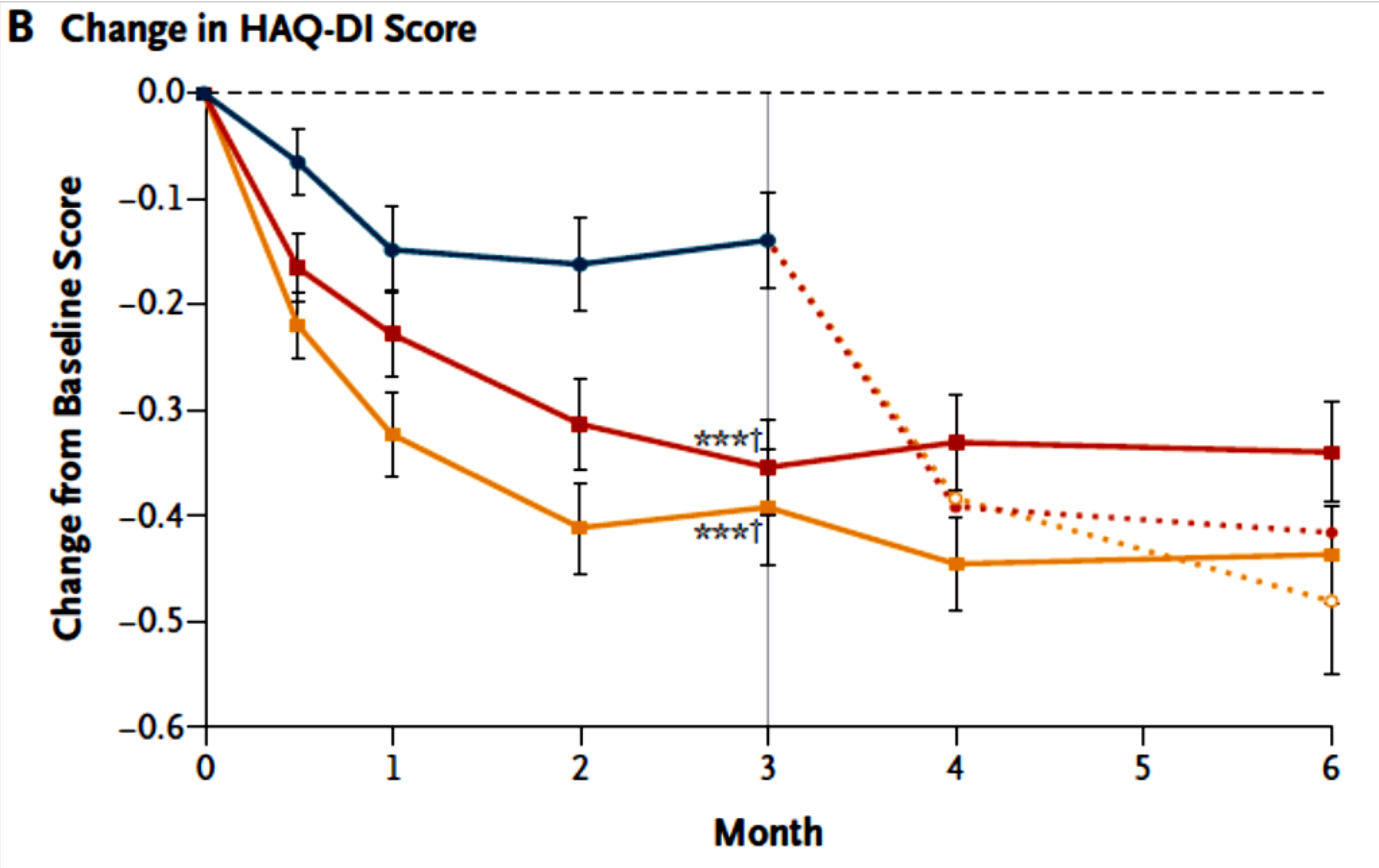
***†


B Change in HAQ-DI Score
0.0
−0.1
−0.2
−0.3
−0.4
−0.5
−0.6
Change from Baseline Score
***†
***†
0
1
2
3
4
5
6
Month

Published on *Pfizer Pharmaceutical News and Media | Pfizer: the world's largest research-based pharmaceutical company* (http://press.pfizer.com) on 12/14/17 7:26 pm EST

Pfizer Announces FDA Approval of XELJANZ® (tofacitinib) and XELJANZ® XR for the Treatment of Active Psoriatic Arthritis

Release Date:
Thursday, December 14, 2017 7:26 pm EST

Terms:

Dateline City:
NEW YORK

XELJANZ/XELJANZ XR, the First Oral JAK Inhibitor in the U.S. for Adults with Moderate to Severe Rheumatoid Arthritis, is now Approved for Adults with Active Psoriatic Arthritis

NEW YORK--(BUSINESS WIRE)--Pfizer Inc. (NYSE:PFE) announced today that the United States Food and Drug Administration (FDA) has approved XELJANZ® 5 mg twice daily (BID) and XELJANZ® XR (tofacitinib) extended release 11 mg once daily (QD) for the treatment of adult patients with active psoriatic arthritis (PsA) who have had an inadequate response or intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs). XELJANZ/XELJANZ XR is the first and only Janus kinase (JAK) inhibitor approved by the FDA for both moderate to severe rheumatoid arthritis (RA) and active PsA.

Ευχαριστώ