ΕΠΕΜΥ
Επιστημονική Εταιρεία
για τη Μυοσκελετική Υγεία

12° Πανελλήνιο Συνέδριο
Ολοκληρωμένη διαχείριση των Φλεγμονωδών
και των Μυοσκελετικών Παθήσεων

Ολοκληρωμένη Διαχείριση της ΨΑ στις γυναίκες

GR-N-CZ-PsA-2000002

ΔΗΜΗΤΡΟΥΛΑΣ ΘΕΟΔΩΡΟΣ
ΕΠΙΚΟΥΡΟΣ ΚΑΘΗΓΗΤΗΣ ΑΠΘ
Δ' ΠΑΘΟΛΟΓΙΚΗ ΚΛΙΝΙΚΗ
ΙΠΠΟΚΡΑΤΕΙΟ ΝΟΣΟΚΟΜΕΙΟ ΘΕΣ/ΝΙΚΗΣ

Σύγκρουση συμφερόντων
Conflict of interest

Παρούσα παρουσίαση: UCB

Εκπαιδευτικές-ερευνητικές-συμβουλευτικές επιχορηγήσεις την τελευταία διετία:

Abbvie, Amgen, Boehringer Ingelheim, Elpen, Enorasis,, JANSSEN, Genesis Pharma, Gilead, ΚΟΠΕΡ, Lilly, Novartis, Pfizer, Mylan, MSD

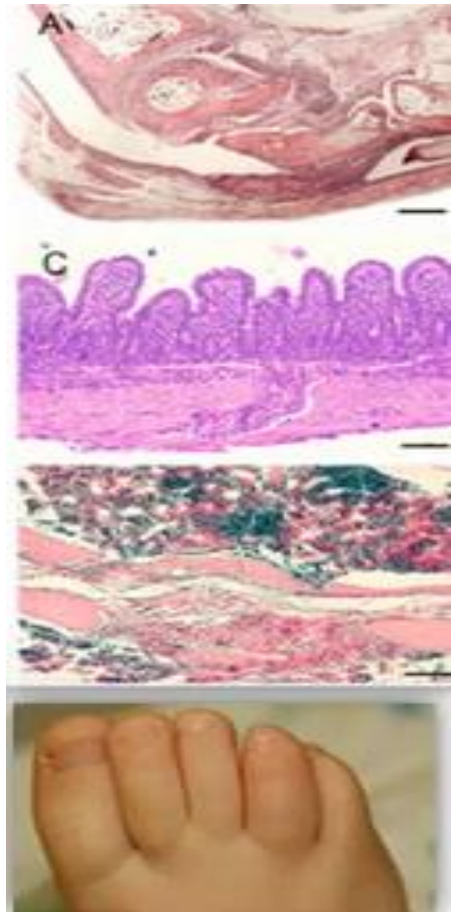
ΨΩΡΙΑΣΙΚΗ ΑΡΘΡΙΤΙΔΑ

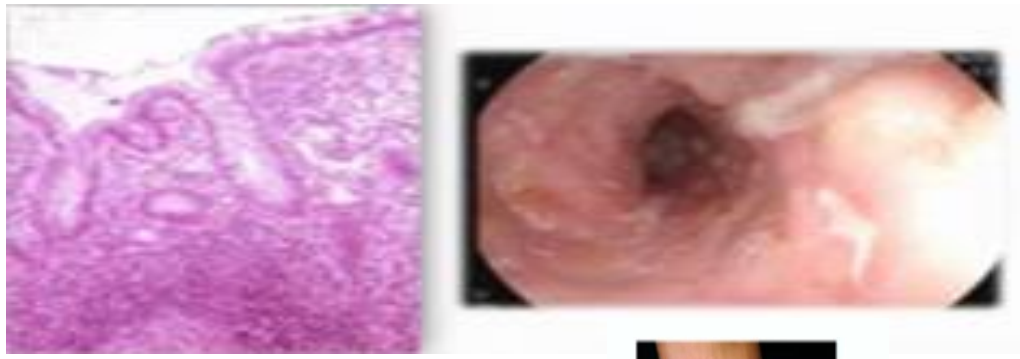
- Πόνος

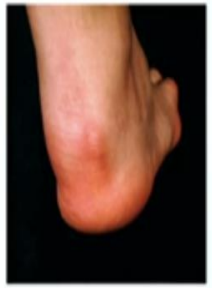
- Δυσφορία

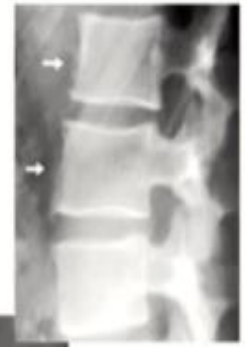
- Στρες

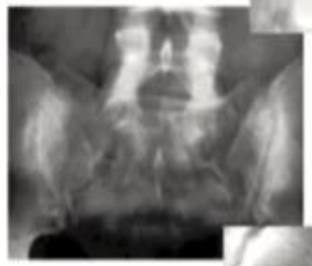
Ετερογένεια κλινικού φαινοτύπου στην Ψωριασική Αρθρίτιδα

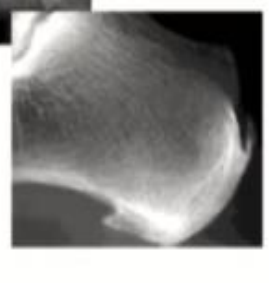


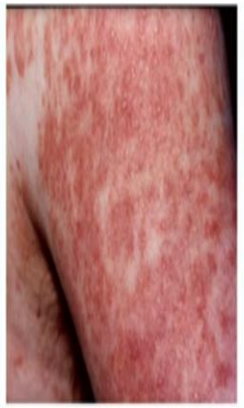


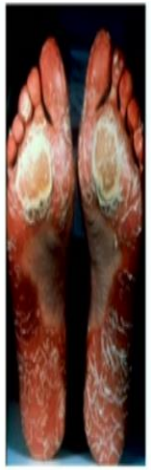


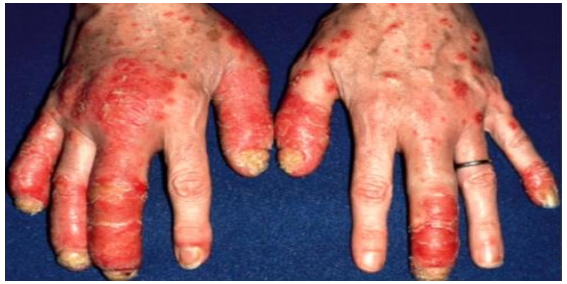




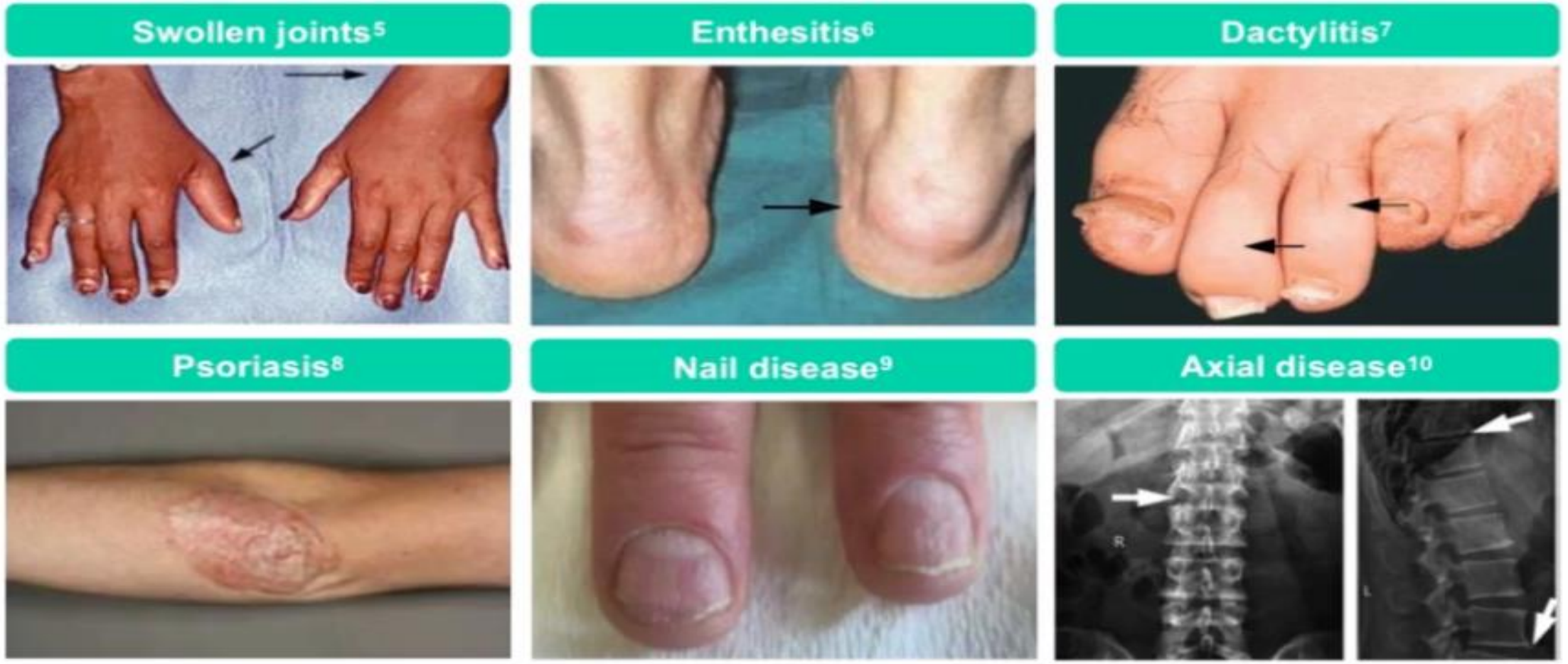








Στην Ψωριασική Αρθρίτιδα εμπλέκονται 6 πεδία της νόσου με τις αντίστοιχες κλινικές εκδηλώσεις

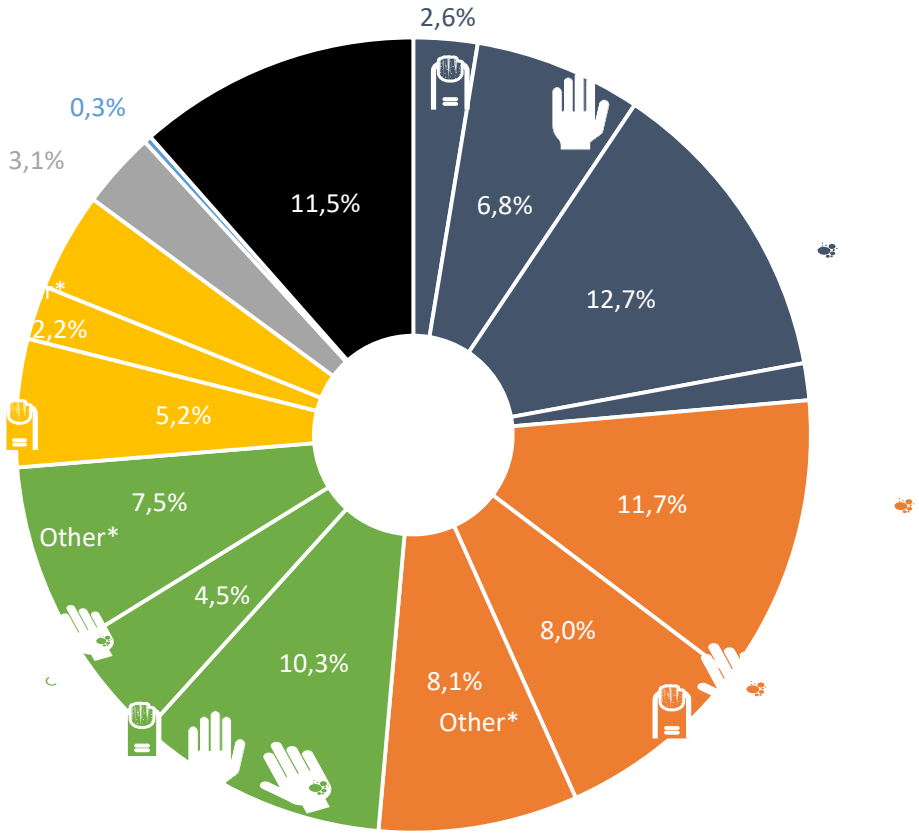


1. Kavanaugh A, et al. Rheumatol Ther 2016;3:91–102; 2. Kyriakou A, et al. Sci World J 2014;Article ID 508178; 3. Lee E, et al. J Exp Med 2004;199:125–30; 4. Lowes M, et al. J Invest Dermatol 2008;128:1207–11;5. Yao Y, et al. PLoS One 2008;3:e2737; 6. Taylan A, et al. Rheumatol Int 2012;32:2511; 7. Limon-Camacho L, et al. J Rheumatol 2012;39:830–5.. 8. Van Kuijk A and Tak P. Curr Rheumatol Rep 2011;13:353–9; 9. Ritchlin C, et al. J Rheumatol 1998;25:1544–52; 10. Menon B, et al. Arthritis Rheumatol 2014;66:1272–81; 11. Celis R, et al. Arthritis Res Ther 2012;14:R93; 12. Spadaro A, et al. Ann Rheum Dis 2002;6:174–6; 13. Molteni S and Reali E. Psoriasis: Targets and Therapy 2012;2:55–66; 14. Siegel E, et al. Curr Opin Rheumatol 2015;27:111–7; 15. Lories R, et al. Nat Med 2012;18:1018–9; 16. Ebihara S, et al. Autoimmunity 2015;29:1–8; 17. Ruutu M, et al. Arthritis Rheum 2012;64;2211–22; 18. Sherlock J, et al. Nat Med 2012;18:1069–77; 19. Yamamoto M, et al. J Invest Dermatol 2015;135:445–53; 20. Reinhardt A, et al. Arthritis Rheumatol 2016;68:2476–86; 21. Coates LC, et al. Lancet 2015;386:2489–98.

Prevalence of Disease Domain Manifestations in Patients with PsA

- Peripheral arthritis
- Nail psoriasis
- Skin disease
- Axial disease
- Enthesitis
- Dactylitis

1	1 domain (n=617)
2	2 domains (n=726)
3	3 domains (n=583)
4	4 domains (n=299)
5	5 domains (n=82)
6	6 domains (n=8)
0	Non-presenters (n=302)



Κάθε ασθενής μπορεί να παρουσιάσει ένα μοναδικό συνδυασμό των συμπτωμάτων και της βαρύτητάς τους με διαφορετικό φορτίο της νόσου γεγονός που αντανακλά τη πολυπλοκότητα της νόσου.

Adapted from Ogdie A et al. Arthritis Rheumatol. 2019;71 (suppl 10). Abstract 2475.

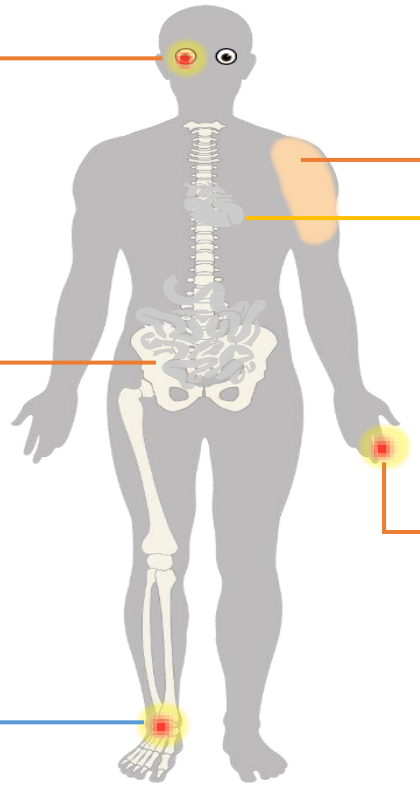
2,617 patients with PsA enrolled in the Corrona PsA/SpA Registry.
*Other (2–4 domains) presentation includes all other combinations of ≥2 domains not shown in the figure; †Other (1 domain) presentation includes axial disease, enthesitis and dactylitis.

Extra-musculoskeletal Manifestations and Comorbidities in Patients with Psoriatic Disease

Extra-musculoskeletal manifestations (EMMs) including psoriasis, uveitis, inflammatory bowel disease (IBD) and nail disease[1-4,8,11-12]

Comorbidities including cardiovascular disease[6,7]

Peripheral articular manifestations such as enthesitis[5-7]



Uveitis

PSO[1]	PsA[2]
7–20%	7–18%

IBD

PSO[3]	PsA[4]
2.3%	4%

Enthesitis

PSO[5]	PsA[6,7]
39.5%*	35–57%

Psoriasis

PSO	PsA[5]
NA	94%

Cardiovascular disease

PSO[6]	PsA[7]
8%	14%

Nail Disease

PSO[11]	PsA[12]
15–79%	Up to 80%

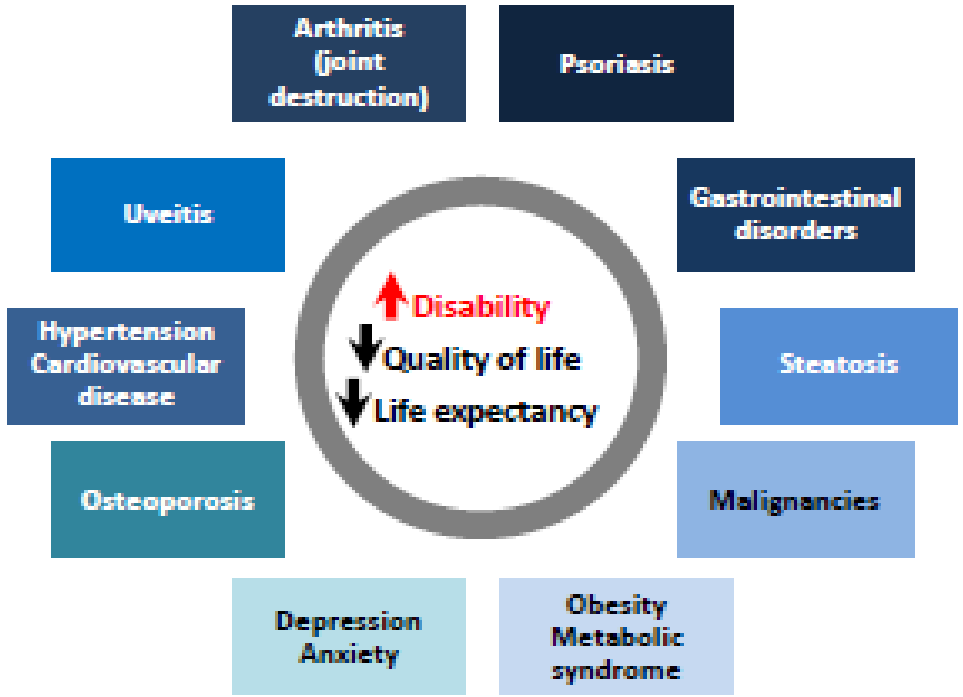
Prevalence of EMMs and comorbidities in patients with PSO is similar to patients with PsA

1. Fraga NA et al. An Bras Dermatol. 2012;87(6):877–883.
2. Chen H and Chou C. Curr Rheumatol Rev. 2008;4:111–14.
3. Loftus E Jr et al. Poster P626. 11th Congress of ECCO, 2016. Abstract P626.
4. Williamson L et al. J Rheumatol. 2004;31:1469–1470.
5. Elnady B et al. Clin Rheumatol. 2019;38(6):1627–1635.
6. Kaeley GS et al. Semin Arthritis Rheum. 2018;48(1):35–43.
7. D'Agostino MA et al. Arthritis Rheum. 2003;48(2):523–533.
8. Kane D et al. Rheumatology (Oxford) 2003; 42(12): 1460–1468.
9. Xiao J et al. JEADV. 2009;23(11):1311–1315.
10. Peluso et al. Clin Rheumatol. 2015;34:745–753
11. Ventura A et al. Drug Design, Development and Therapy. 2017;11:2527–2535.
12. Sobolewski P et al. Reumatologia. 2017;55(3):131–135.

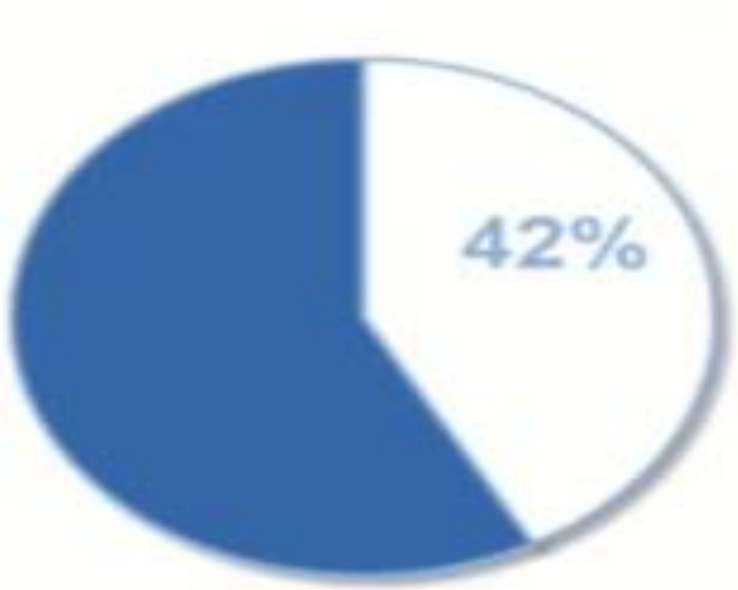
*Patients with enthesitis and/or synovitis.

ΣΥΝΝΟΣΗΡΟΤΗΤΕΣ ΚΑΙ ΨΑ

Συννοσηρότητες σε ασθενείς με ΨΑ



Ασθενείς με >3 συννοσηρότητες

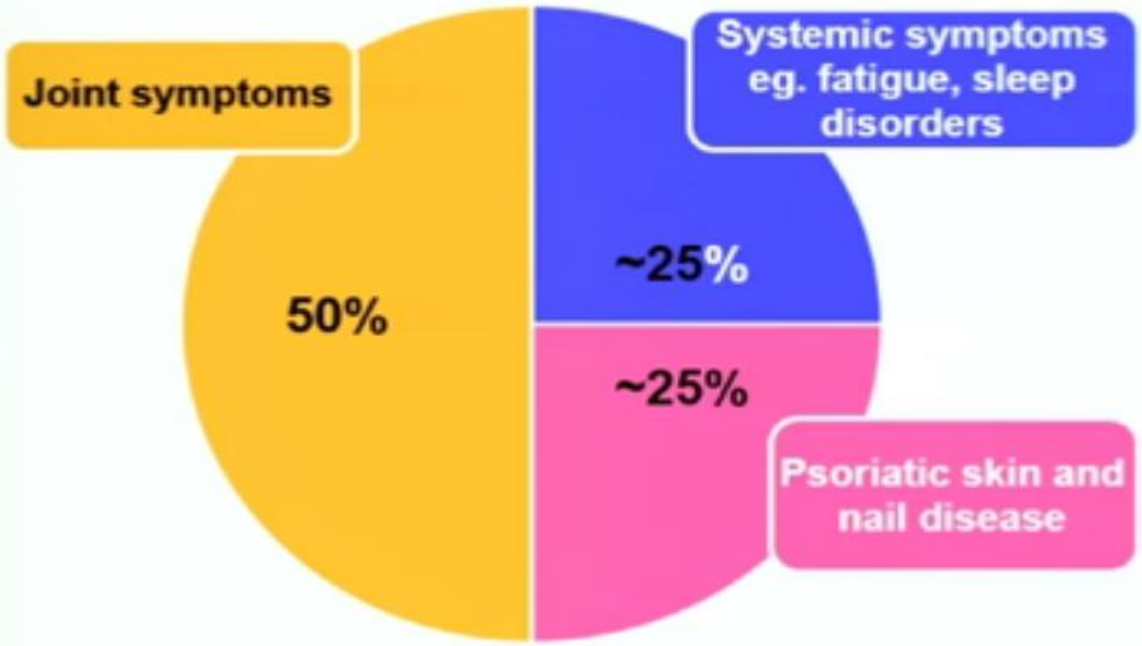


Polachek A, et al Arthr Care Res 2016
Caotes L, Arthritis Rhemauatl 2016
Husted JA et al, J Rheumatol 2013

The Global Burden of PsA

Patient surveys on the global burden of disease

PsA population with predominant musculoskeletal involvement:[1]



Contribution to overall burden of PsA

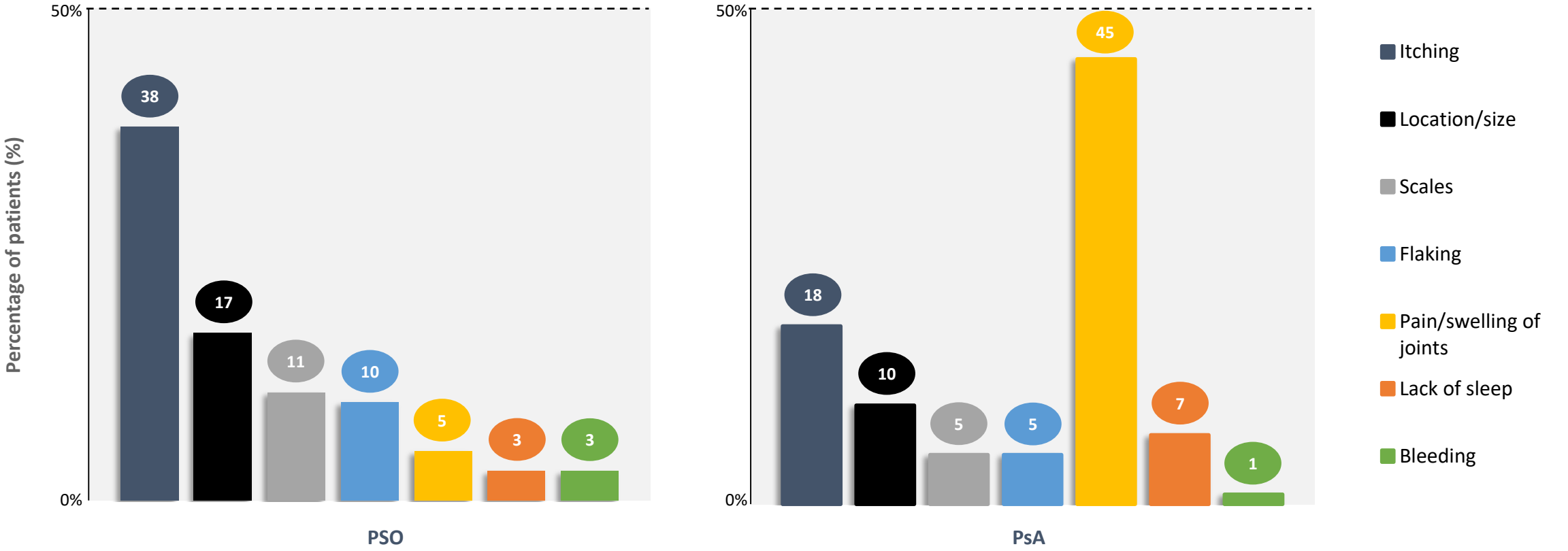
Patient-derived and patient-reported outcome measure for PsA

Domains with the highest relative importance to patients:

- Pain
- Fatigue
- Skin problems

Dandorfer et al, Semin Rheum 2012;42:32-41
Gossec et al, Ann Rheum Dis 2014;73:1012-19

Key Factors Contributing to Disease Severity in Psoriatic Disease



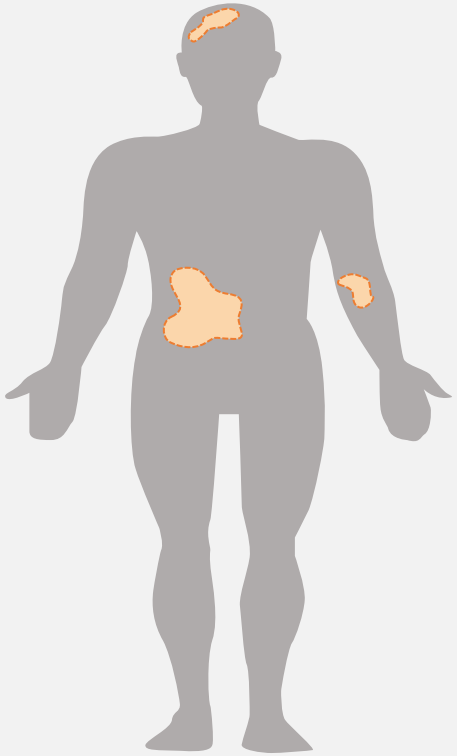
Itching and location of skin involvement in psoriasis, and pain/swelling of joints upon joint involvement, are the patient-reported factors mostly contributing to disease severity

Adapted from Lebwohl MG et al. J Am Acad Dermatol. 2014;70(5):871–881.

Self-reported data (population-based patient survey).

Progression of Psoriatic Disease

Psoriasis

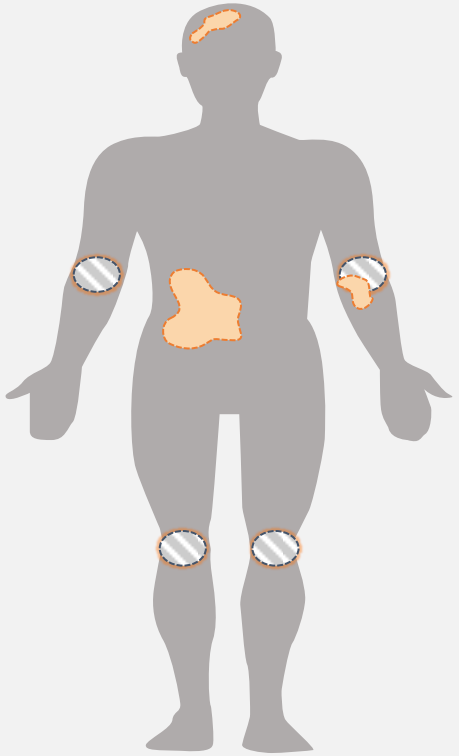


In 70% of cases, psoriasis precedes PsA, with a mean interval of ~10 years [3,4]

In 13% of cases, history of joint involvement precedes onset of skin symptoms, with a mean interval of ~4 years[4]

Parallel onset of skin and joint manifestations is seen in **15–21%** of cases[3–5]

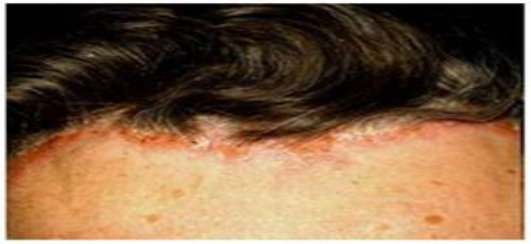
Psoriatic Arthritis



Of all PSO patients, as many as ~40% will develop PsA[1,2]

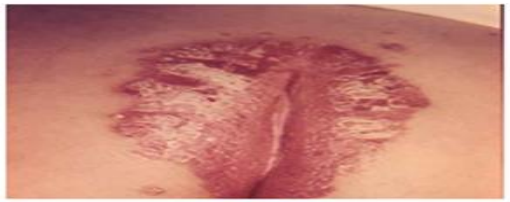
1. Mease PJ and Armstrong AW. Drugs. 2014;74(4):423–441.
2. Gladman DD et al. Ann Rheum Dis. 2005;64 Suppl 2:ii14–17.
3. Leung Y et al. J Postgrad Med. 2007;53:63–71.
4. Kumar R et al. Indian J Dermatol Venereol Leprol. 2014;80(1):15–23.
5. Cohen M et al. J Rheumatol. 1999;26:1752–1756.

PSO Features Associated with a Higher Risk of PsA

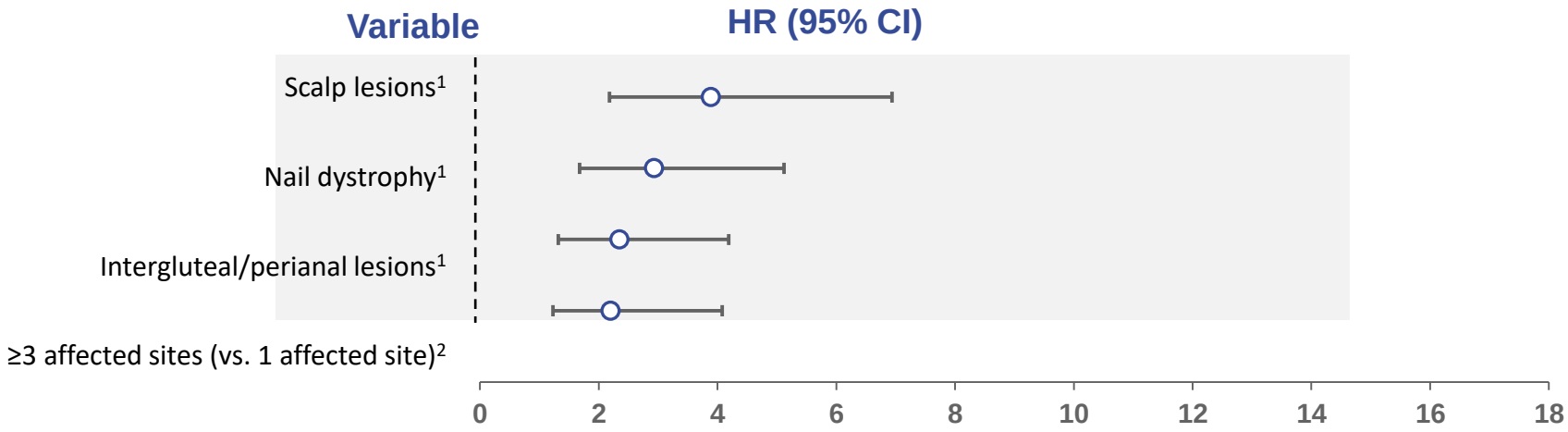


HR 3.89
95% CI (2.18-6.94)

HR 2.93
95% CI (1.68-5.12)



HR 2.35
95% CI (1.32-4.19)



Other features found to be a risk factor for PsA included more extensive skin psoriasis[3], psoriatic nail pitting[4] and uveitis[4]

1. Wilson FC et al. Arthritis Rheum. 2009;61(2):233–239.
2. McLeod B. Evid Based Med. 2009;14(6):185.
3. Ogdie A. Rheumatol. 2013;52:568–575.
4. Eder L et al. Arthritis Rheum. 2016;68(4):915–923.

Time to Diagnosis

"Window of Opportunity"

<6 months | **12 months** | **2+ years**

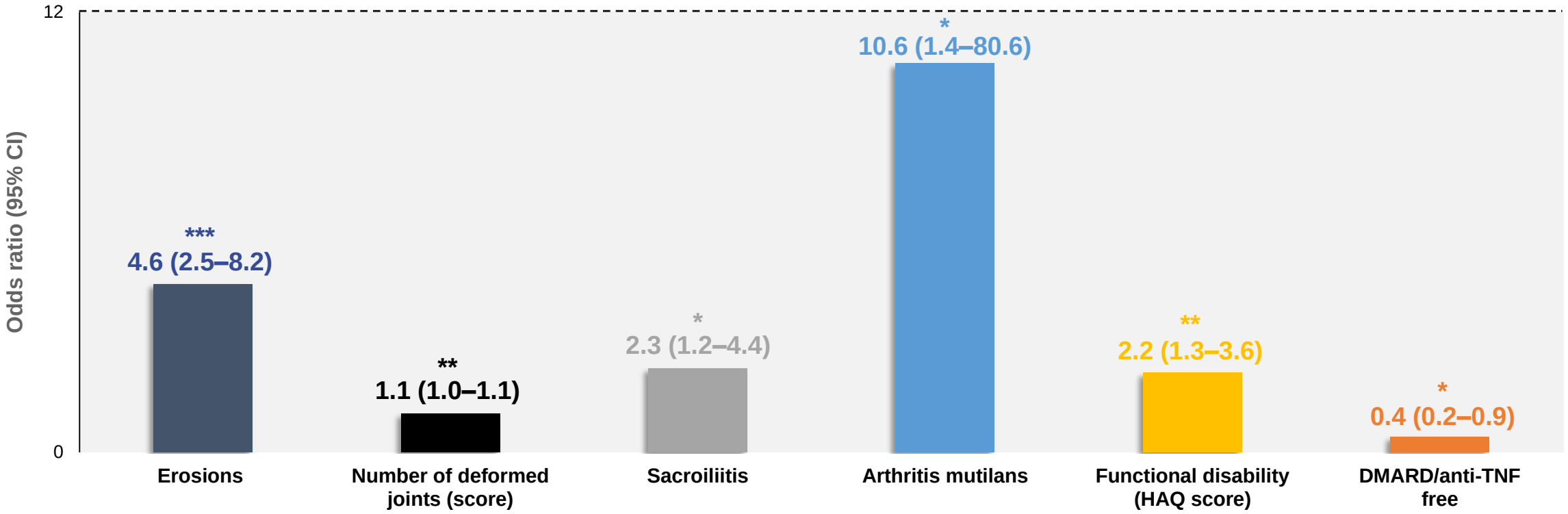
- Less disability
- Less radiographic damage
- Lower risk of joint erosion
- Higher probability of drug-free remission

- Increased disability
- Poor physical health factors
- Increased radiographic damage
- Higher risk of arthritis mutilans
- Lower probability of drug-free remission

Probability of achieving drug-free remission has significant negative association with a diagnostic delay of >1 year, and significant positive association with early rheumatologist encounter of <6 months

Haroon M et al. Ann Rheum Dis. 2015;74(6):1045–1050.

Association of Clinical Features with >6 Month Delay in Diagnosis

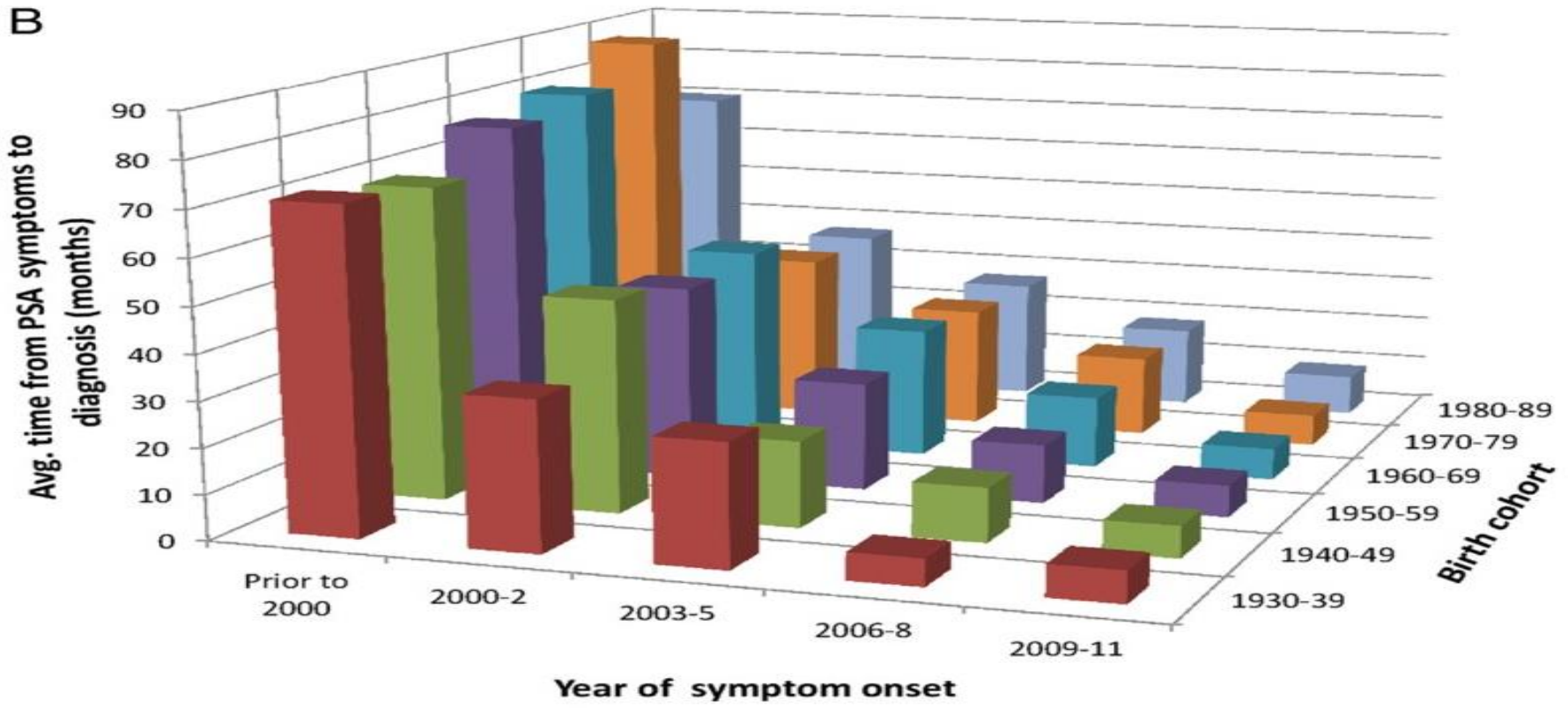


Delayed diagnosis of PsA is associated with poorer long-term outcomes

Haroon M et al. Ann Rheum Dis. 2015;74(6):1045–1050.

*p<0.05; **p<0.01; ***p<0.001

Η καθυστέρηση στη διάγνωση της ΨΑ φαίνεται να βελτιώνεται



Jan Sørensen and Merete Lund Hetland Ann Rheum Dis 2015;74:e12

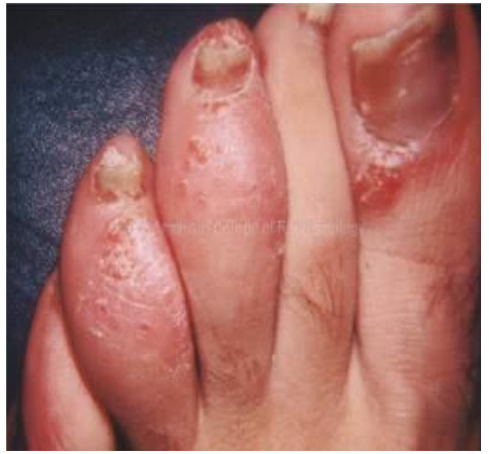
Arthritis Care & Research
AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION · TREATMENT · RESEARCH

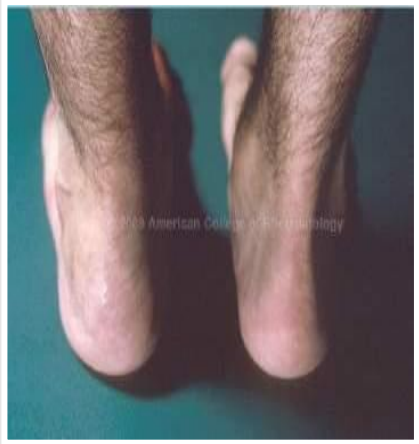
Original Article

Accepted manuscript online: 4 April 2017

Clinical Characteristics, Disease Activity, and Patient-Reported Outcomes in Psoriatic Arthritis Patients With Dactylitis or Enthesitis: Results From the Corrona Psoriatic Arthritis/Spondyloarthritis Registry

Philip J. Mease MD ✉, Chitra Karki MPH, Jacqueline B. Palmer PHARMD, Carol J. Etzel PHD, Arthur Kavanaugh MD, Christopher T. Ritchlin MD, Wendi Malley MS, Vivian Herrera DDS, MPH, Melody Tran PHARMD, Jeffrey D. Greenberg MD, MPH





CORONA Registry 1,567 PsA patients - 420 with enthesitis, 228 with dactylitis

	Ενθεσίτιδα	Δακτυλίτιδα
Αυξημένα πιθανότητα μη επίτευξης LDA/MDA	2.53 (1.55–4.15)	1.88 (1.23–2.86)
Πόνος – VAS	7.40 (3.78–11.02)	7.31 (3.88–10.75)
Κόπωση - VAS	3.30 (-1.22–7.82)	2.47 (-1.86–6.79)
Επίπτωση στη εργασία (απώλεια ωρών εργασίας – μειωμένης απόδοσης)	1.57 (1.05–2.35)	1.21 (0.66–2.22)
Συνολικά μειωμένη δραστηριότητα	2.00 (1.37–2.93)**	1.77 (1.16–2.69)

Impact of Enthesitis and Dactylitis on Physical Function

PsA patients with enthesitis and dactylitis reported more disability compared to all PsA patients in:*

Bending down to pick up objects from the floor
Enthesitis ~35%
Dactylitis ~30%

Walking outdoors on flat ground
Enthesitis ~26%
Dactylitis ~22%

Getting in and out of a car
Enthesitis ~23%
Dactylitis ~21%

Dressing themselves
Enthesitis ~20%
Dactylitis ~22%

Getting in and out of bed
Enthesitis ~22%
Dactylitis ~18%

Washing and drying their body
Enthesitis ~18%
Dactylitis ~16%

Turning faucets on/off
Enthesitis ~12%
Dactylitis ~15%

Lifting a glass to their mouth
Enthesitis ~12%
Dactylitis ~11%

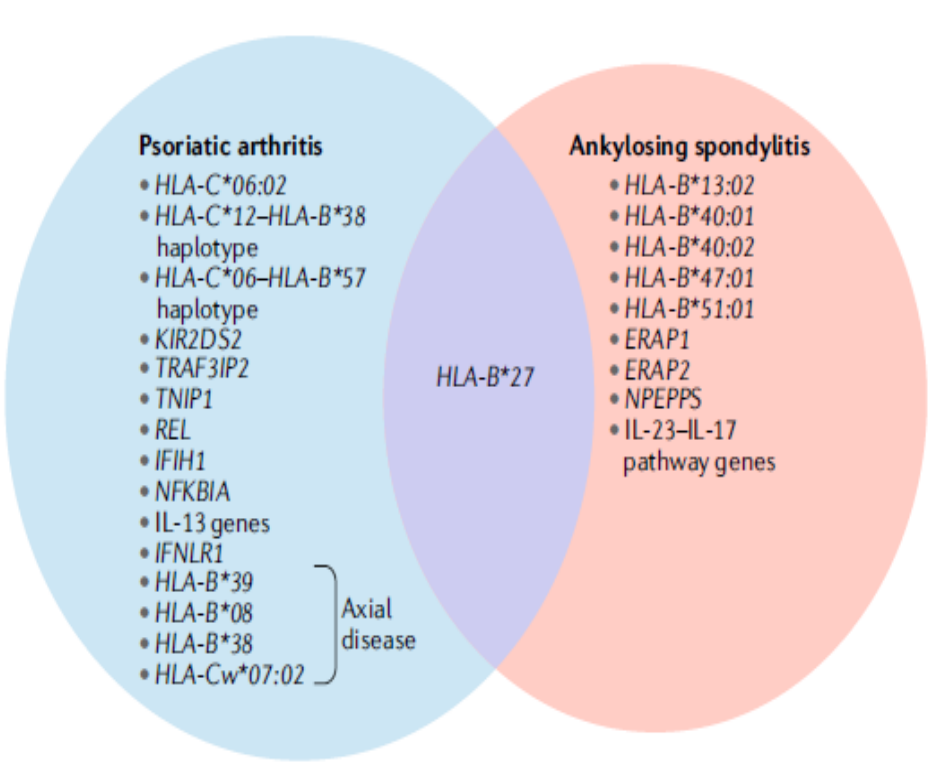
Kavanaugh A et al. Rheumatol Ther. 2016;3:91–102.

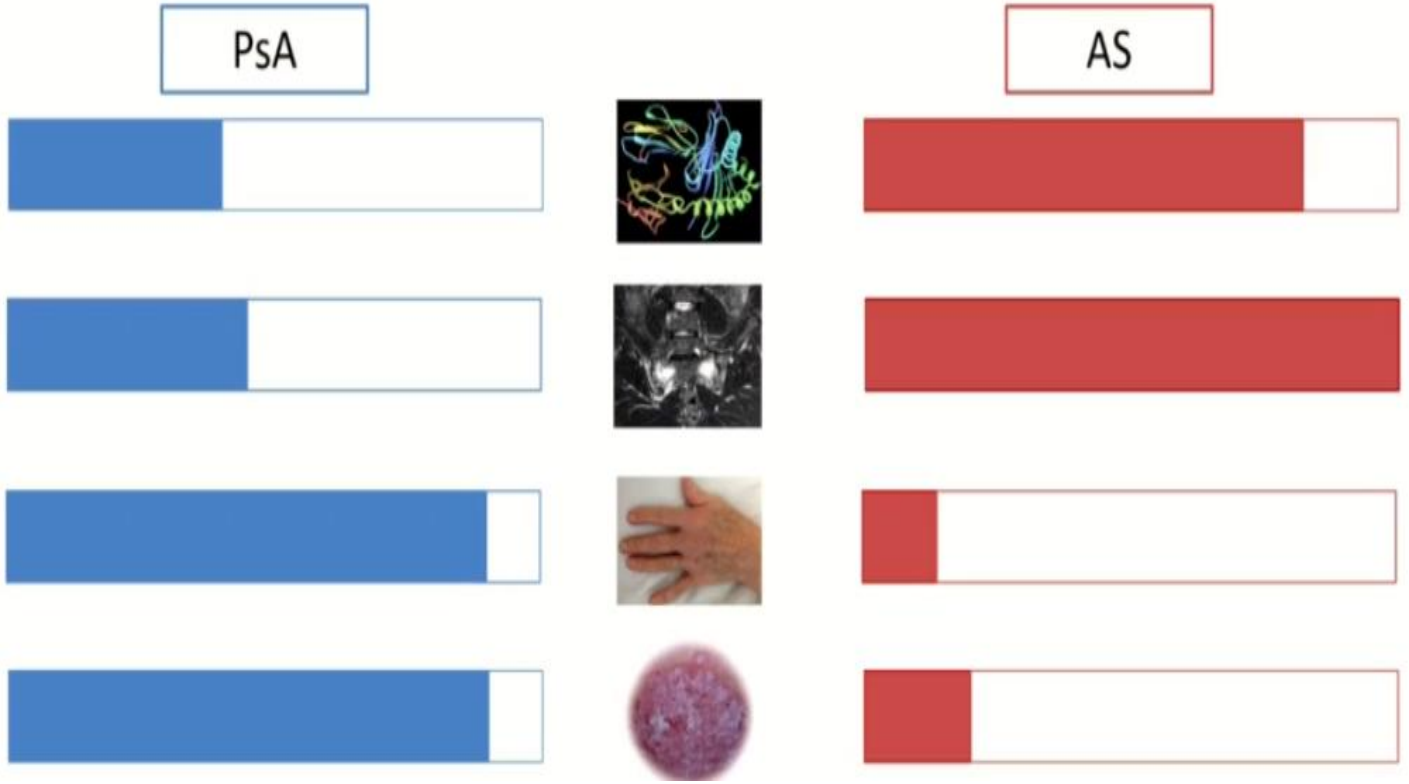
*Proportion of patients responding "with much difficulty" or "unable to do"; Values estimated from figure.

nature REVIEWS RHEUMATOLOGY

Axial disease in psoriatic arthritis and ankylosing spondylitis: a critical comparison

Feld et al, 2018 Jun;14(6):363-371





EXTENDED REPORT

Axial Disease in Psoriatic Arthritis study: defining the clinical and radiographic phenotype of psoriatic spondyloarthritis

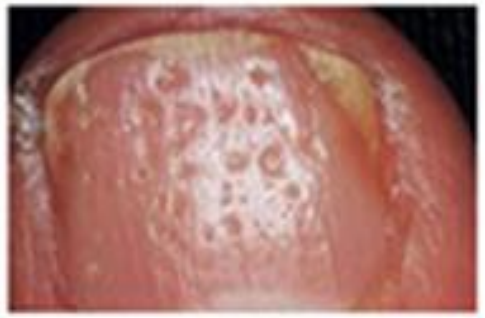
Deepak R Jadon,[1,2] Raj Sengupta,[1] Alison Nightingale,[3] Mark Lindsay,[3] Eleanor Korendowych,[1] Graham Robinson,[1] Amelia Jobling,[4] Gavin Shaddick,[4] Jing Bi,[5] Robert Winchester,[5] Jon T Giles,[5] Neil J McHugh[1,3]

Ann Rheum Dis. 2017 Apr; 76(4): 701–707.

201 PsA, 201 AS

-Μεγαλύτερη διάρκεια νόσου
-Ανδρικό φύλο
- ↑ ΤΚΕ
- Πολυαρθριτικός τύπος
- HLA-B27

Burden of Nail Disease on Patients



- Among PsA patients, nail disease can cause:

Pain
(52%)[1]

Cosmetic problems
(93%)[1]

Difficulties with activities in daily living
(58%)[1]

PsA patients with severe nail disease are reported to have	Severity of nail psoriasis is associated with
• Higher functional impairment[2] • Greater anxiety scores[2] • Greater depression scores[2]	• Enthesitis[2] • Polyarticular disease[2] • Progressive arthritis in PsA[2]

1. Williamson L et al. Rheum. 2004;43:790–794
2. Lee S et al. P&T. 2010;35(12):680–689.

Psoriatic Arthritis (PsA) Features[1–7]

Extra-musculoskeletal manifestations Psoriasis, uveitis, and IBD

Sacroiliitis and spondylitis
Inflammation of sacroiliac joints

Peripheral articular manifestations
Peripheral arthritis, enthesitis and dactylitis

Comorbidities
Cardiovascular disease

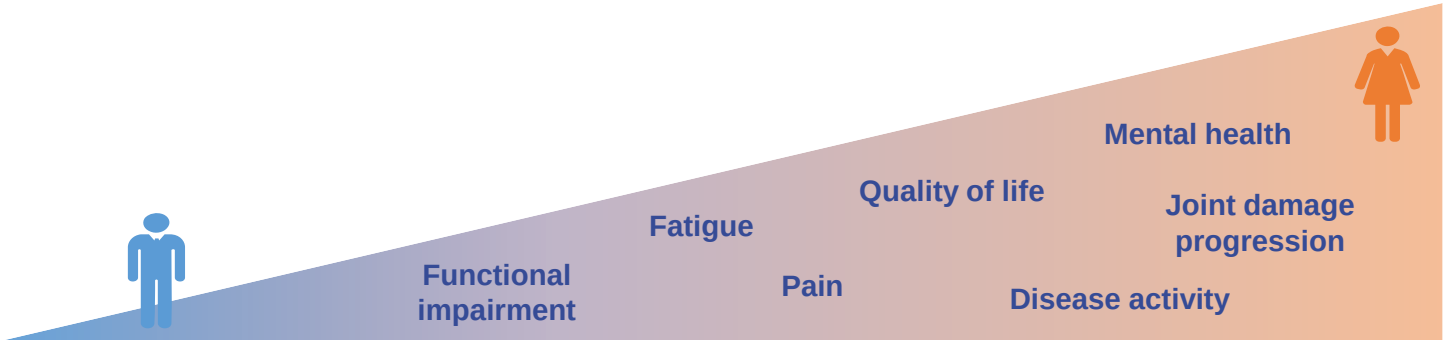
Progression[8,9]

~40% of patients may progress from PSO to PsA

Window of Opportunity for Diagnosis[13]

Early diagnosis		Late diagnosis
↓	Disability	↑
↓	Radiographic damage	↑
↑	Probability of drug-free remission	↓
↓	Sacroiliitis	↑
↓	Functional disability	↑

Diagnosis is Delayed[10] and Outcomes are Worse in Women[11,12]



~15–30% of patients with PSO have **undiagnosed PsA**[14,15]

Burden of Disease

Pain/swelling[16]

Itching[17]

Difficulty with every day activities[18]

Quality of life reduced[18,19]

Depression, anxiety and mental health[11,19]

1. Garg N et al. Best Pract Res Clin Rheumatol. 2014;28(5):663–672.
2. Collantes E et al. Rheumatology. 2007;46(8):1309–1315.
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4. Chen H and Chou C. Curr Rheumatol Rev. 2008;4:111–14.
5. Williamson L et al. J Rheumatol. 2004;31:1469–1470.
6. Kane D et al. Rheumatology (Oxford) 2003; 42(12): 1460–1468.
7. Peluso et al. Clin Rheumatol. 2015;34:745–753.
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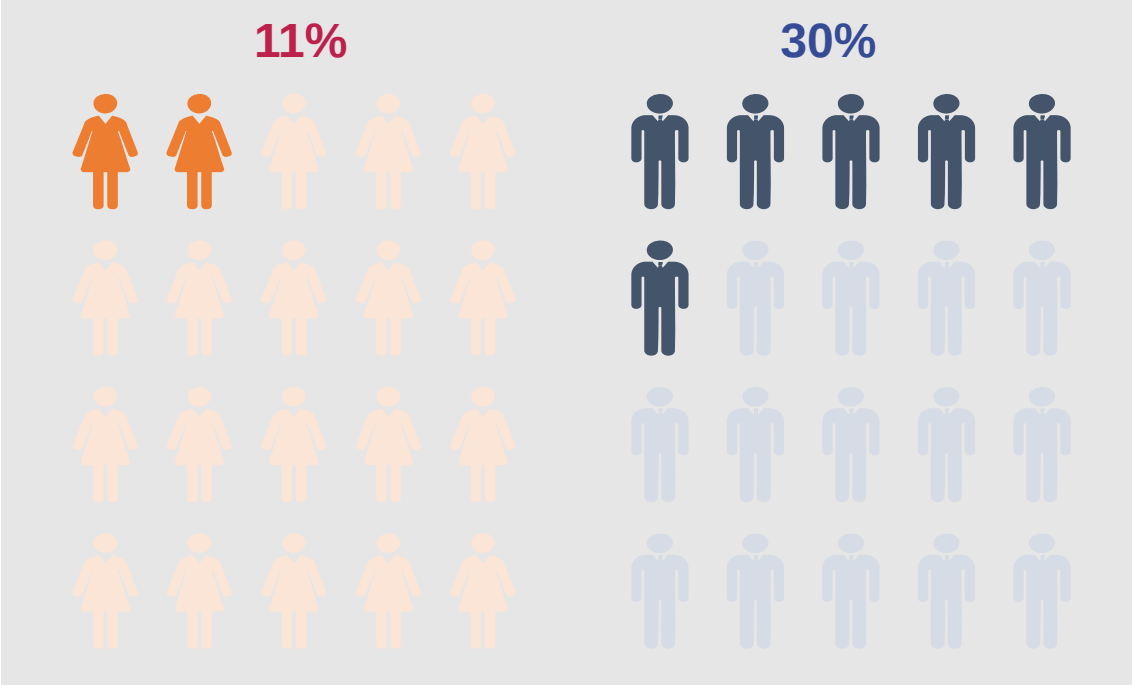
10. Jovani V et al. PLoS One. 2018;13(10):e0205751.
11. Nas K et al. Ann Rheum Dis 2019; 78(Suppl 2):920–921. Abstract FRI0456.
12. Eder L et al. Ann Rheum Dis. 2013;72(4):578–582.
13. Haroon M et al. Ann Rheum Dis. 2015;74(6):1045–1050.
14. Villani et al. J Am Acad Dermatol. 2015;73:242–248.
15. Haroon M et al. Ann Rheum Dis. 2013;72(5):736–740.
16. Lebwohl MG et al. J Am Acad Dermatol. 2014;70(5):871–881.
17. Kavanaugh A et al. Rheumatol Ther. 2016;3:91–102.
18. Picchianti-Diamanti A et al. Qual Life Res. 2010;19:821–826.
19. Salaffi F et al. Health Qual Life Outcomes. 2009;7:25.

Female Patients have a Higher Probability of Misdiagnosis

First Correct Diagnosis of SpA



Common Misdiagnoses Before SpA Diagnosis

Misdiagnosis	Women	Men
Herniated disc, n (%)	5 (10.9)	11 (19.0)
Scoliosis, n (%)	2 (4.4)	5 (8.6)
Sciatica, n (%)	9 (19.6)	4 (6.9)
Osteoarthritis, n (%)	6 (13.0)	3 (5.2)
Fibromyalgia, n (%)	3 (6.5)	1 (1.7)

Only 11% of women received a first correct diagnosis of spondyloarthritis vs 30% of men

Jovani V et al. PLoS One. 2018;13(10):e0205751.

A cross-sectional study of 96 men and 54 women with spondyloarthritis was performed at Alicante University General Hospital in Spain using a semistructured interview and clinical records.

Before Definitive Diagnosis of SpA, Male Patients are Referred to Specialists More Often than Female Patients

	Attending Prior Diagnosis in Rheumatology Clinic			Referring to Rheumatology Clinic		
Health Services	**Women (N=54)**	**Men (N=96)**	**P value**	**Women (n=54)**	**Men (n=96)**	**P value**
Primary care	44 (81.5)	86 (89.6)	0.16	14 (25.9)	30 (31.3)	0.49
Orthopaedic surgery	34 (63.0)	49 (51.0)	0.16	11 (20.4)	23 (24.0)	0.62
Rehabilitation services	9 (16.7)	16 (16.7)	1	0	2 (2.0)	NA
Emergency department	**21 (38.9)**	**15 (15.6)**	**0.001**	**9 (16.7)**	**6 (6.3)**	**0.04**
Workers' compensation insurance	2 (3.7)	14 (14.6)	0.05	**0**	4 (4.2)	NA
Neurology	2 (3.7)	4 (4.2)	1.0	1 (1.9)	2 (2.1)	1.0
Physiotherapy	2 (3.7)	3 (3.1)	1.0	0	0	NA
Pain unit	2 (3.7)	2 (2.1)	0.62	0	0	NA
Urology	1 (1.9)	2 (2.1)	1.0	1 (1.9)	1 (1.0)	1.0
Gastroenterology	0	3 (3.1)	NA	0	2 (2.1)	NA
Ophthalmology	**6 (11.1)**	**1 (1.0)**	**0.009**	**5 (9.3)**	**1 (1.0)**	**0.02**
Rheumatology	3 (5.6)	1 (1.0)	0.13	0	0	NA
Neurosurgery	1 (1.9)	1 (1.0)	1.0	0	0	NA
General internal medicine	0	1 (1.0)	NA	0	1 (1.0)	NA
Psychology	0	1 (1.0)	NA	0	0	NA
Cardiology	0	1 (1.0)	NA	0	2 (2.1)	NA
Vascular surgery	1 (1.9)	0	NA	0	0	NA
Gynaecology	1 (1.9)	0	NA	0	0	NA
Intensive care unit	1 (1.9)	0	NA	0	0	NA
Non health services	0	0	NA	11 (20.4)	14 (14.6)	0.36
Don't know	0	0	NA	2 (3.7)	8 (8.3)	0.33

Jovani V et al. PLoS One. 2018;13(10):e0205751.

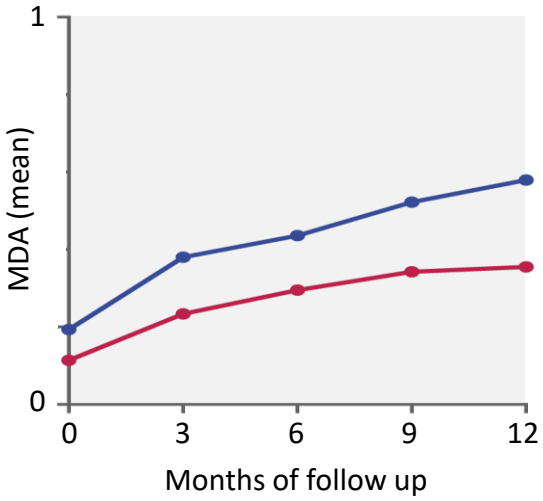
A cross-sectional study of 96 men and 54 women with spondyloarthritis was performed at Alicante University General Hospital in Spain using a semistructured interview and clinical records.

Gender Specific Differences in Early PsA

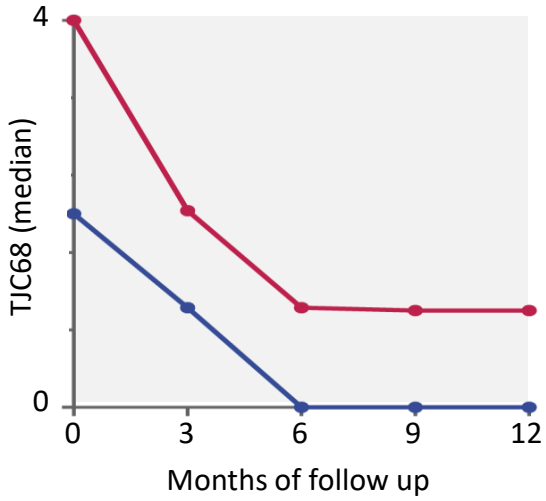
Patients with newly diagnosed PsA were included in the Dutch south-west Early Psoriatic Arthritis prospective cohort study (273 men and 294 women)

Women reported significantly longer duration of symptoms before diagnosis and significantly fewer of them were in paid employment at baseline

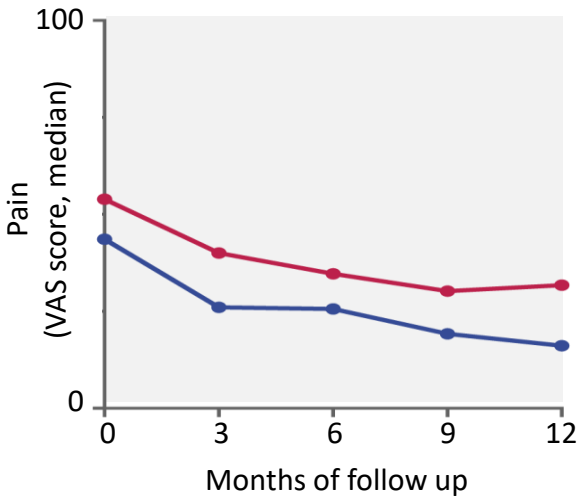
Minimal Disease Activity (MDA)



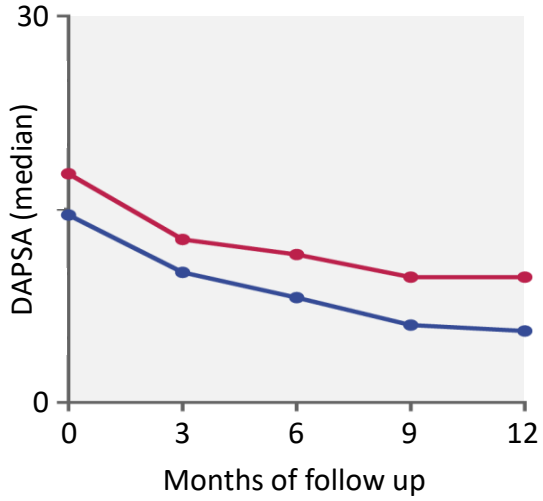
Tender Joint Count



Pain



Disease Activity Index for Psoriatic Arthritis (DAPSA)



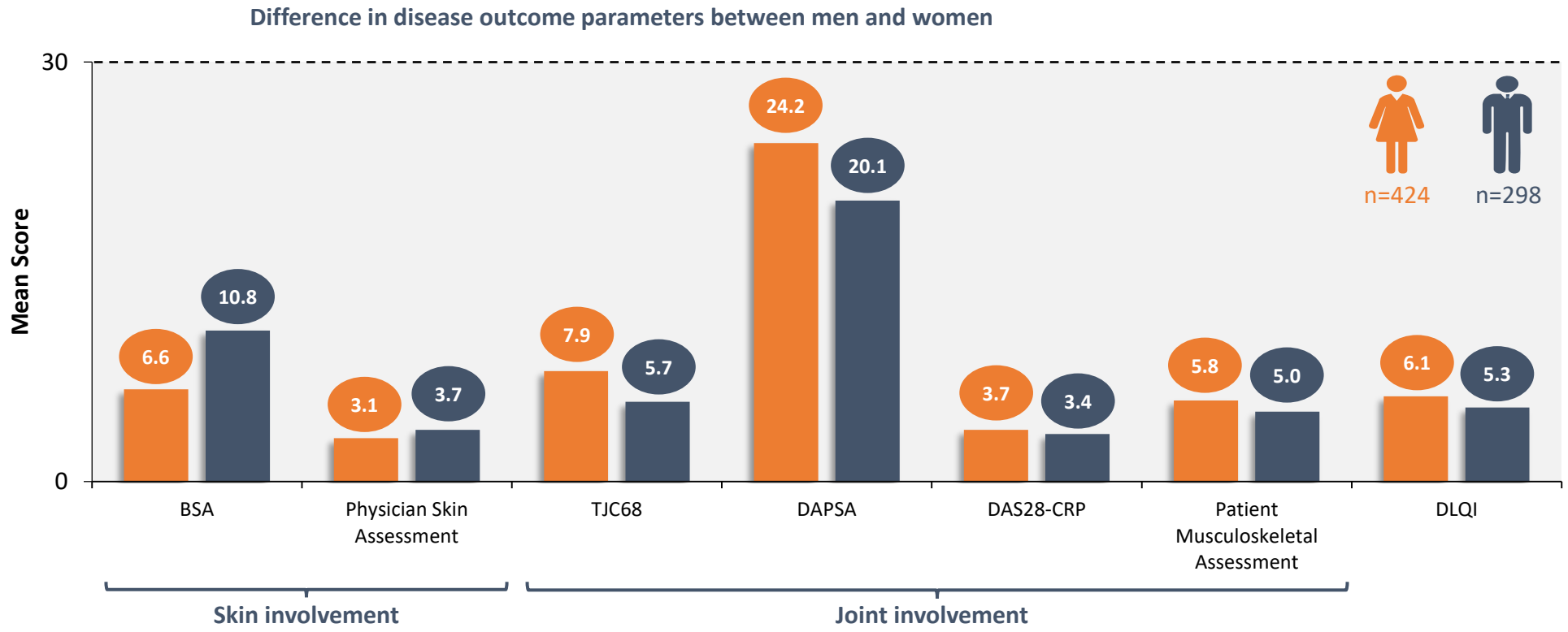
Men Women

After 1 year of follow-up women still experience higher disease activity, more pain and lower functional capacity than men

Passia E et al. Ann Rheum Dis. 2020;79(suppl 1):38–39. Abstract OP0057.

Men Have More Severe Skin Involvement, While Women Have Higher Burden of Joint Involvement*

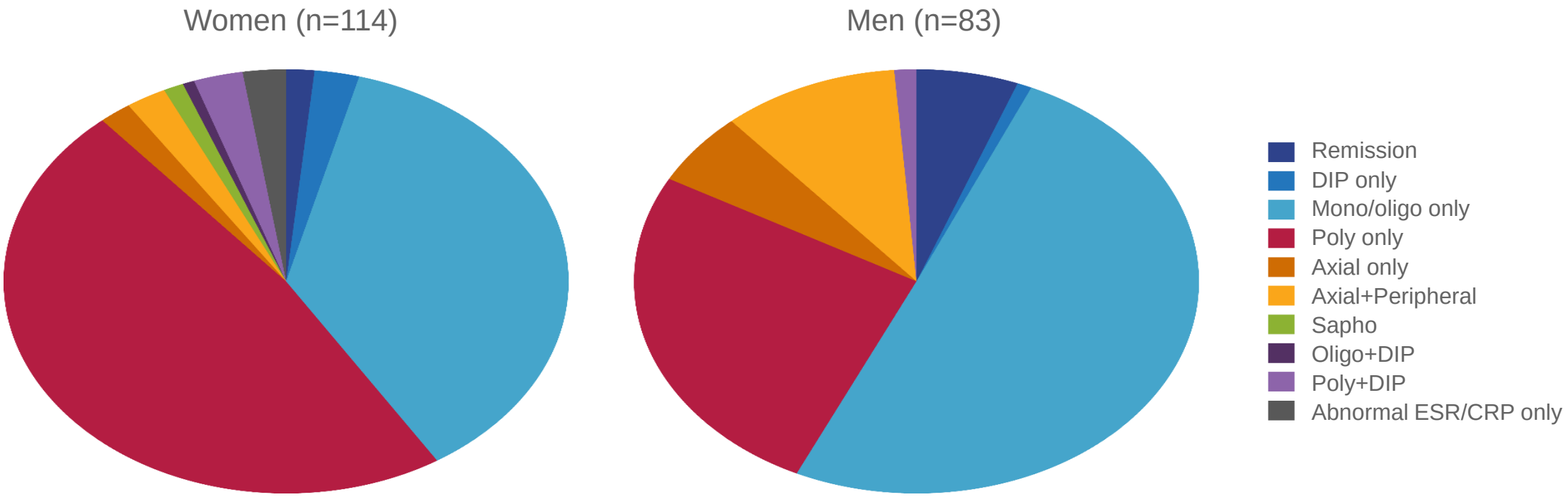
RABBIT-SpA is a prospective longitudinal cohort study including PsA patients enrolled at start of a new csDMARD, bDMARD or tsDMARD (N=722)



Regierer A et al. Ann Rheum Dis. 2020;79(suppl 1):1175–1176. Abstract SAT0437.

*Skin involvement was measured by BSA and physician skin assessment and joint involvement was measured by TJC68, DAPSA, DAS28-CRP and patient musculoskeletal assessment.

Polyarticular Joint Pattern Most Commonly Seen in Women at Presentation of PsA

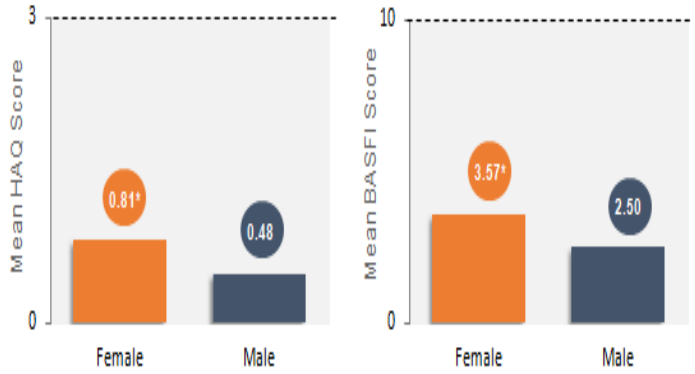


Theander E et al. Ann Rheum Dis. 2014;73:407–413.

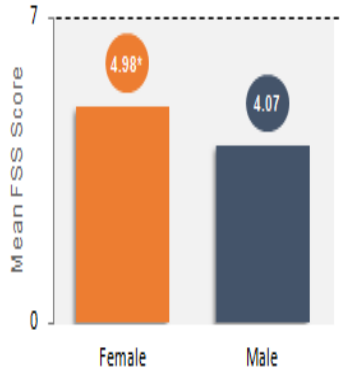
Study of 197 patients in the Swedish Early Psoriatic Arthritis Register fulfilling CASPAR (classification for psoriatic arthritis) criteria, to obtain information on predictors of clinical outcomes over a 5-year period.
DIP: Distal interphalangeal joint; Mono/oligo: Mono or oligoarticular joint involvement; Poly: Polyarticular joint pattern; Sapho: synovitis, acne, pustulosis, hyperostosis, osteitis.

Women Experience More Limitations in Daily Function Worse Quality of Life and Greater Work Impairment

Function[1]

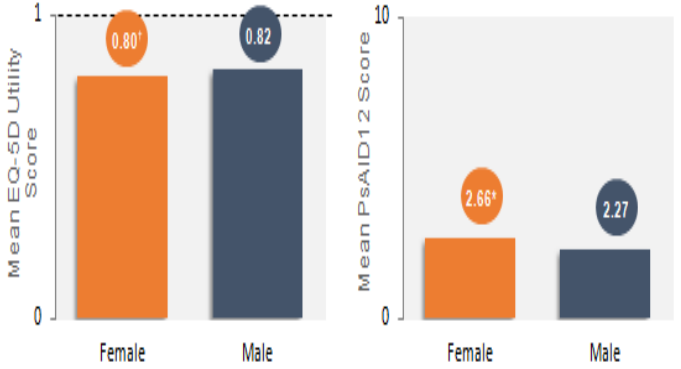


Fatigue[1]

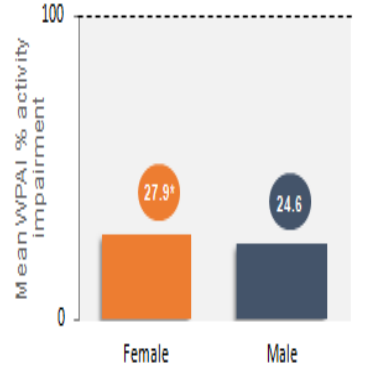


Women with PsA have significantly worse scores in PROs than males, independent of age and other disease-related variables[1]

QoL



Work Productivity



Women with PsA have significantly worse scores in QoL than males and a greater work impairment

1. Eder L et al. Int J Clin Rheumatol. 2012;7(6);641–649.
2. Eder L et al. Ann Rheum Dis. 2013;72(4):578–582.

Gossec L et at. Arthritis Rheumatol. 2019;71 (suppl 10). Abstract 2489.

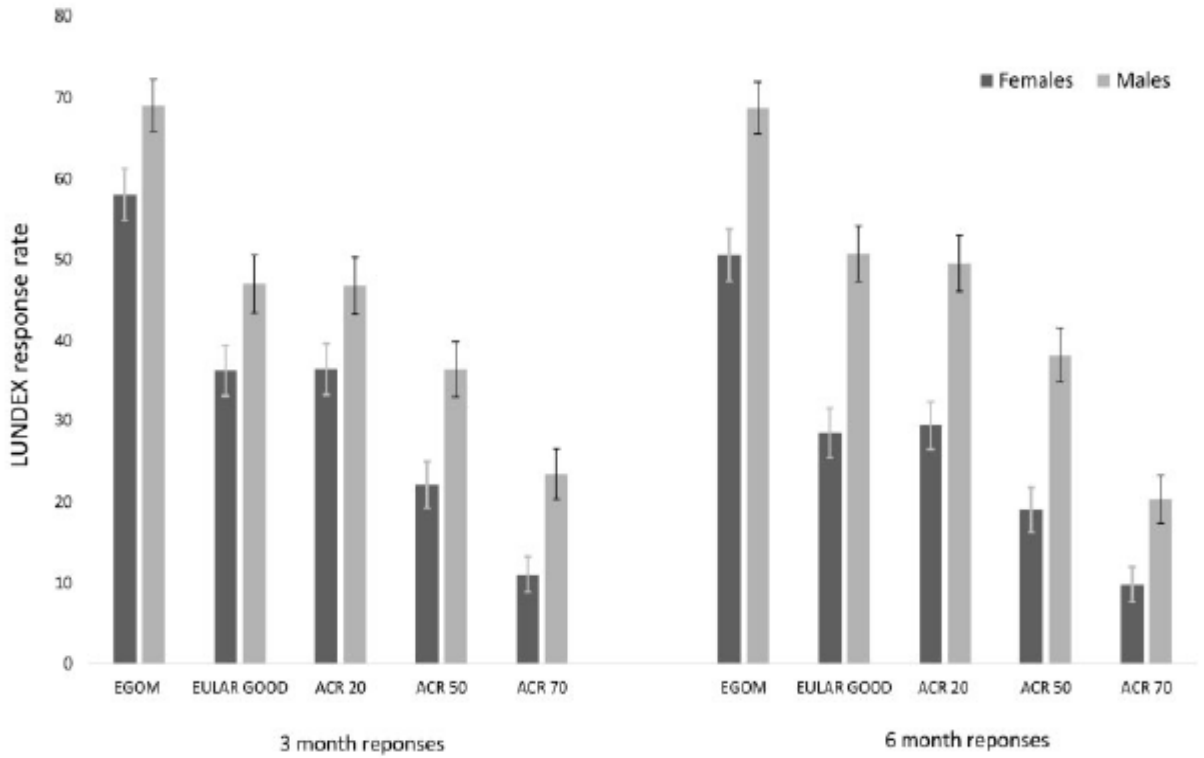
RHEUMATOLOGY

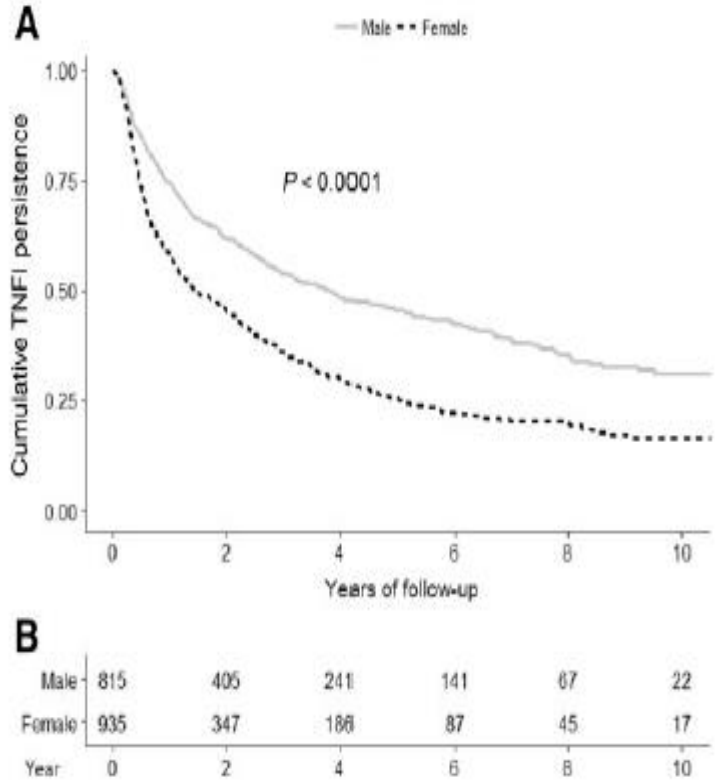
Gender differences in biologic treatment outcomes—a study of 1750 patients with psoriatic arthritis using Danish Health Care Registers

Pil Højgaard[1,2], Christine Ballegaard[1,2], René Cordtz[1,2], Kristian Zobbe[1,2], Marianne Clausen[1], Bente Glintborg[1,3], Lars Erik Kristensen[2] and Lene Dreyer[1,2,4]

2018 Sep 1;57(9):1651-1660.

1750 PsA patients (935 women) biologic naïve – first anti-TNF





Impact of Gender on Treatment Effectiveness in PsA

Response rates after 6 months of biologic therapy in patients with axial PsA and peripheral PsA

	Axial PsA (n=55)		
	Males (n=35)	Females (n=20)	P value
LDA			
ASDAS <2.1	25 (74%)	7 (37%)	0.02
BASDAI <4	24 (72%)	5 (26%)	0.02
Clinical improvement			
Change in ASDAS ≥1.1	20 (59%)	7 (37%)	0.15
BASDAI50	16 (48%)	3 (16%)	0.04

	Peripheral PsA (n=54)		
	Males (n=20)	Females (n=34)	P value
LDA			
DAPSA ≤14	14 (74%)	12 (39%)	0.02
DAS28 ≤3.2	13 (68%)	6 (31%)	0.09
Clinical improvement			
DAPSA50	10 (53%)	11 (36%)	0.25
Change in DAS28 ≥1.2	11 (57%)	8 (42%)	0.15

Male gender is associated with a higher rate of response to biologic treatment in axial PsA and peripheral PsA

Benavent D et al. Arthritis Rheumatol. 2019;71 (suppl 10). Abstract 2484.

Observational study; disease activity indexes were collected before starting drug and 6 months later.

Effect of Gender on Disease Activity, Functional Index and Quality of Life in Patients with Axial PsA

- TLAR-Network PsA Study:
- **251 women** and **169 men** with PsA and axial involvement

Outcomes were Significantly Worse in Female PsA Patients with Axial Involvement

Pain VAS Pain	**Fatigue**	**Inflammation** ESR	**Disease Activity** DAS28, BASDAI
Quality of Life PsAQoL	**Function** HAQ, HAQ-S, FACIT	**Mental Health** Anxiety, depression	**Fibromyalgia** FiRST

Female patients with PsA who have axial involvement have higher disease activity, physical disability, functional limitation and higher depression and anxiety risk than male patients

Nas K et al. Ann Rheum Dis 2019; 78(Suppl 2):920–921. Abstract FRI0456.

1130 patients (36% male, 64% female) with PsA who met the CASPAR classification criteria were enrolled. Turkish League Against Rheumatism (TLAR)-Network was formed with the participation of 25 centres. All outcomes listed were significantly worse in female vs male patients to $p<0.001$, except depression ($p<0.02$).
FACIT: Functional Assessment of Chronic Illness Therapy; FiRST: Fibromyalgia Rapid Screening Tool.

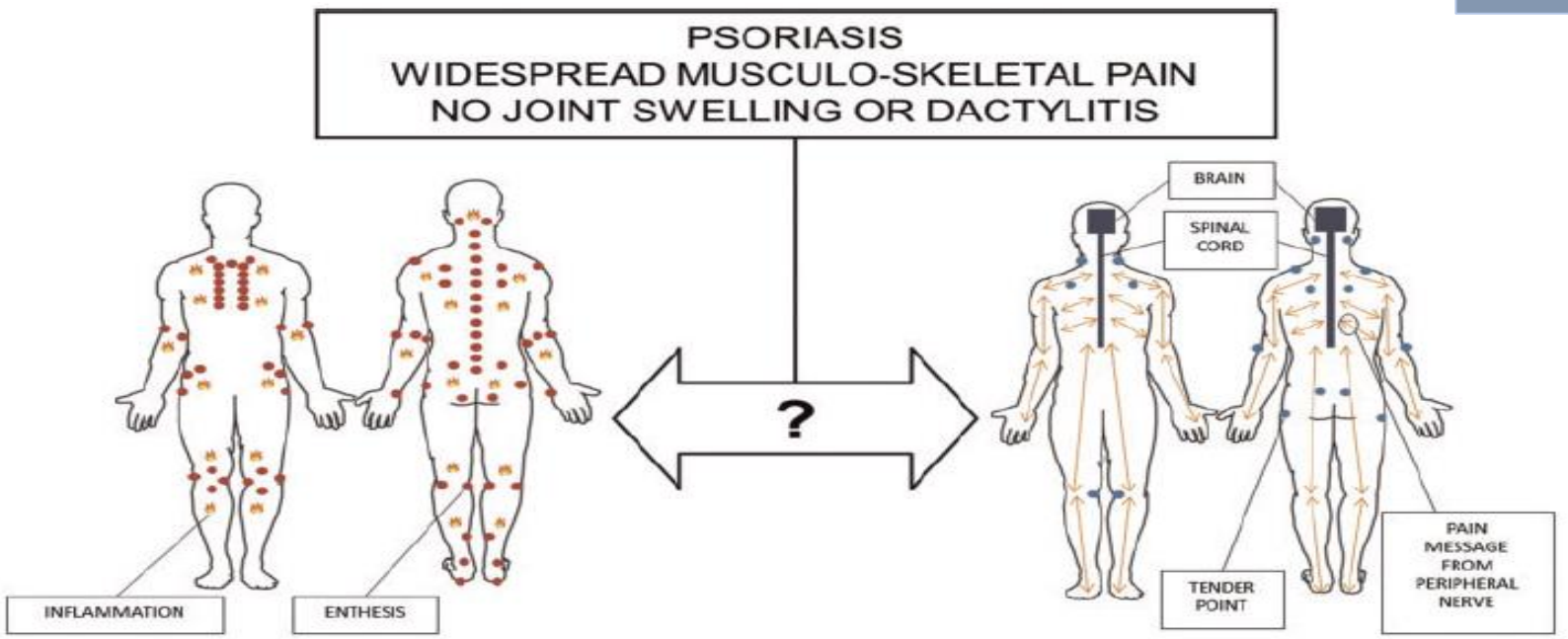
RHEUMATOLOGY
Review
doi:10.1093/rheumatology/kex079

The problem in differentiation between psoriatic-related polyenthesitis and fibromyalgia

Antonio Marchesoni[1], Gabriele De Marco[2,3], Mira Merashli[4], Frank McKenna[5], Ilaria Tinazzi[6], Helena Marzo-Ortega[2,3] and Dennis G. McGonagle[2,3]

Ραχιαλγία στην ΨΑ: Ενθεσίτιδα ή Ινομυαλγία;

5-8% PsA patients suffer from FMS



MULTI-ENTHESITIC PsA

- Stiffness after prolonged immobility
- Anterior chest wall pain
- Heel swelling
- Favourable response to:
  - NSAIDs
  - Biologics
  - DMARDs?

FMS

- Somatoform symptoms:
  - Sleep disturbancies
  - Cognitive impairment
  - Anxiety
  - Migraine
  - Raynaud's phenomenon
  - Irritable bowel
- Indifference to emotional stimulations

Σημεία σχετιζόμενα με ενθεσοπάθεια στην ΨΑ και σύνδρομα ινομυαλγίας. Οι δυο οντότητες μπορεί να αλληλεπικαλύπτονται και οι δείκτες φλεγμονής να είναι φυσιολογικοί. Ακόμη και η απεικόνιση μπορεί να μην είναι διαγνωστική.

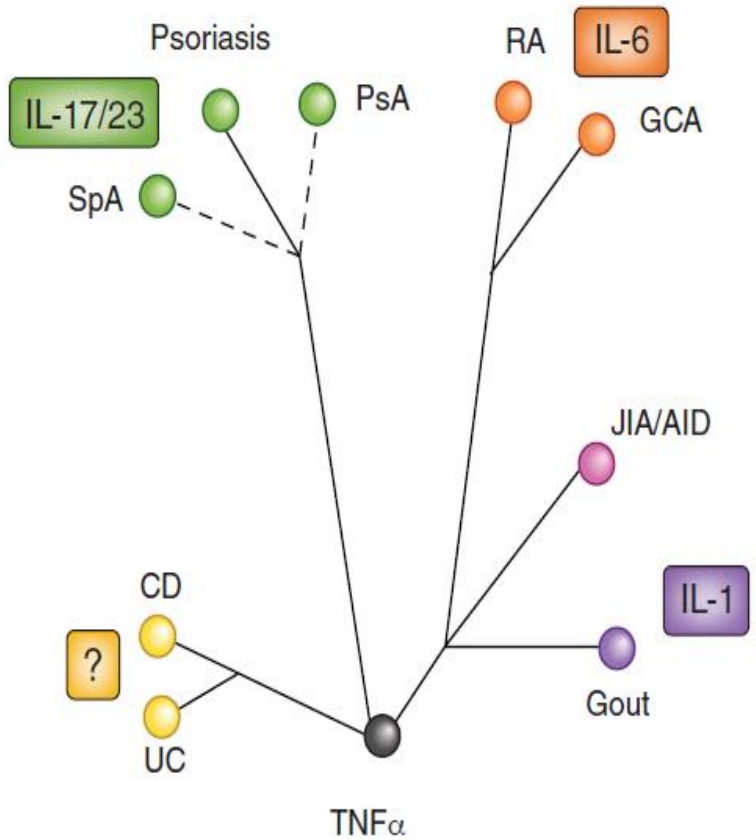
Marchesoni A, Rheumatology (Oxford) 2018 ;57:32-40

Nat. Med. 2014: 19;822–824

Toward a cytokine-based disease taxonomy

Georg Schett, Dirk Elewaut, Iain B McInnes, Jean-Michel Dayer & Markus F Neurath

a



Nat. Med. 2014: 19;822–824

Toward a cytokine-based disease taxonomy

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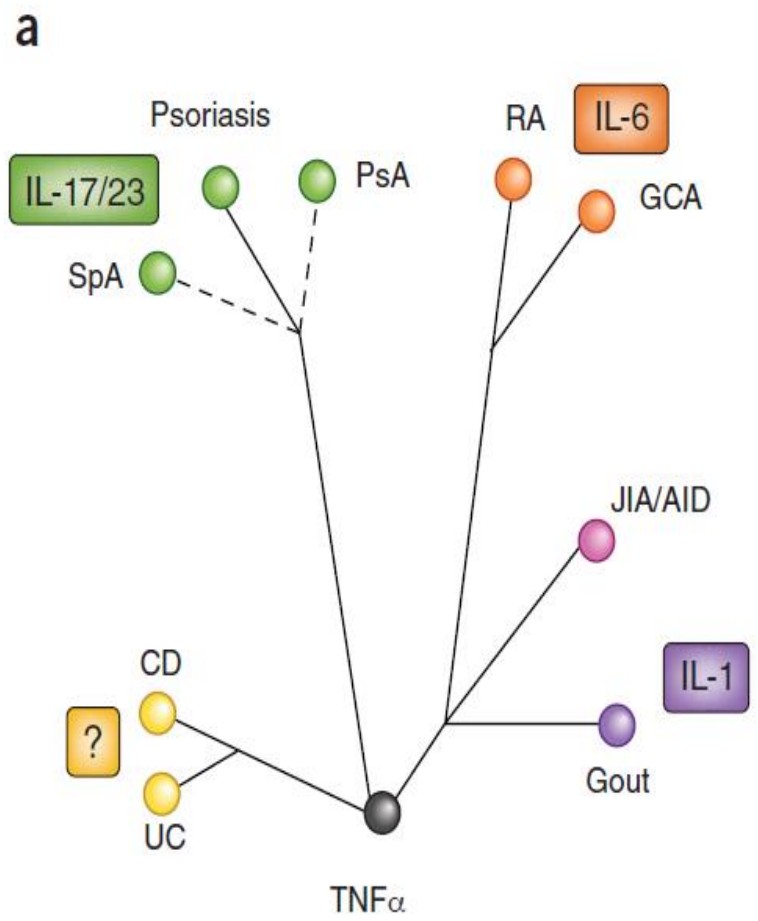
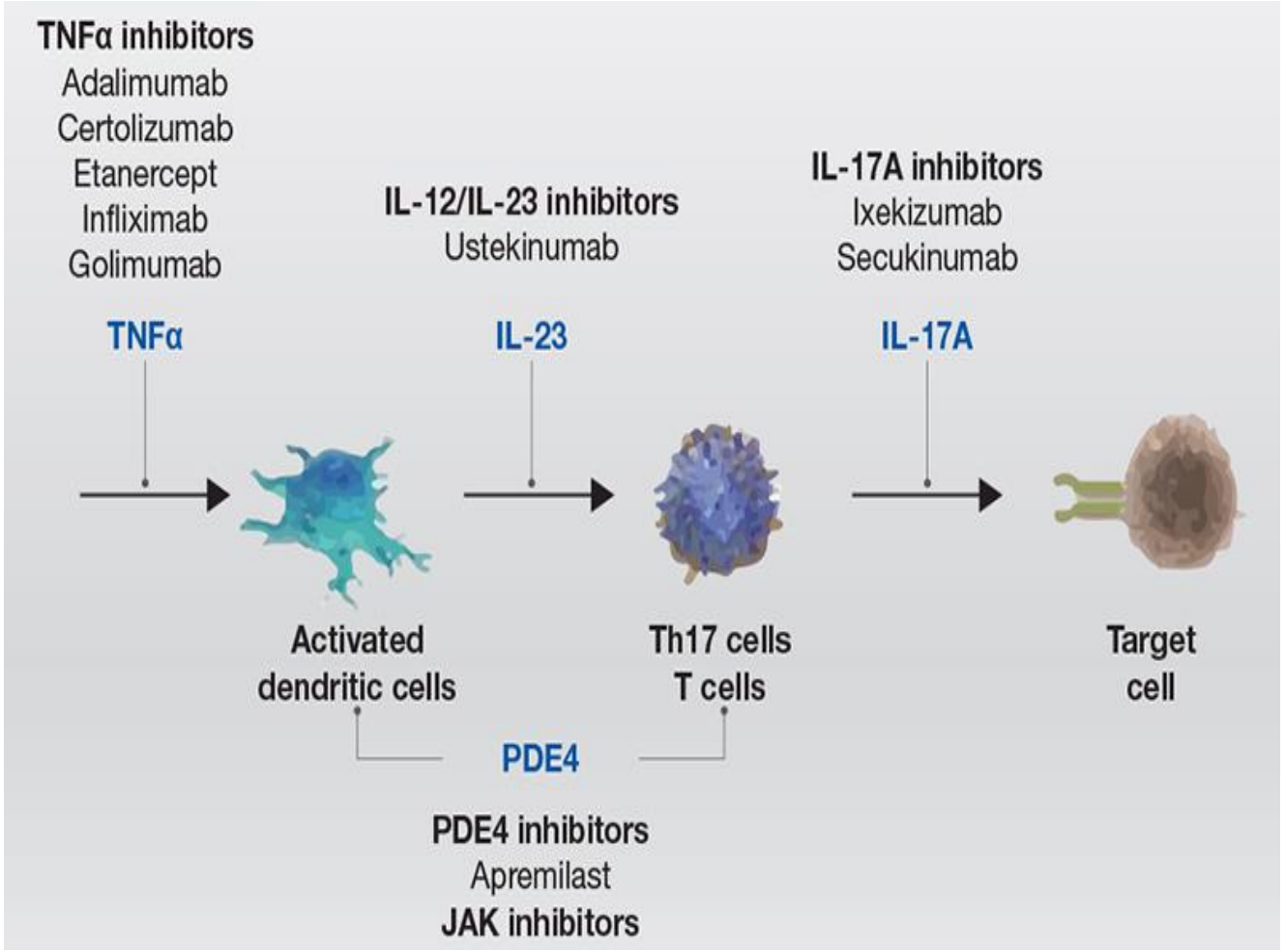




ARTHRITIS & RHEUMATOLOGY
Vol. 68, No. 5, May 2016, pp 1060–1071
DOI 10.1002/art.39573

SPECIAL ARTICLE

Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis

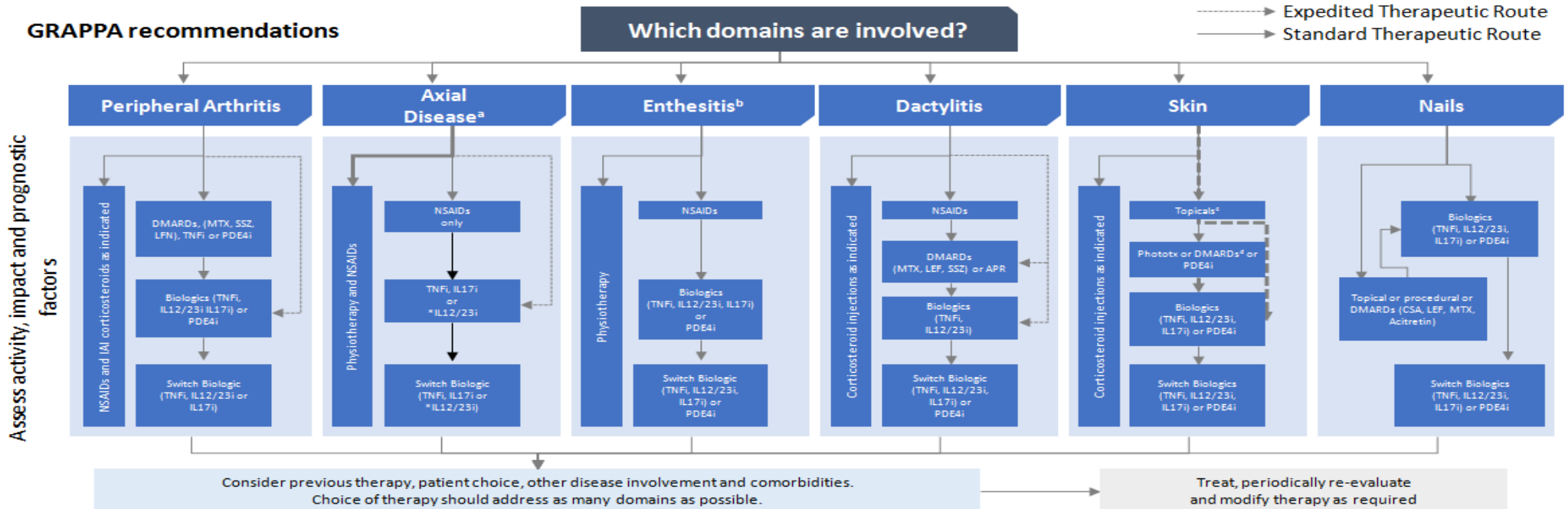
Laura C. Coates,[1] Arthur Kavanaugh,[2] Philip J. Mease,[3] Enrique R. Soriano,[4] Maria Laura Acosta-Felquer,[4] April W. Armstrong,[5] Wilson Bautista-Molano,[6] Wolf-Henning Boehncke,[7] Willemina Campbell,[8] Alberto Cauli,[9] Luis R. Espinoza,[10] Oliver FitzGerald,[11] Dafna D. Gladman,[12] Alice Gottlieb,[13] Philip S. Helliwell,[14] M. Elaine Husni,[15] Thorvardur J. Love,[16] Ennio Lubrano,[17] Neil McHugh,[18] Peter Nash,[19] Alexis Ogdie,[20] Ana-Maria Orbai,[21] Andrew Parkinson,[22] Denis O'Sullivan,[23] Cheryl F. Rosen,[24] Sergio Schwartzman,[25] Evan L. Siegel,[26] Sergio Toloza,[27] William Tuong,[28] and Christopher T. Ritchlin[29]

Recommendation

OPEN ACCESS

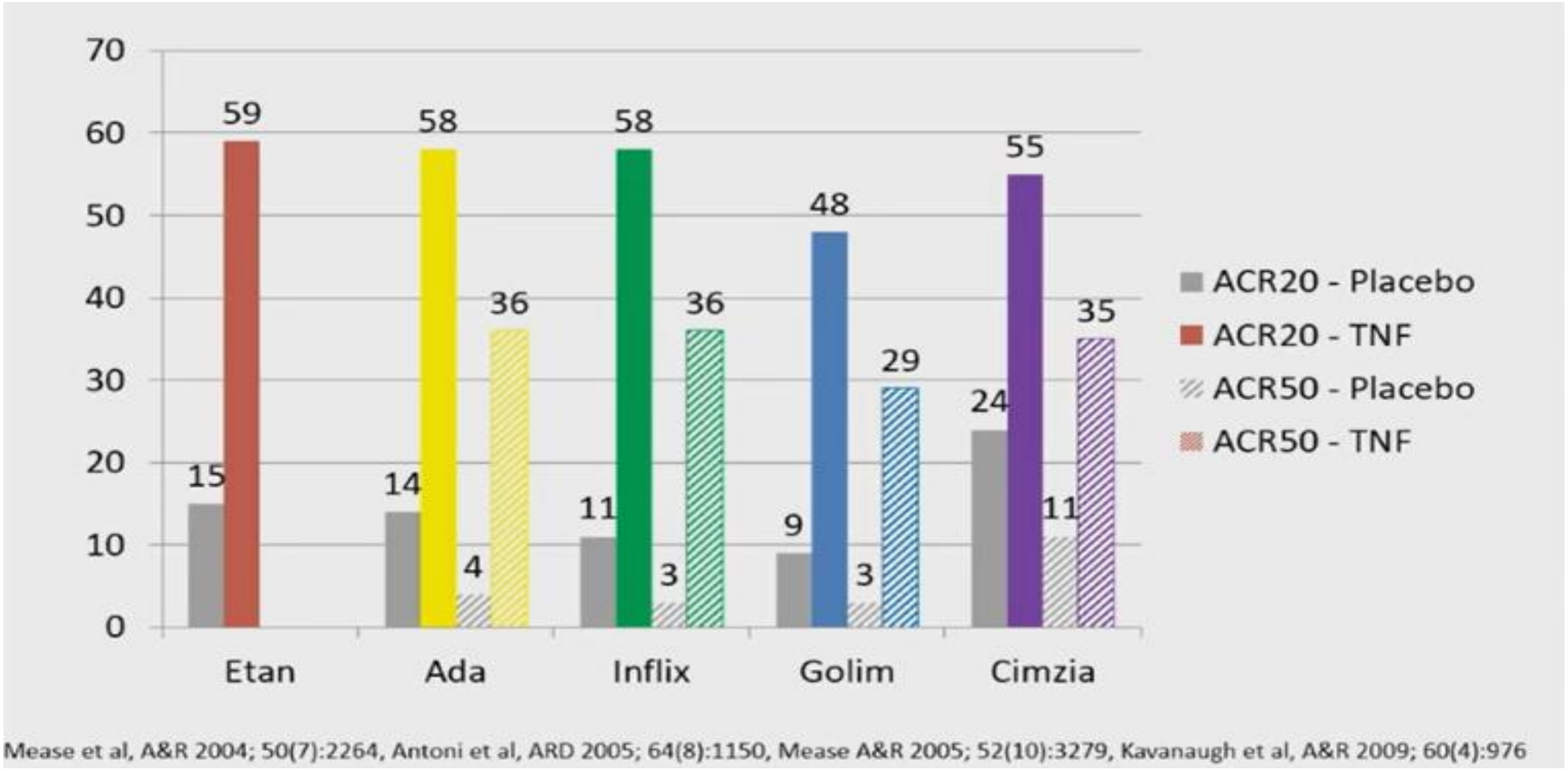
EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update

Laure Gossec ,[1,2] Xenofon Baraliakos,[3] Andreas Kerschbaumer ,[4] Maarten de Wit ,[5] Iain McInnes,[6] Maxime Dougados,[7] Jette Primdahl ,[8,9] Dennis G McGonagle,[10,11] Daniel Aletaha,[12] Andra Balanescu,[13] Peter V Balint,[14] Heidi Bertheussen,[15] Wolf-Henning Boehncke,[16] Gerd R Burmester,[17] Juan D Canete ,[18] Nemanja S Damjanov,[19] Tue Wenzel Kragstrup,[20,21] Tore K Kvien,[22] Robert B M Landewé,[23,24] Rik Jozef Urbain Lories,[25,26] Helena Marzo-Ortega,[10,11] Denis Poddubnyy ,[27,28] Santiago Andres Rodrigues Manica ,[29,30] Georg Schett ,[31] Douglas J Veale ,[32] Filip E Van den Bosch,[33] Désirée van der Heijde ,[22,34] Josef S Smolen[35,36]



CSA, cyclosporine A; DMARD, disease-modifying anti-rheumatic drug; IAI, intra-articular injection; IL12/23i, interleukin 12/23 inhibitor; IL17i, interleukin 17 inhibitor; LFN, leflunomide; MTX, methotrexate; NSAID, non-steroidal anti-inflammatory drug; PDE4i, phosphodiesterase 4 inhibitor; phototx, phototherapy; SSZ, sulfasalazine; TNFi, tumor necrosis factor inhibitor.
[a]No direct evidence for therapies in axial PsA, recommendations based on axial SpA literature; [b]Corticosteroid injections: consider on an individual basis due to potential for serious side effects; no clear evidence for efficacy; [c]Keratolytics, steroids, vitamin D analogues, emollients calcineurini; [d]MTX, CSA Acitretin, Fumaric acid esters
Coates LC, et al. *Arthritis Rheumatol.* 2016;68:1060–71.

ΑΝΑΣΤΟΛΕΙΣ ΤΟΥ TNF-α



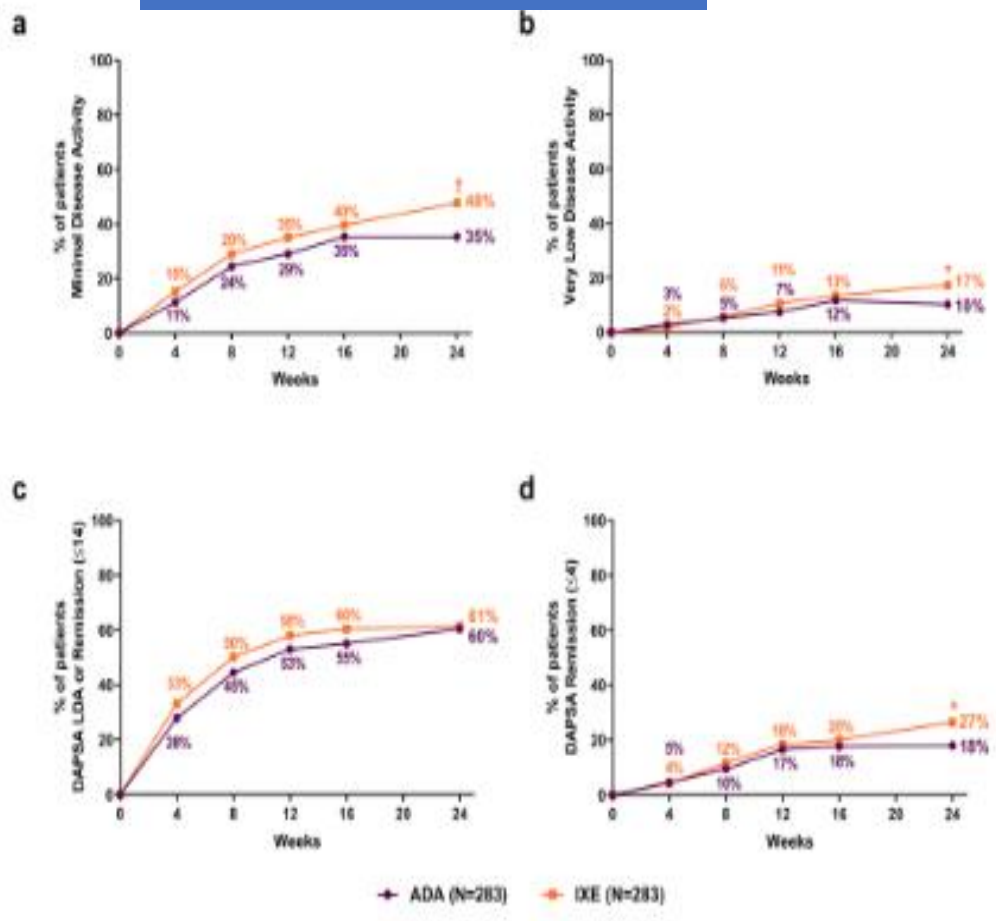
Mease et al, A&R 2004; 50(7):2264, Antoni et al, ARD 2005; 64(8):1150, Mease A&R 2005; 52(10):3279, Kavanaugh et al, A&R 2009; 60(4):976

CLINICAL SCIENCE

A head-to-head comparison of the efficacy and safety of ixekizumab and adalimumab in biological-naïve patients with active psoriatic arthritis: 24-week results of a randomised, open-label, blinded-assessor trial

Philip J Mease ,[1] Josef S Smolen,[2] Frank Behrens,[3] Peter Nash,[4] Soyi Liu Leage,[5] Lingnan Li,[5] Hasan Tahir,[6] Melinda Gooderham,[7] Eswar Krishnan,[5] Hong Liu-Seifert,[5] Paul Emery ,[8,9] Sreekumar G Pillai,[5] Philip S Helliwell,[10] The SPIRIT H2H study group

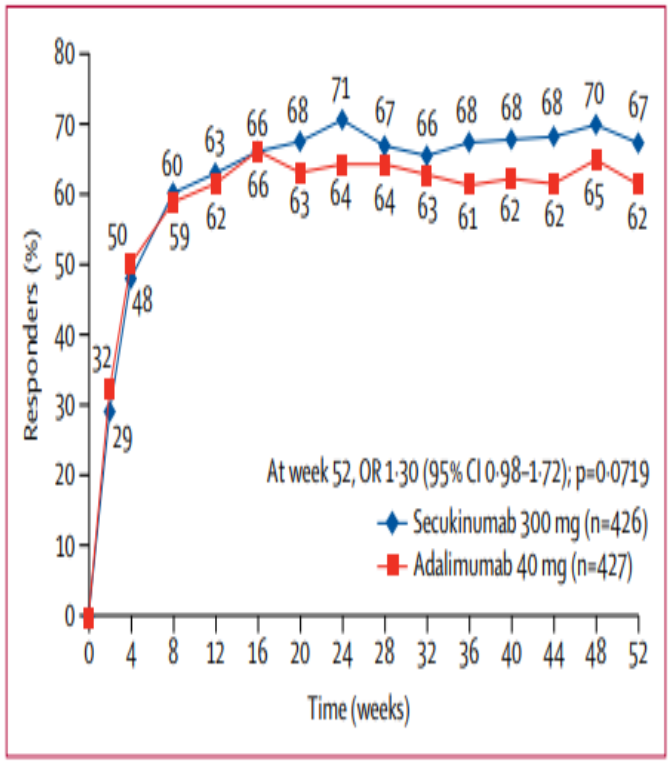
combined ACR50 and PASI 100 response

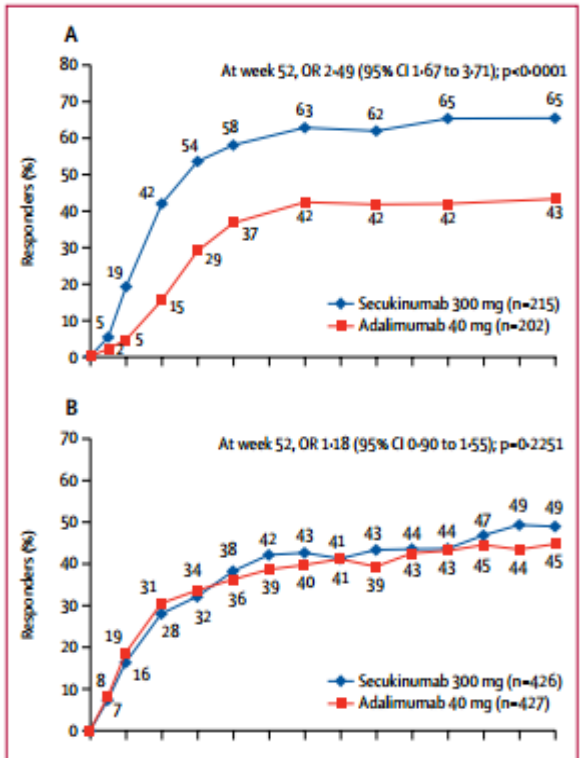


Mease PJ, et al. Ann Rheum Dis 2020;79:123–131

Secukinumab versus adalimumab for treatment of active psoriatic arthritis (EXCEED): a double-blind, parallel-group, randomised, active-controlled, phase 3b trial

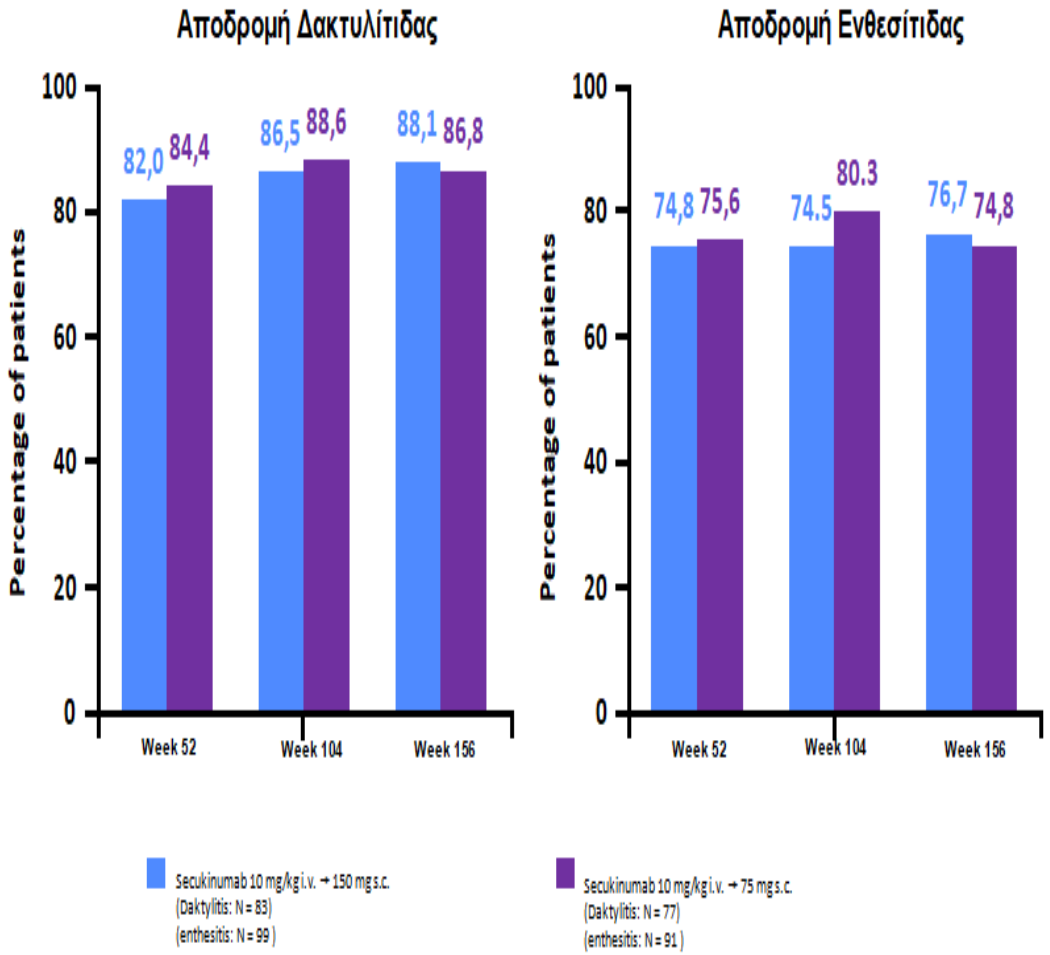
Iain B McInnes, Frank Behrens, Philip J Mease, Arthur Kavanaugh, Christopher Ritchlin, Peter Nash, Jordi Gratacós Masmitja, Philippe Goupille, Tatiana Korotaeva, Alice B Gottlieb, Ruvie Martin, Kevin Ding, Pascale Pellet, Shephard Mpofu, Luminita Pricop, on behalf of EXCEED Study Group



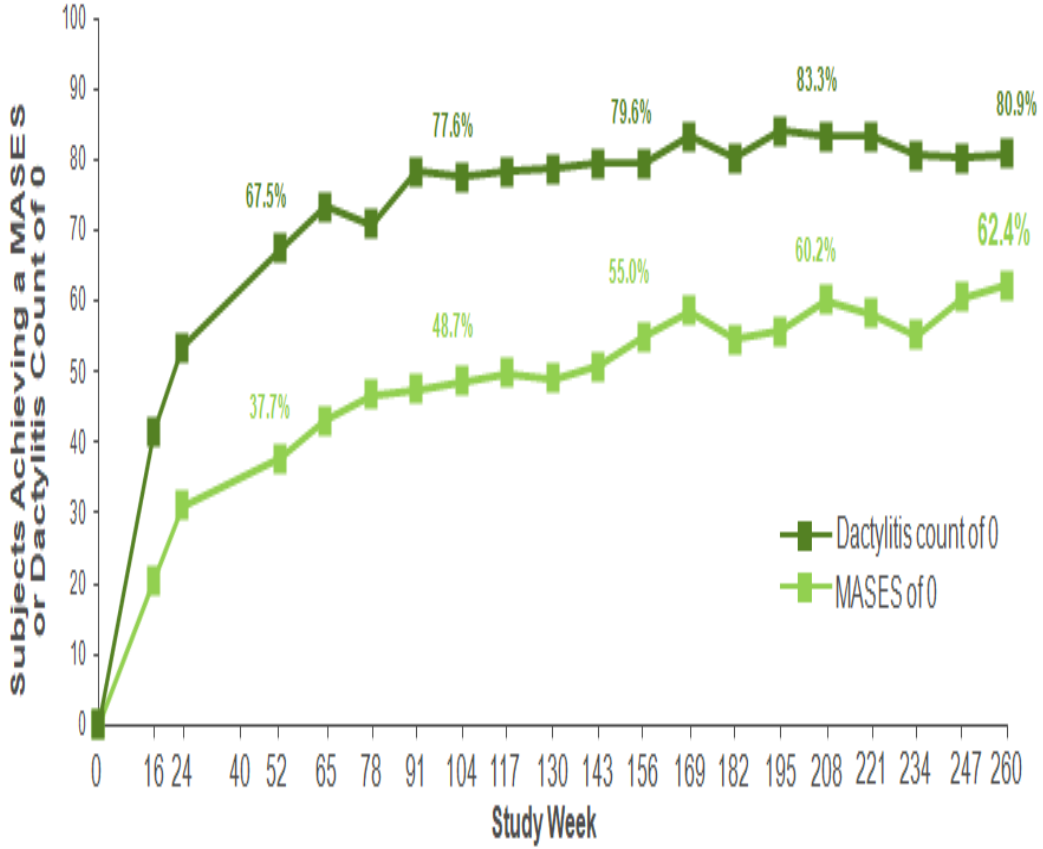


Mc Innes IB et al. Lancet. 2020 May 9;395(10235):1496-1505

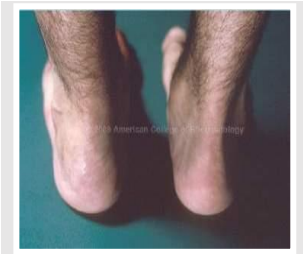
FUTURE -1 - SECUKINUMAB

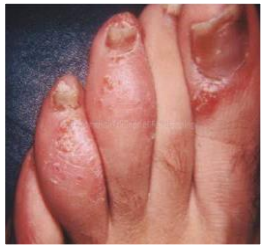


PALACE 1-3 – APREMILAST



MASES=0, n	377	341	329	314	302	293	293	283	278	268	260	247	246	240	232	226	218
Dactylitis count=0, n	249	226	221	207	201	195	194	186	181	175	173	165	162	158	151	148	141





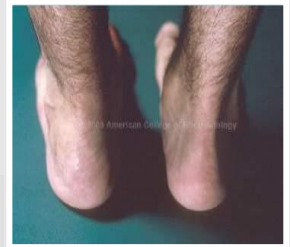
Mease PJ, et al. *Arthritis Rheumatol*. 2017;76 (suppl 2): abstract SAT0470 .

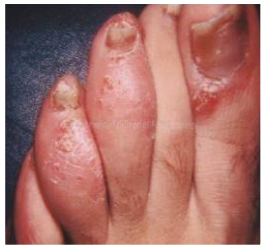
ACR/ARHP Annual Meeting. Arthritis Rheumatol, 70: 747-8, Abstract 686. doi:10.1002/art.40700

Semin Arthritis Rheum. 2019 Feb;48(4):632-637. doi: 10.1016/j.semarthrit.2018.05.011. Epub 2018 Jun 13.

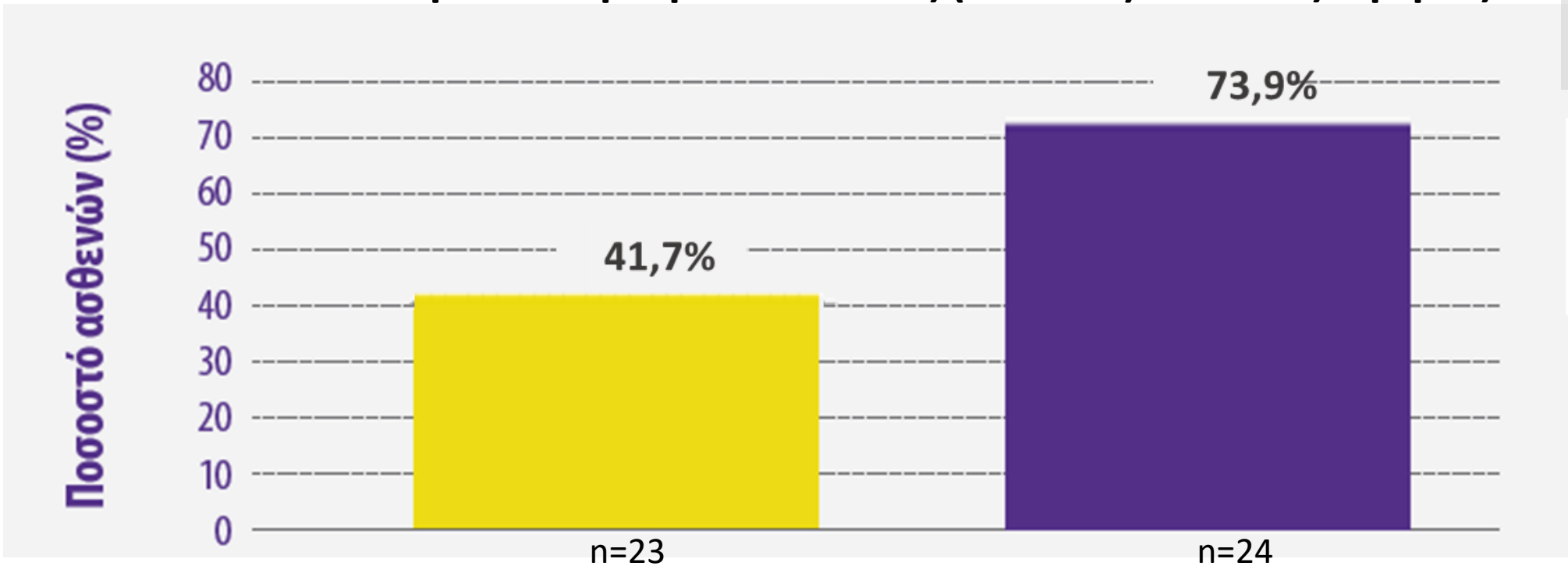
Effects of ustekinumab versus tumor necrosis factor inhibition on enthesitis: Results from the enthesial clearance in psoriatic arthritis (ECLIPSA) study.

Araujo EG[1], Englbrecht M[1], Hoepken S[1], Finzel S[1], Kampylafka E[1], Kleyer A[1], Bayat S[1], Schoenau V[1], Hueber A[1], Rech J[1], Schett G[2].

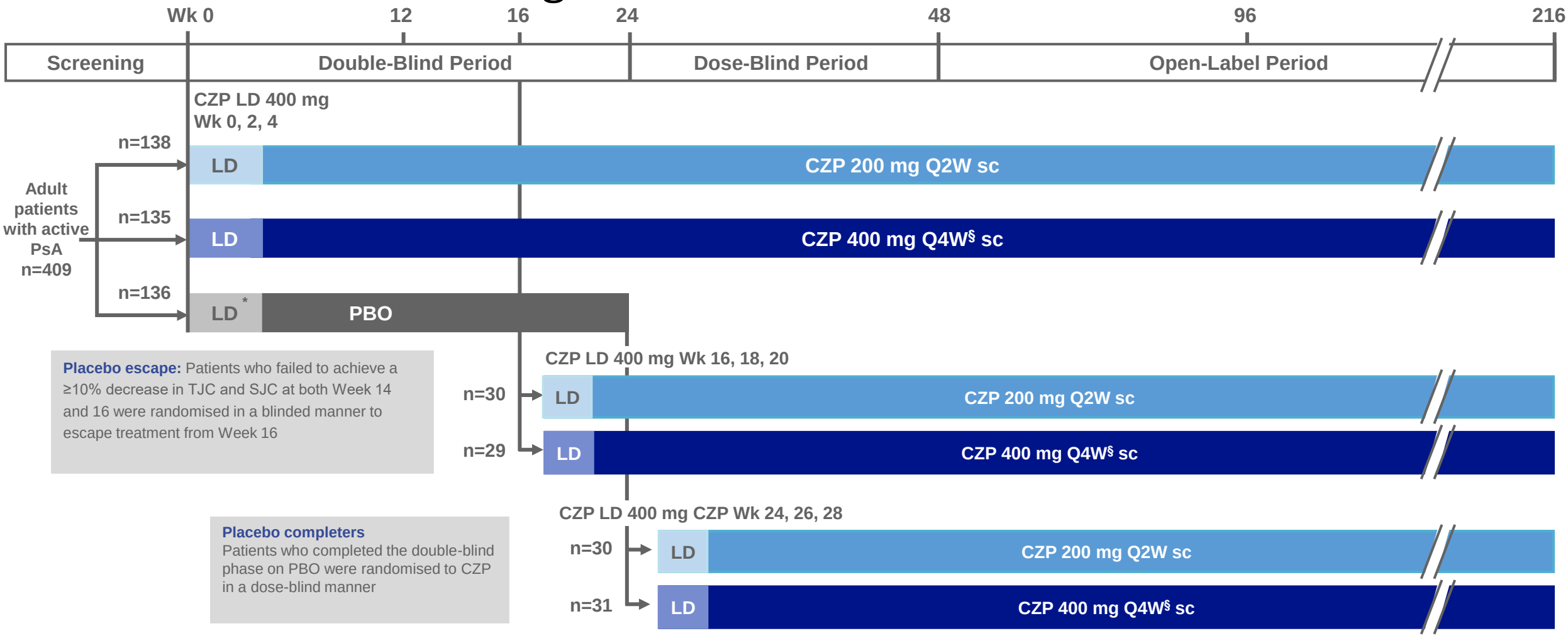




Ποσοστό ασθενών με κάθαρση ενθεσίτιδας (SPARCC)=0 στους 6 μήνες



RAPID-PsA Trial Design to Week 216



Adapted from Mease PJ et al. RMD Open. 2015;1(1):e000119.

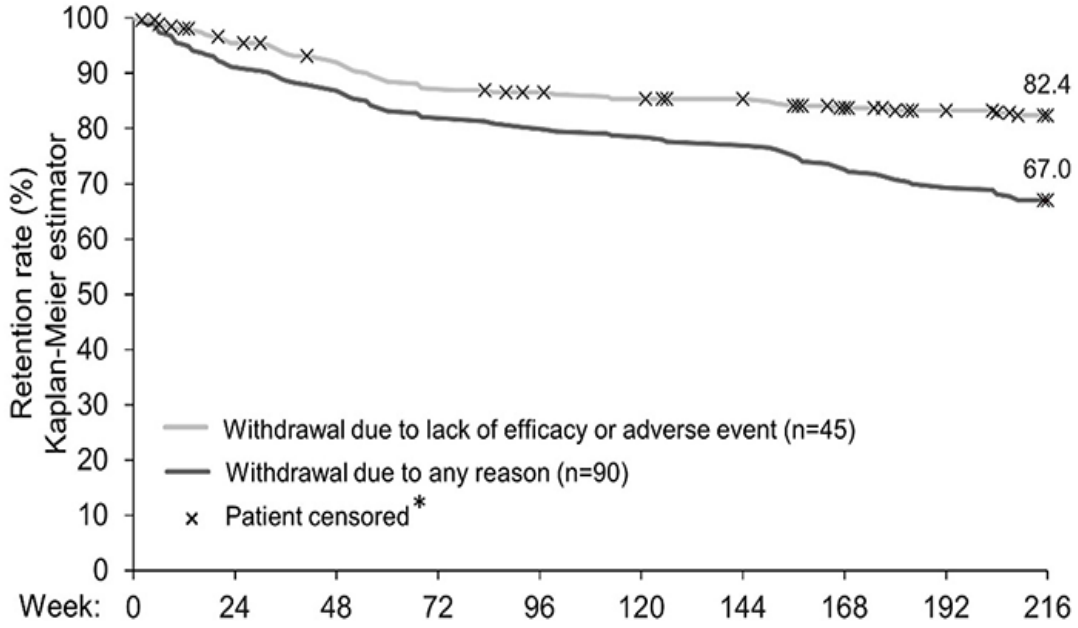
§For maintenance in PsA, CZP 400 mg Q4W before clinical response is confirmed is not an approved dose in the European Union.

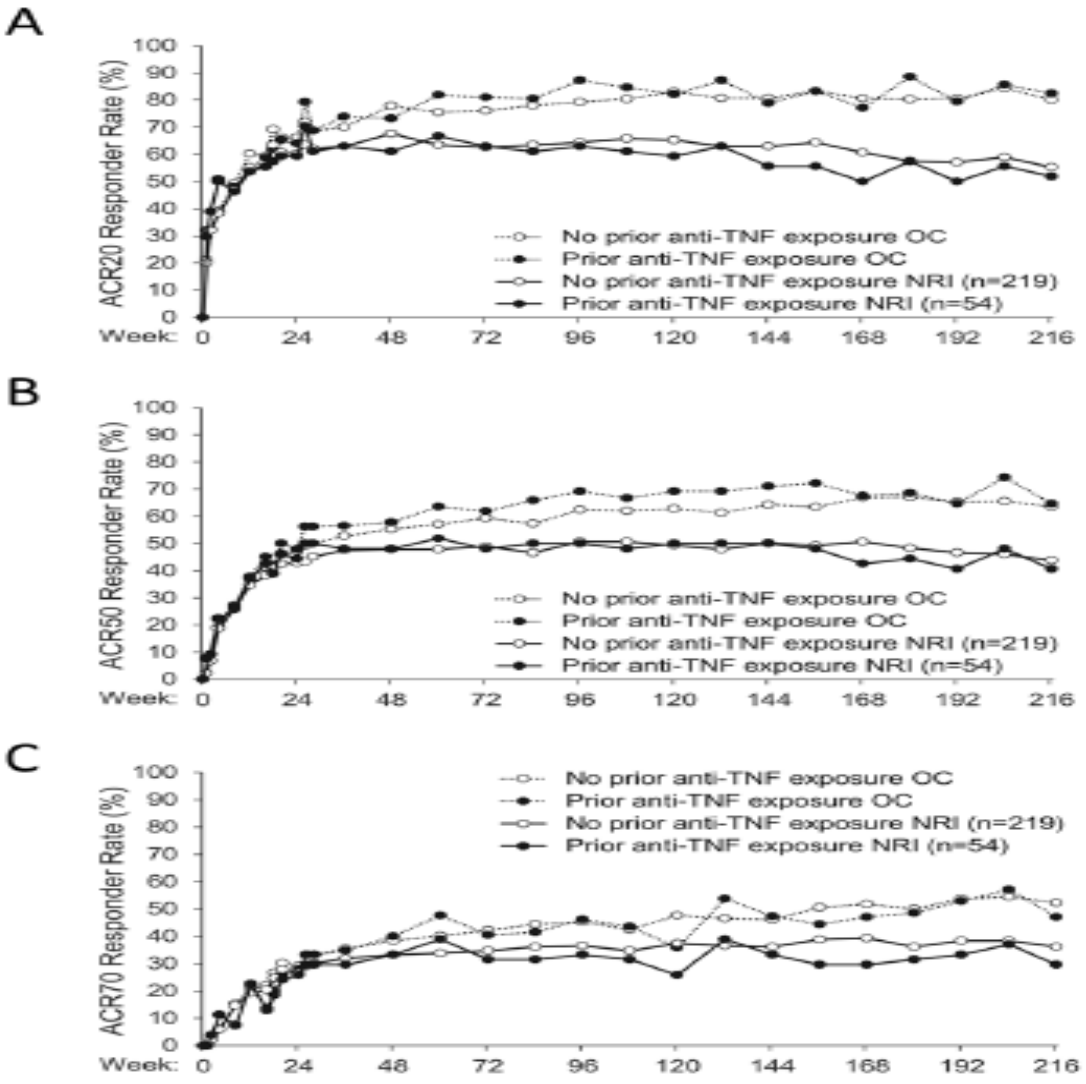
*Loading dose of PBO.

RMD Open
Rheumatic & Musculoskeletal Diseases

ORIGINAL ARTICLE

4-year results from the RAPID-PsA phase 3 randomised placebo-controlled trial of certolizumab pegol in psoriatic arthritis



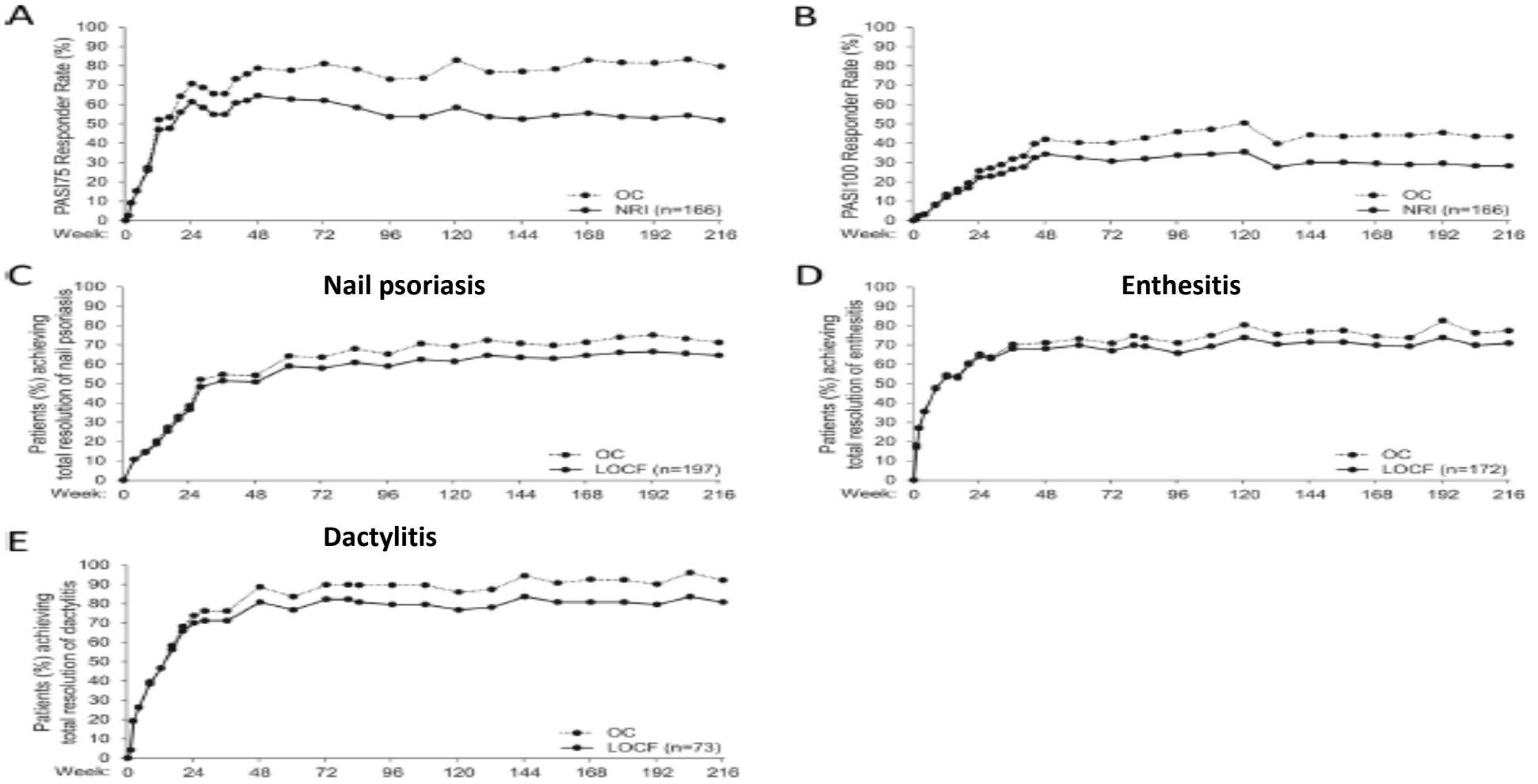


van der Heijde D, et al. RMD Open 2018;4:e000582.

RMD Open
Rheumatic & Musculoskeletal Diseases

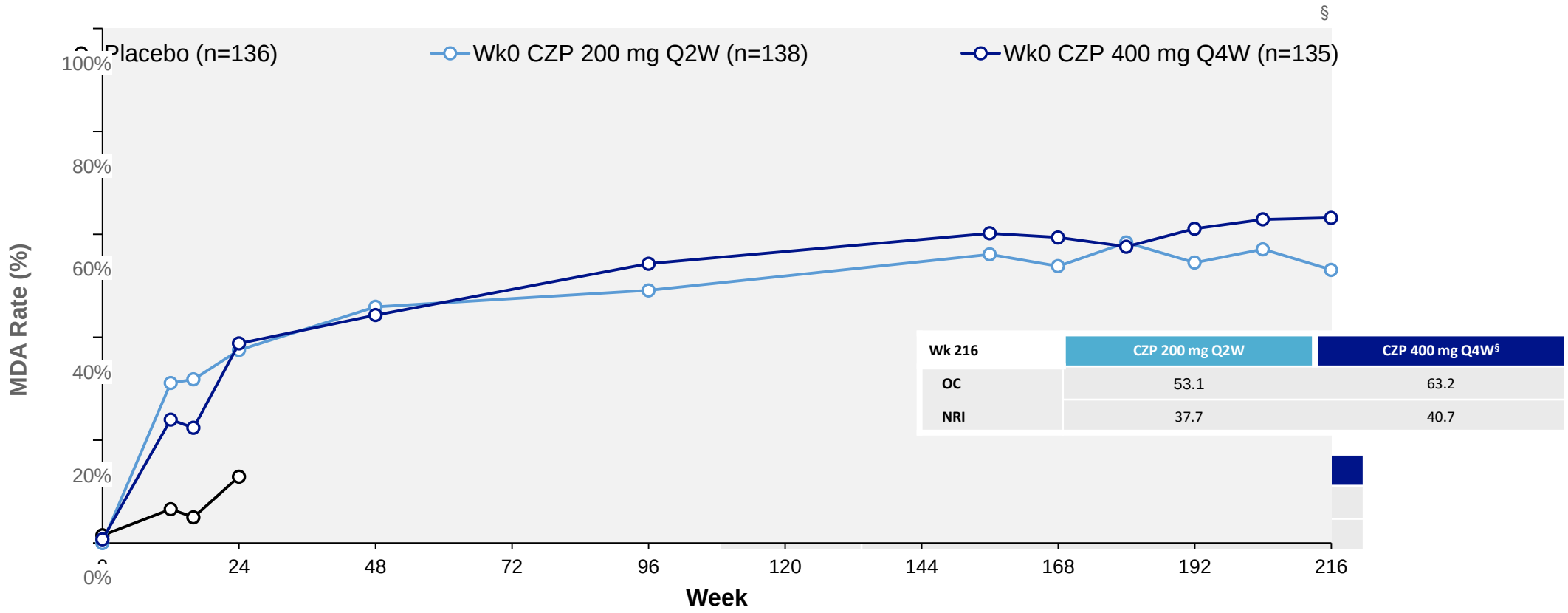
ORIGINAL ARTICLE

4-year results from the RAPID-PsA phase 3 randomised placebo-controlled trial of certolizumab pegol in psoriatic arthritis



van der Heijde D, et al. RMD Open 2018;4:e000582.

MDA Rate Over 216 Weeks (Observed Case)



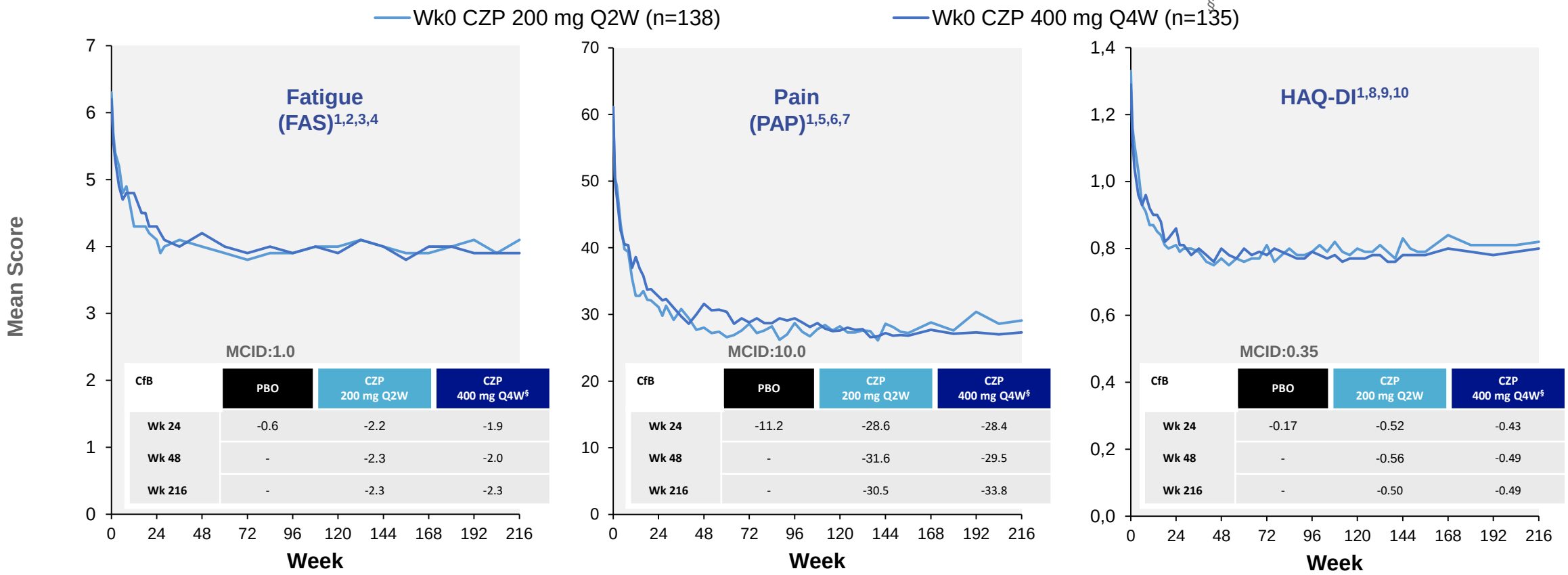
Wk 216	CZP 200 mg Q2W	CZP 400 mg Q4W§
OC	53.1	63.2
NRI	37.7	40.7

Sustained improvement in disease activity from Week 24 to Week 216

Wk 24, 48 and 216 values from van der Heijde D et al. RMD Open. 2018; 4:e000582.
Exact data values from UCB Data on File (PsA001 Wk216 Final Tables 2016, Table 4.58.1, 4.58.2) – Data are available on request.
Placebo data from UCB Data on File (PsA001 Wk24 Post-hoc Tables, Table 4.75.2) – Data are available on request.

§For maintenance in PsA, CZP 400 mg Q4W before clinical response is confirmed is not an approved dose in the European Union.
Randomised set (observed case). Placebo arm taken from Week 24 dataset, for comparison.

Fatigue, Pain and HAQ-DI Over 216 Weeks (LOCF)



Fatigue (FAS) CfB	PBO	CZP 200 mg Q2W	CZP 400 mg Q4W§
Wk 24	-0.6	-2.2	-1.9
Wk 48	-	-2.3	-2.0
Wk 216	-	-2.3	-2.3

Pain (PAP) CfB	PBO	CZP 200 mg Q2W	CZP 400 mg Q4W§
Wk 24	-11.2	-28.6	-28.4
Wk 48	-	-31.6	-29.5
Wk 216	-	-30.5	-33.8

HAQ-DI CfB	PBO	CZP 200 mg Q2W	CZP 400 mg Q4W§
Wk 24	-0.17	-0.52	-0.43
Wk 48	-	-0.56	-0.49
Wk 216	-	-0.50	-0.49

Pain improved by more than 50% by Week 216

1. Wk 0, 24, 48 and 216 data from van der Heijde D et al. RMD Open. 2018; 4:e000582.
2. UCB Data on File (PsA001 Wk216 Final Tables. 2016. Table 4.32.1).
3. Placebo data from UCB Data on File (PsA001 Wk24 Final Tables. 2012. Table 4.34).
4. MCID value from UCB Data on File (Protocol Study PsA001 Amendment 5. 2013. p59).
5. UCB Data on File (PsA001 Wk216 Final Tables. 2016 Table 4.25.1).
6. Placebo data from UCB Data on File (PsA001 Wk24 Final Tables. 2012. Table 4.27.1).
7. MCID value from UCB Data on File (Protocol Study PsA001 Amendment 5. 2013. p58).
8. UCB Data on File (PsA001 Wk216 Final Tables. 2016. Table 4.6.1).
9. Placebo data from UCB Data on File (PsA001 Wk24 Final Tables. 2012. Table 4.22.1).
10. MCID value Mease PJ et al. J Rheumatol. 2011;38:2461–246.

§For maintenance in PsA, CZP 400 mg Q4W before clinical response is confirmed is not an approved dose in the European Union.

Randomised set (LOCF). Placebo arm taken from Week 24 dataset, for comparison.

RAPID-PsA

The first published randomised controlled trial of an anti-TNF in **PsA** to include **patients with prior anti-TNF exposure**[1]

PASI75*

Significant and sustained responses in PASI75 to Week 216

Week 12[1]	14.0%	46.7%	47.4%
Week 216[2]	N/A	60.0%	42.1%

Significant responses in PASI75 were also reported in PSO studies, CIMPASI 1/2 and CIMPACT[3,4]

ACR responses demonstrated regardless of prior anti-TNF use[2] **or +/- concomitant DMARD use**[5]

ACR20**

Sustained responses in ACR20 to Week 216

Week 12[1]	24.3%	58.0%	51.9%
Week 216[2]	N/A	54.3%	54.8%

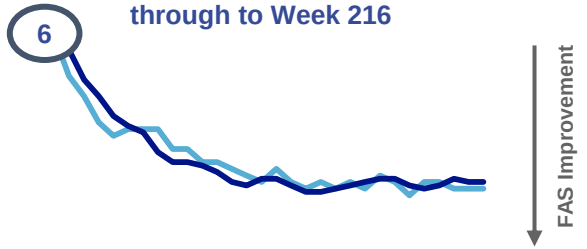
Enthesitis†[2]

Sustained resolution to Week 216

Week 216	69.3%	72.6%

Fatigue[2,6]

Sustained improvements in fatigue through to Week 216



Nail Disease¥[2]

Sustained resolution to Week 216

Week 216	60.9%	67.6%

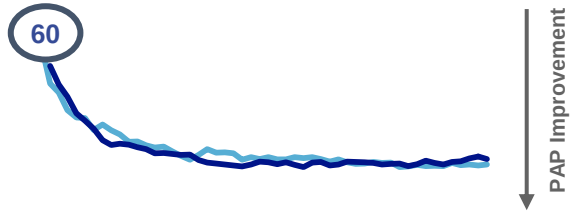
Dactylitis‡[2]

Sustained resolution to Week 216

Week 216	88.6%	73.7%

Pain[2,7]

Pain improved by more than 50% by Week 216



Safety Profile

No new safety signals identified with increased exposure to CZP and safety outcomes were in line with those published previously[2]

PBO | CZP 200 mg Q2W | CZP 400 mg Q4W§

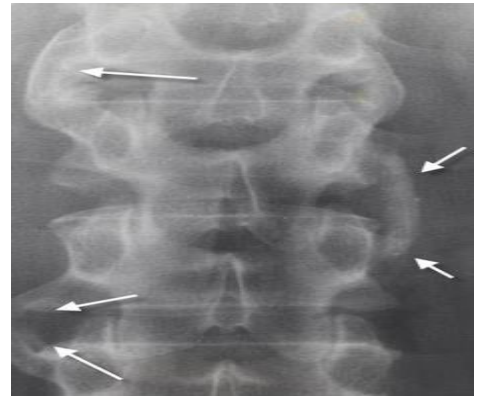
1. Mease PJ et al. Ann Rheum Dis. 2014;73(1):48–55.
2. van der Heijde D et al. RMD Open. 2018; 4:e000582.
3. Gottlieb AB et al. J Am Acad Dermatol. 2018;79(2):302–314.
4. Lebwohl M et al. J Am Acad Dermatol. 2018;79(2):266–276.
5. Walsh JA et al. Clin Rheumatol. 2018;37(12):3285–3296.
6. UCB Data on File (PsA001 Wk216 Final Tables. 2016. Table 4.32.1).
7. UCB Data on File (PsA001 Wk216 Final Tables. 2016 Table 4.25.1).

§For maintenance in PsA, CZP 400 mg Q4W before clinical response is confirmed is not an approved dose in the European Union.

*In patients with psoriasis involving ≥3% BSA at baseline (**n=86**, **n=90**, **n=76**); †In patients with enthesitis at baseline (**n=88**, **n=84**); ‡In patients with dactylitis at baseline (**n=35**, **n=38**); ¥In patients with nail psoriasis at baseline (**n=92**, **n=105**); **ACR20 (**n=136**, **n=138**, **n=135**).

OP0053 SECUKINUMAB IMPROVES CLINICAL AND IMAGING OUTCOMES IN PATIENTS WITH PSORIATIC ARTHRITIS AND AXIAL MANIFESTATIONS WITH INADEQUATE RESPONSE TO NSAIDS: WEEK 52 RESULTS FROM THE MAXIMISE TRIAL FREE

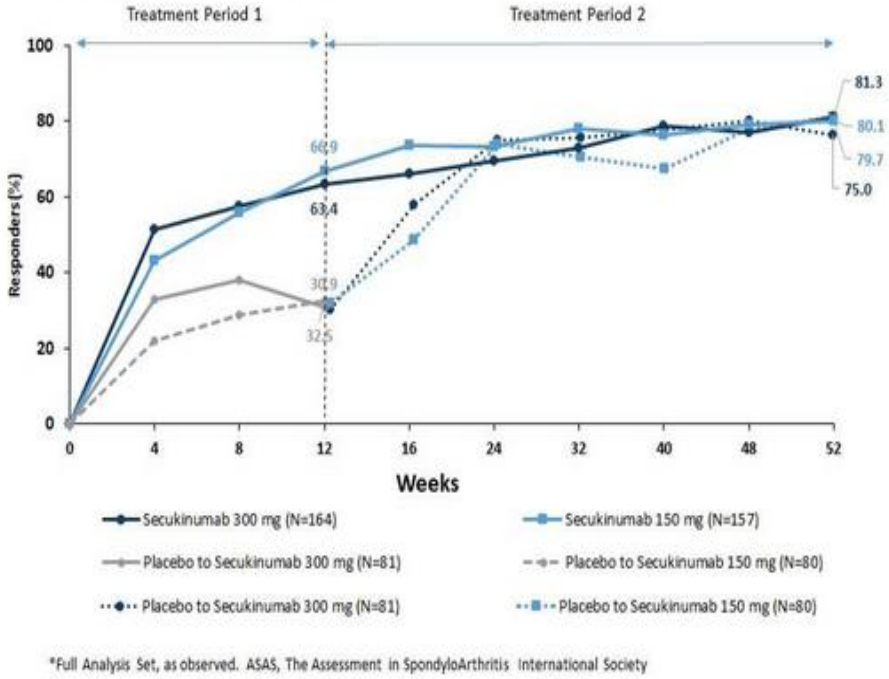
X. Baraliakos[1], L. Gossec[2], E. Pournara[3], S. Jeka[4], R. Blanco[5], S. D'angelo[6], G. Schett[7], B. Schulz[3], M. Rissler[3], K. Nagar[8], C. Perella[3], L. C. Coates[9]



Phase 3b, double-blind, placebo (PBO)-controlled, multicentre 52-wk trial included 498 pts (aged ≥18 years) with a diagnosis of PsA and classified by CASPAR criteria, spinal pain VAS score ≥ 40/100 and BASDAI score ≥ 4 despite use of at least two NSAIDs

Figure 1.

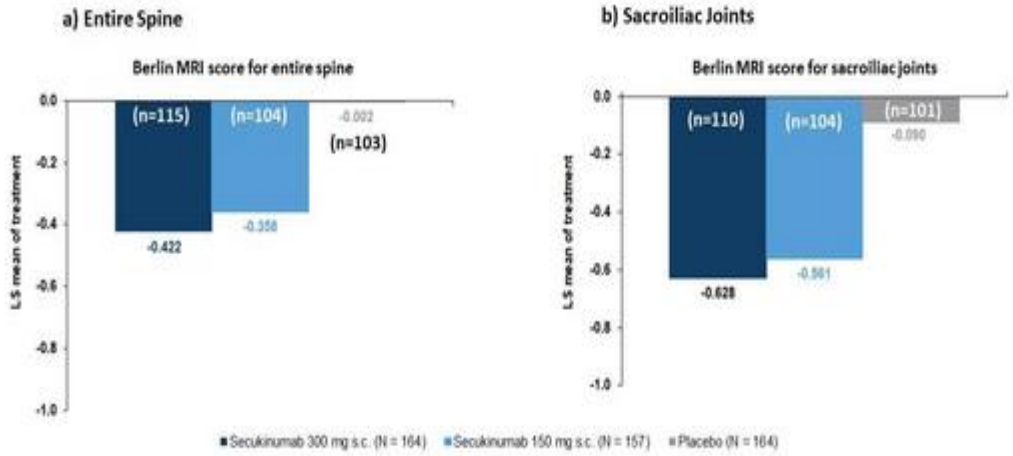
ASAS20 Response over 52 Wks*



*Full Analysis Set, as observed. ASAS, The Assessment in SpondyloArthritis International Society

Figure 2.

Total Berlin MRI score for the Entire Spine and Sacroiliac Joints at Wk 12



LS Mean difference
Secukinumab 300 mg vs placebo: -0.4 (0.14), ***p*=0.0031**
Secukinumab 150 mg vs placebo: -0.4 (0.15), ***p*= 0.0145**

LS Mean difference
Secukinumab 300 mg vs placebo: -0.5 (0.18), ***p*=0.0032**
Secukinumab 150 mg vs placebo: -0.5 (0.18), ***p*= 0.0107**

*MRI, Magnetic resonance imaging

http://dx.doi.org/10.1136/annrheumdis-2020-eular.638

EXTENDED REPORT

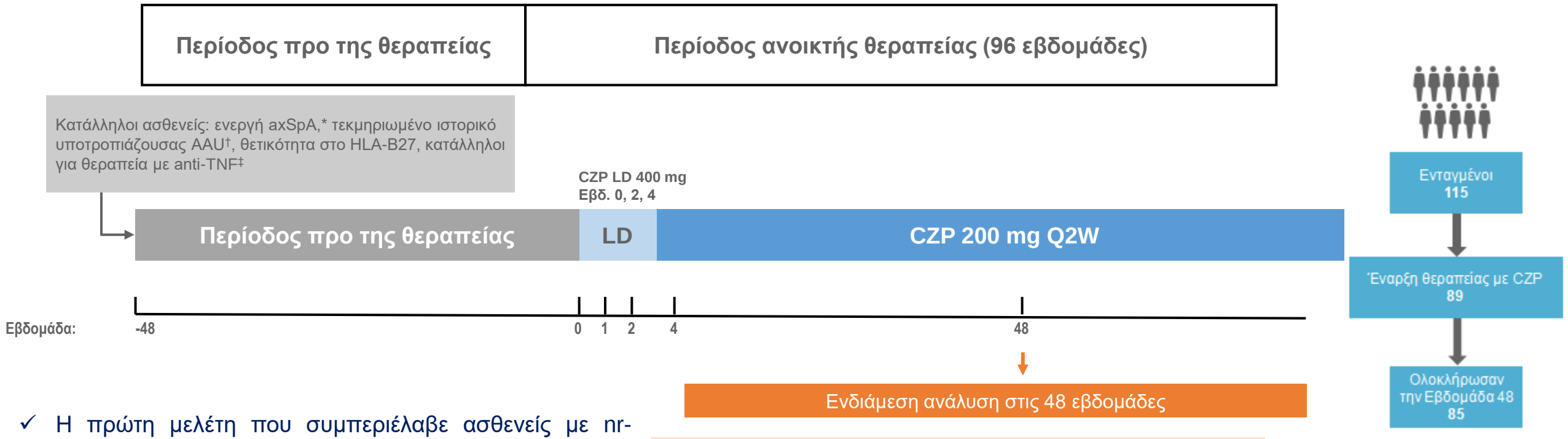
Efficacy of tumour necrosis factor blockers in reducing uveitis flares in patients with spondylarthropathy: a retrospective study

S Guignard, L Gossec, C Salliot, A Ruyssen-Witrand, M Luc, M Duclos, M Dougados

Ann Rheum Dis 2006;65:1631–1634. doi: 10.1136/ard.2006.052092

	Period before anti-TNF treatment			Period during anti-TNF treatment			
Anti-TNF (n= patients)	**Duration of period (years) Mean (SD)**	**Number of uveitis flares/patient Mean (SD)**	**Number of uveitis flares/100 patient-years Mean (SD)**	**Treatment period (years) Mean (SD)**	**Number of uveitis flares/patient Mean (SD)**	**Number of uveitis flares/100 patient-years Mean (SD)**	**p Value***
All anti-TNF n=46	15.2 (10.2)	6.3 (9.7)	51.8 (65.0)	1.2 (1.1)	0.2 (1.0)	21.4 (74.9)	0.03
Soluble TNF receptor (etanercept) n=13	11.5 (10.4)	3.6 (4.1)	54.6 (78.2)	1.2 (1.1)	0.5 (0.8)	58.5 (121.9)	0.92
Anti-TNF antibodies (adalimumab and infliximab) n=33	16.7 (9.8)	7.3 (11.1)	50.6 (61.0)	1.2 (1.1)	0.1 (1.0)	6.8 (39.3)	0.001
Infliximab n=25	16.8 (10.4)	7.3 (12.1)	47.4 (58.9)	1.4 (1.3)	0.2 (1.2)	9.0 (45.2)	0.008
Adalimumab n=8	16.2 (8.7)	7.2 (7.8)	60.5 (70.4)	0.6 (0.2)	0	0	0.04

C-VIEW Σχεδιασμός της μελέτης [1,2] open-label, phase 4 study.



- ✓ Η πρώτη μελέτη που συμπεριέλαβε ασθενείς με nr-axSpA και r-axSpA/AS, οι οποίοι ήταν θετικοί στο HLA-B27, για την εκτίμηση της επίδρασης του CZP στη μείωση των εξάρσεων AU σε ασθενείς με axSpA και ιστορικό AU

Πρωτεύον καταληκτικό σημείο:
Αριθμός διακριτών επεισοδίων έξαρσης της AAU κατά την περίοδο θεραπείας (έως την Εβδομάδα 96), σε σύγκριση με τα ιστορικά ποσοστά

Το CZP δεν έχει εγκριθεί για τη θεραπεία της ραγοειδίτιδας στην Ευρωπαϊκή Ένωση

* Η axSpA ορίζεται με βάση τα κριτήρια ASAS και η ενεργή νόσος στην προκαταρκτική αξιολόγηση ορίζεται με βάση βαθμολογία BASDAI ≥4 και βαθμολογία άλγους της σπονδυλικής στήλης ≥4 σε μία NRS 0-10 (από το στοιχείο 2 του BASDAI). Οι ασθενείς με nr-axSpA πρέπει να έχουν CRP>ULN και/ή τρέχουσες ενδείξεις ιερολαγονίτιδας στην MRI σύμφωνα με τα κριτήρια ASAS. Οι ασθενείς με AS πρέπει να έχουν ενδείξεις ιερολαγονίτιδας στην ακτινογραφία που πληρούν τα κριτήρια mNY κατά την κρίση του ερευνητή.

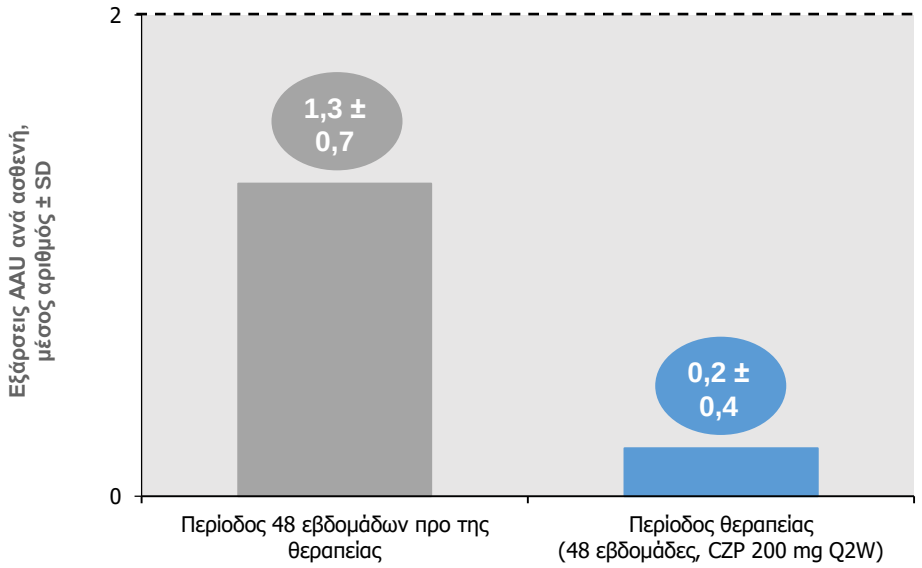
† Διαγνωσμένη από οφθαλμίατρο και ≥2 εξάρσεις AAU στο παρελθόν, από τις οποίες ≥1 τουλάχιστον 12 μήνες πριν από την έναρξη,

‡ Ενεργή axSpA, προηγούμενη αποτυχία με ≥2 ΜΣΑΦ, δεν έχουν λάβει βιολογικούς παράγοντες, ή προηγούμενη αποτυχία με ≤1 αντι-TNF.

1. ClinicalTrials.gov NCT03020992. Accessed 10.01.2020.
2. van der Horst-Bruinsma I et al. Arthritis Rheumatol. 2019; 71(suppl 10). Abstract 935.

Ενδιάμεση ανάλυση στις 48 εβδομάδες (δεδομένα παρατηρήσεων) (1/2)

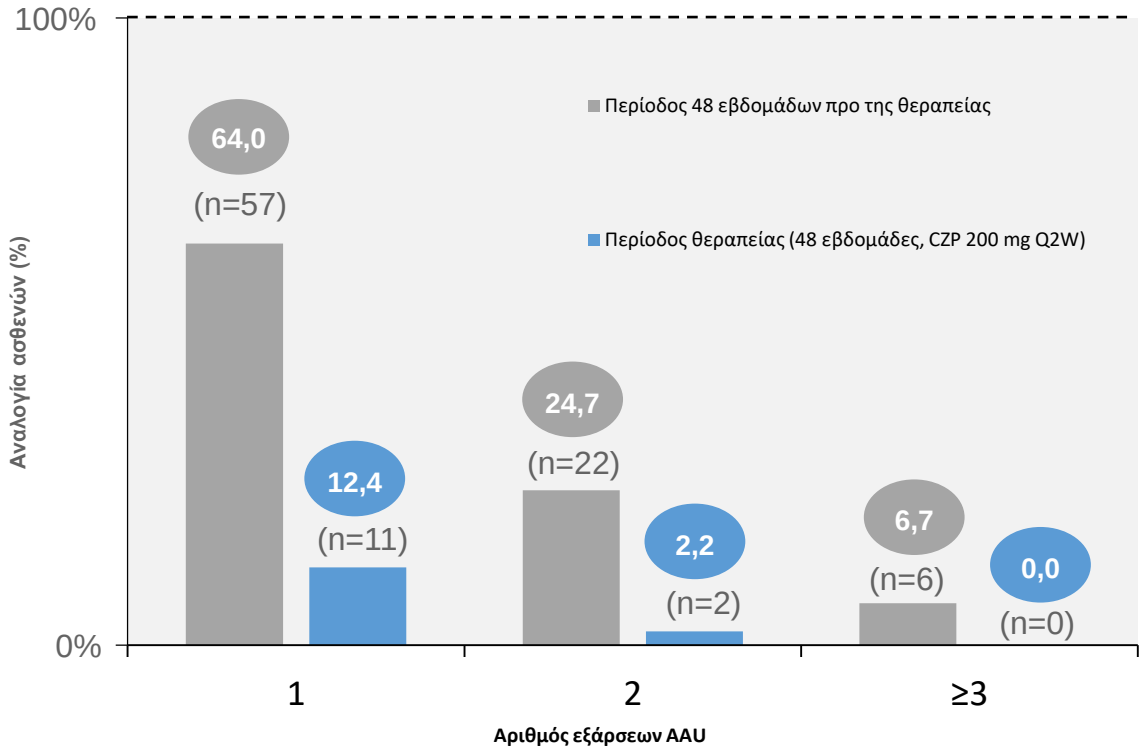
Μέσος αριθμός εξάρσεων AAU (N=89)



Επίπτωση προσαρμοσμένη κατά Poisson:*
Προ της θεραπείας: 1,5 Στη διάρκεια της θεραπείας: 0,2

87% μείωση της επίπτωσης AAU

Ποσοστό ασθενών που είχαν 1, 2 ή ≥3 εξάρσεις της AAU (N=89)

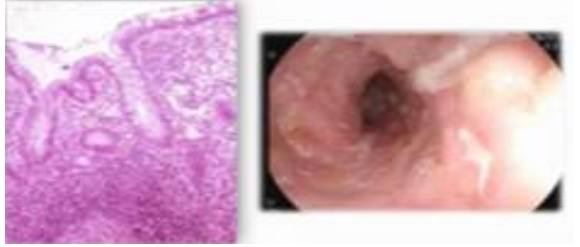


Σημαντική μείωση στο ποσοστό εξάρσεων AAU στις πρώτες 48 εβδομάδες της θεραπείας με CZP

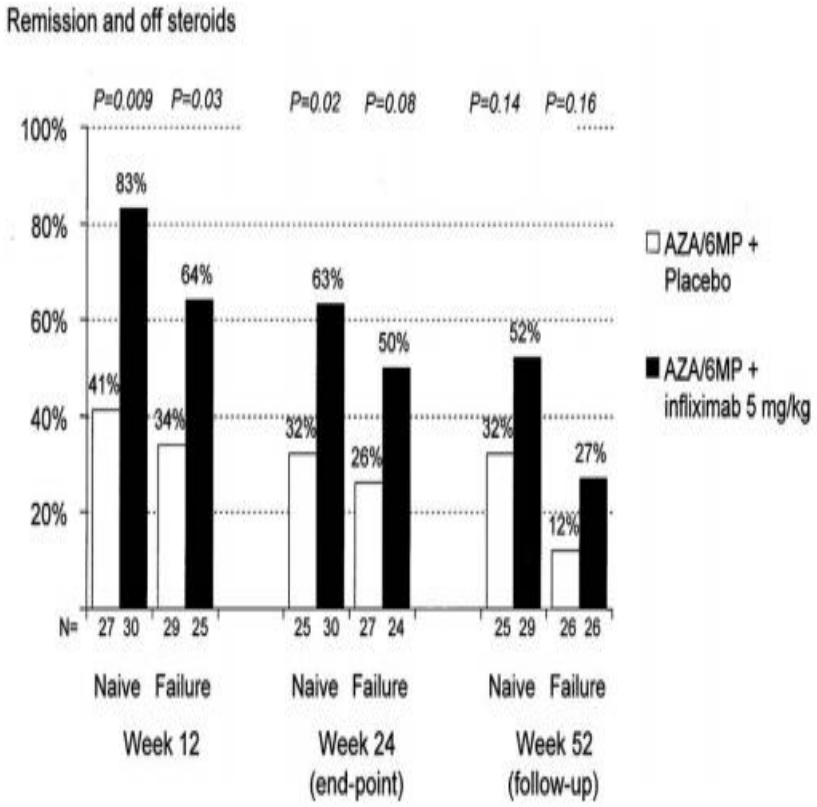
van der Horst-Bruinsma I et al. Arthritis Rheumatol. 2019; 71 (suppl 10). Abstract 935.

Όλοι οι ασθενείς (N=89).
Περίοδος προ της θεραπείας: 48 εβδομάδες πριν από την έναρξη της μελέτης.
* Χρήση παλινδρόμησης Poisson με προσαρμογή για πιθανούς συσχετισμούς για τον ίδιο ασθενή, με συμμεταβλητές την περίοδο (πριν και μετά την έναρξη της μελέτης) και τη διάρκεια της axSpA.

ΕΝΤΕΡΙΚΗ ΦΛΕΓΜΟΝΗ

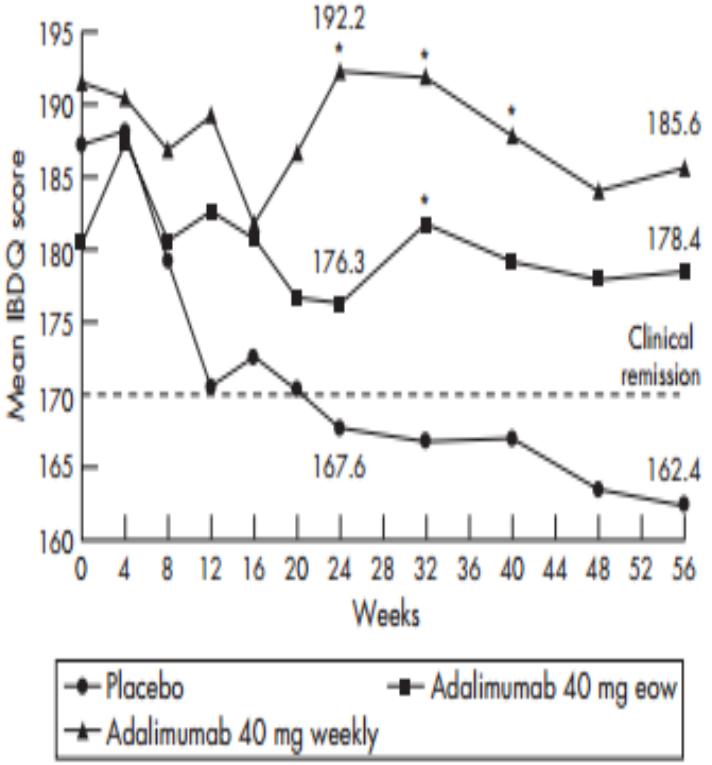


Infliximab



Lémann M *et al*, Gastroenterology 2006;130:1054-61

Adalimumab



Sandborn *et al*, Gut 2007;56:1232–9

Certolizumab pegol

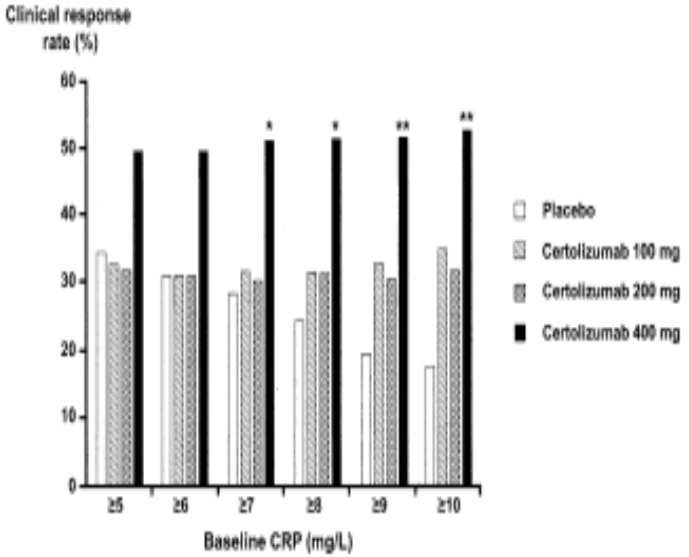
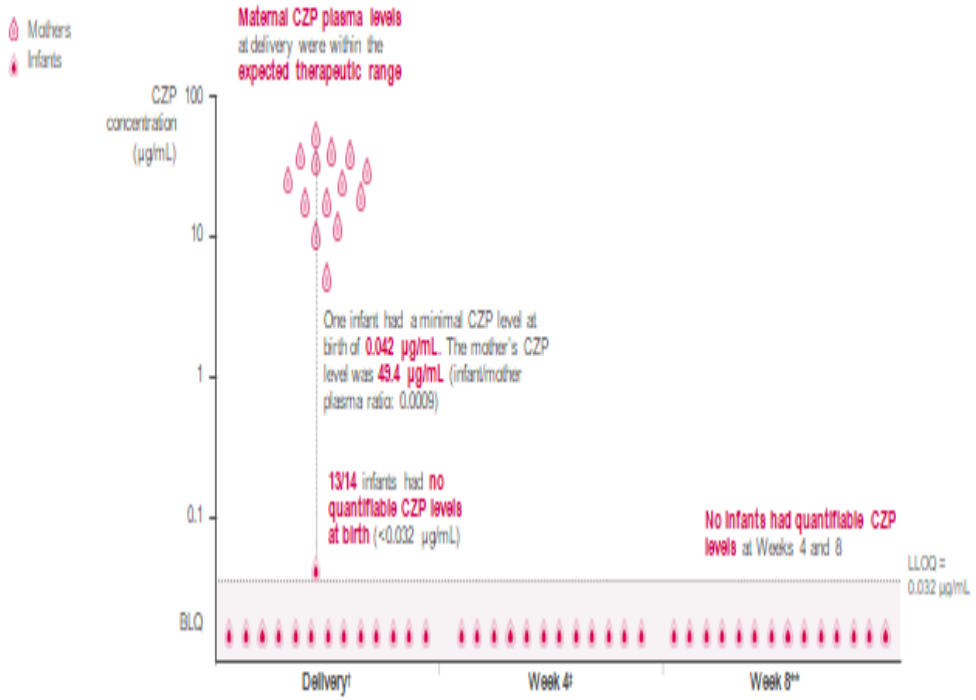


Figure 6. Clinical response rates (decrease in CDAI score ≥100 points or remission [CDAI score, ≤150 points]) to certolizumab 100, 200, and 400 mg and placebo at week 12 according to mean baseline CRP concentrations. *$P \leq .05$, **$P \leq .01$ compared with placebo.

Schreiber S *et al*, Gastroenterology 2005;129:807–18

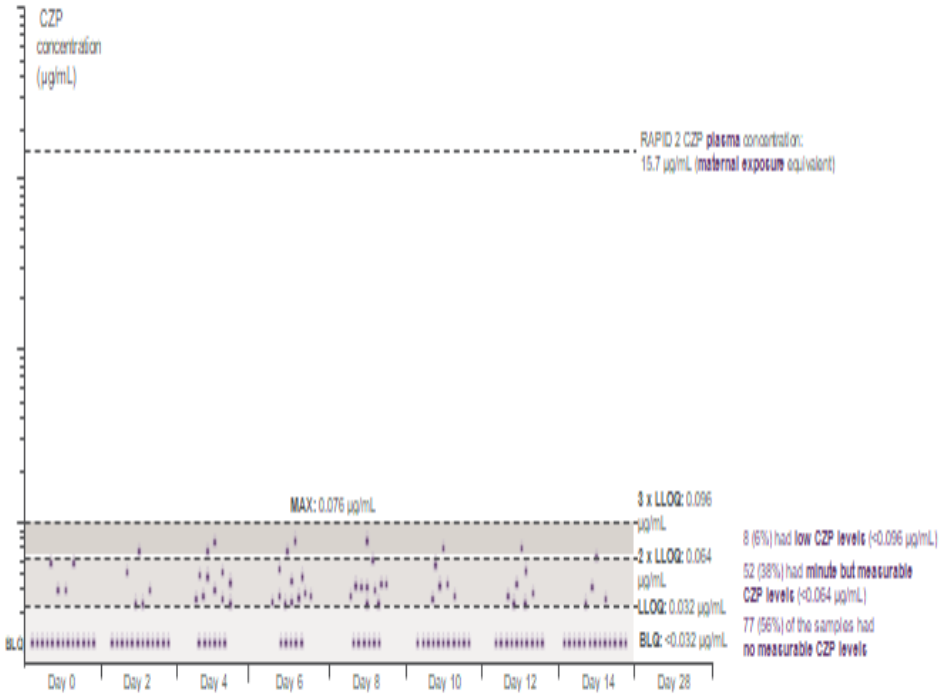
CRIB Study



CZP showed no to minimal (<0.1% of the adult therapeutic level) placental transfer from mother to infant.[1] CZP should only be used during pregnancy if clinically needed.[2]

Mariette X et al. Ann Rheum Dis. 2018;77:228–233.

CRADLE: Breast Milk Transfer Study



CZP can be used during breastfeeding due to minimal transfer to breast milk

Adapted from Clowse ME et al. Ann Rhem Dis. 2017;76:1890–1896.

ΣΥΜΠΕΡΑΣΜΑΤΑ

Η ΨΑ αποτελεί μία ετερογενή νόσο με κλινικές εκδηλώσεις από διάφορα συστήματα και πλήθος συννοσυροτήτων που καθιστούν δύσκολη την αντιμετώπιση και επιλογή της κατάλληλης θεραπευτικής αγωγής

Το γυναικείο φύλο σχετίζεται με καθυστερημένη παραπομπή και διάγνωση της νόσου γεγονός που συνοδεύεται από σημαντικότερες επιπτώσεις σε ότι αφορά το συνολικό φορτίο και τις συνέπειες της ΨΑ σε δραστηριότητες της καθημερινής ζωής

Η καλύτερη γνώση και κατανόηση των μηχανισμών της νόσου έχει οδηγήσει σε νέες θεραπευτικές προσεγγίσεις και στρατηγικές θεραπείας που αποσκοπούν στην ολοκληρωμένη αντιμετώπιση της ΨΑ

Το certolizumab-pegol αποτελεί τον μοναδικό αναστολέα του TNF-α με μακροχρόνια δεδομένα που αφορούν όλα τα πεδία της ΨΑ καθώς και στις εξωαρθρικές εκδηλώσεις και αποτελεί αξιόπιστη επιλογή για την αντιμετώπιση του συνόλου των ετερογενών εκδηλώσεων της νόσου.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