Θεραπεία στην Ψωριασική αρθρίτιδα;»

Προσέγγιση βασισμένη σε κλινικό περιστατικό

Πούλια Βασιλική

Ειδικευόμενη Ρευματολογίας

Ρευματολογική μονάδα Α'ΠΠΚ Λαϊκό Νοσοκομείο

Σύγκρουση συμφερόντων

- Δεν υπάρχουν για την συγκεκριμένη παρουσίαση

Εισαγωγή

Μεγάλο εύρος εκδηλώσεων

- Μυοσκελετικό σύστημα (άρθρωση, ένθεση, δακτυλίτιδα)
- Δέρμα
- Γαστρεντερικό σύστημα
- Οφθαλμός

Συννοσηρότητες

-Μεταβολικό σύνδρομο

-Καρδιαγγειακή νόσος

-Κατάθλιψη

Παρουσίαση περιστατικού

Γυναίκα, 45 ετών

Έξεις: κάπνισμα (-) , BMI: 29 kg/m² (υπέρβαρος)

Επάγγελμα: Δασκάλα πρωτοβάθμιας εκπαίδευσης

Ιστορικό:

- **Ψωρίαση** από 12ετίας (ψωριασικές πλάκες σε αγκώνες & τριχωτό κεφαλής) – άνευ αγωγής
- Από **8μήνου:** οσφυαλγία, πρωινή δυσκαμψία >1 ώρα, βελτίωση με την δραστηριότητα.
- **Οίδημα – ερυθρότητα** στο 2ο δάκτυλο αριστερού ποδιού από μηνός.

Ατομικό αναμνηστικό : ελεύθερο

Οικογενειακό ιστορικό: ψωρίαση πατέρα, αδελφός πατέρα με ψωριασική αρθρίτιδα

Συνέχεια περιστατικού

- **Κλινικά: FABER test** (+) (ΔΕ), **δακτυλίτιδα** 2ου δακτύλου αριστερού ποδιού

PASI< 3

Εργαστηριακά: CRP 8 mg/L (κφ< 5), HLA-B27 αρνητικό, RF/anti-CCP αρνητικά.

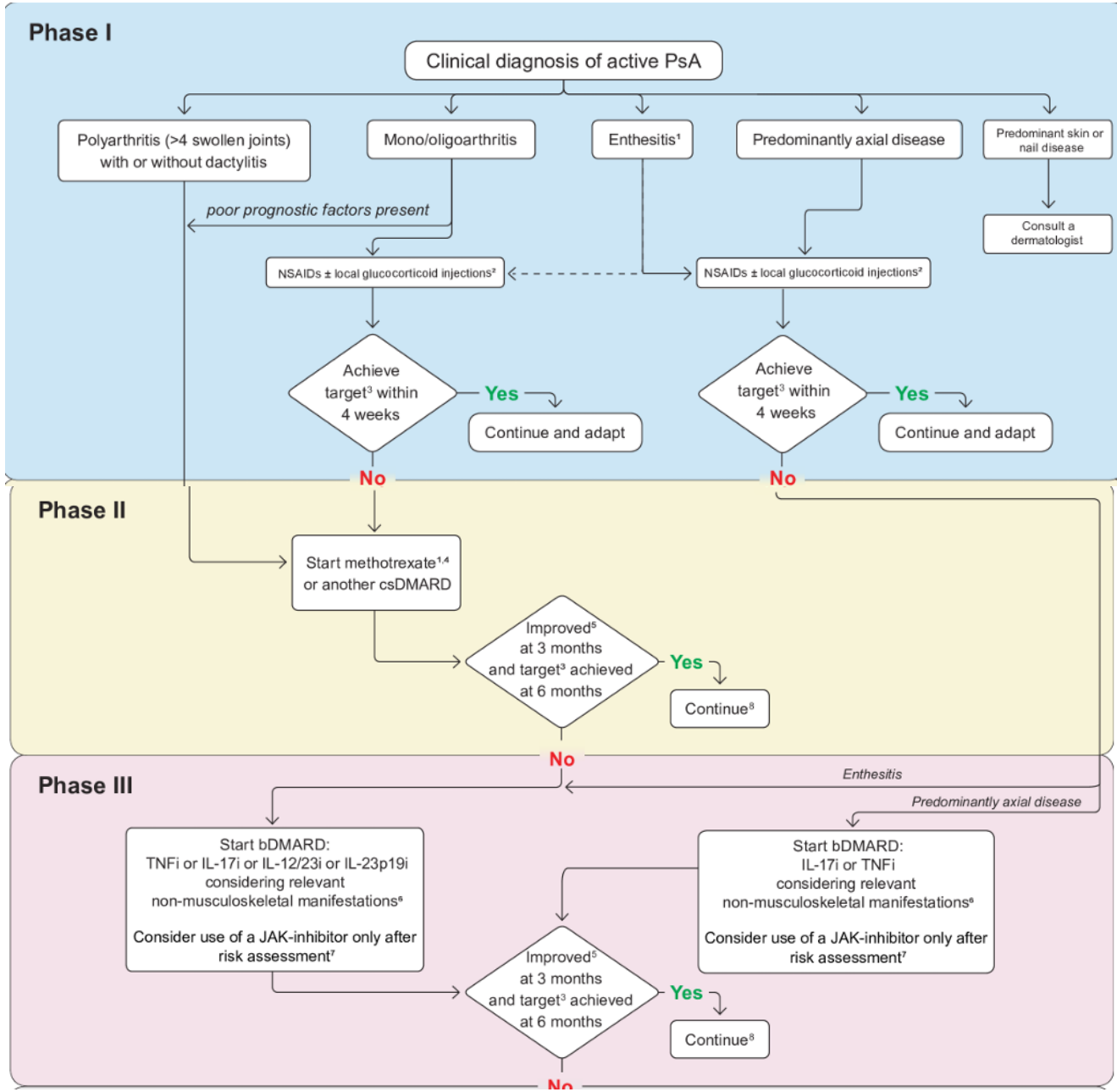
- **Απεικόνιση:** MRI ιερολαγονίων με ενεργό φλεγμονή, συμβατή με αξονική προσβολή.

Πρωτοδιάγνωση ψωριασικής αρθρίτιδας με αξονική προσβολή (AxPsa) και ήπια δερματική προσβολή

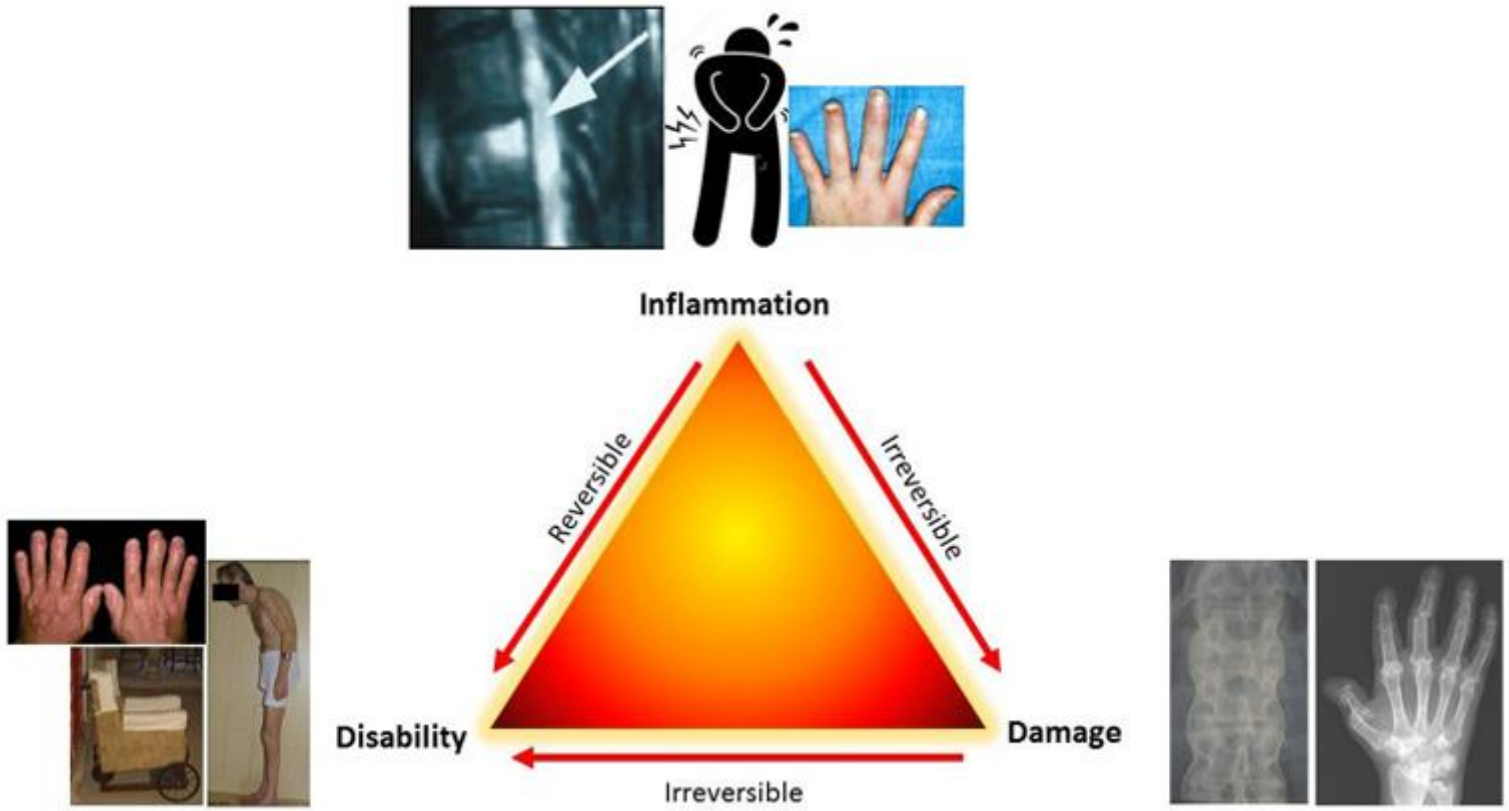
OPEN ACCESS

EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2023 update

Laure Gossec ,[1,2] Andreas Kerschbaumer ,[3] Ricardo J O Ferreira ,[4,5] Daniel Aletaha ,[3] Xenofon Baraliakos ,[6] Heidi Bertheussen,[7] Wolf-Henning Boehncke,[8] Bente Appel Esbensen ,[9,10] Iain B McInnes,[11] Dennis McGonagle,[12,13] Kevin L Winthrop ,[14] Andra Balanescu,[15] Peter V Balint,[16] Gerd R Burmester ,[17] Juan D Cañete ,[18,19] Pascal Claudepierre,[20,21] Lihi Eder ,[22] Merete Lund Hetland ,[23,24] Annamaria Iagnocco ,[25] Lars Erik Kristensen,[26,27] Rik Lories,[28,29] Rubén Queiro ,[30,31] Daniele Mauro ,[32] Helena Marzo-Ortega ,[12,13] Philip J Mease ,[33,34] Peter Nash ,[35] Wendy Wagenaar,[36,37] Laura Savage,[38] Georg Schett ,[39] Stephanie J W Shoop-Worrall ,[40] Yoshiya Tanaka ,[41] Filip E Van den Bosch ,[42] Annette van der Helm-van Mil,[43] Alen Zabotti ,[44] Désirée van der Heijde ,[43] Josef S Smolen[3]



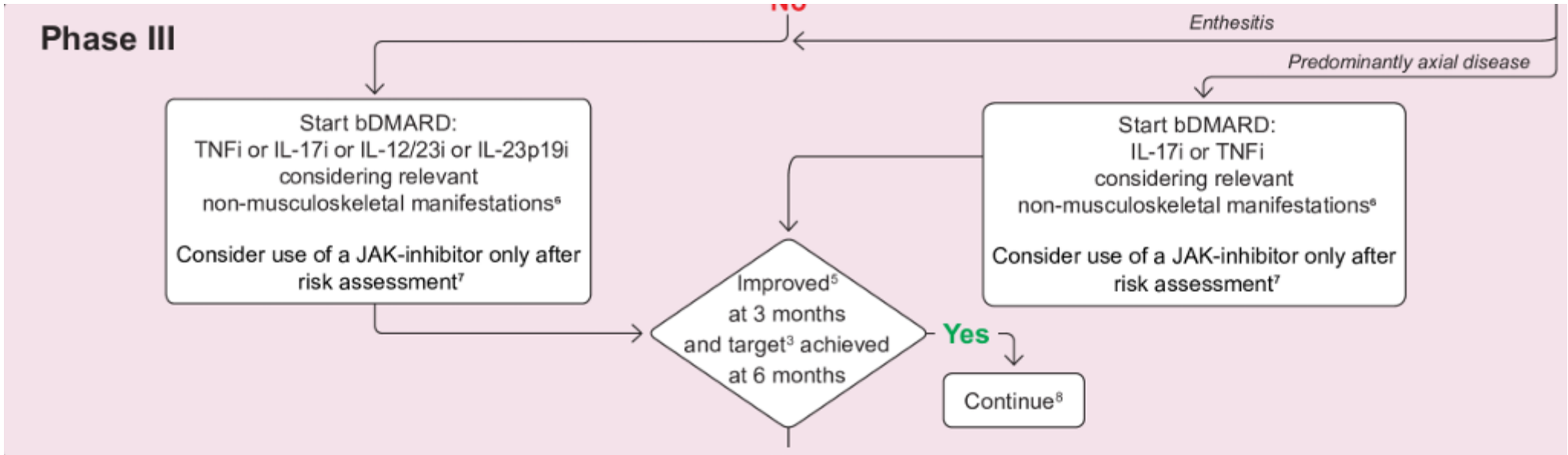
Gossec L, et al. Ann Rheum Dis 2024;8



Smolen JS , et al. Ann Rheum Dis 2

Επιλογή θεραπευτικής προσέγγισης

- Screening για ηπατίτιδες, λανθάνουσα ΤΒ
  - ✓ HBsAg (-), HBcAb (-),HBsAb (-), HCV (-), HIV (-)
  - ✓Quantiferon (-), ακτινογραφία θώρακος: χωρίς παθολογικά ευρήματα.



Φαρμακευτικές επιλογές σε ψωριασική αρθρίτιδα με αξονική προσβολή:

- Anti- IL17
- Anti-TNF
- JAKi

Gossec L, et al. Ann Rheum Dis 2024;

Ustekinumab in Axial PsA
Data from Psummit-1 & 2

- Pooled data from PSUMMIT 1 & 2
- Week 24
  - mean changes were larger in UST Vs PBO
  - neck/back/hip pain (−1.99 vs −0.18)
  - mBASDAI (−2.09 vs −0.59).
  - ⇧ proportions of UST Vs PBO achieved ASDAS clinically important improvement
    - decrease ≥ 1.1; 49.6% vs 12.7%; nominal p<0.05

Kavanaugh A et al, Ann Rheum Dis. 2016
Helliwell PS et al, RMDOpen 2020

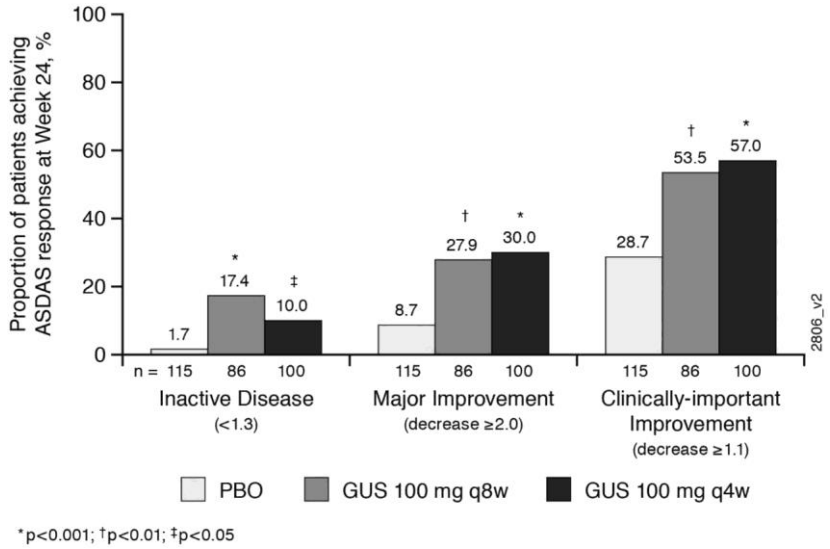
Guselkumab in Axial PsA Data from Discover-1 & 2

- 312 pts with axial PsA (imaging confirmed SI)

Table. Efficacy of GUS in PsA patients with axial involvement at week 24.[a]

	PBO (n=118)	GUS 100 mg every 8 weeks (n=91)	GUS100 mg every 4 weeks (n=103)
LS Mean change in BASDAI	-1.35	-2.67*	-2.68*
LS Mean change in spinal pain[b]	-1.30	-2.73*	-2.48*
BASDAI50[c], %	21/110 (19.1%)	34/84 (40.5%)**	36/95 (37.9%)**
LS Mean change in modified BASDAI[d]	-1.13	-2.16*	-2.18*
LS Mean change in ASDAS-CRP	-0.71	-1.43*	-1.46*

[a]Pts with axial involvement consistent with sacroiliitis at baseline and either a history of imaging confirmation or pelvic X-ray at screening (pooled data from DISCOVER-1 & 2)
[b]Question 2 of the BASDAI.
[c]Pts with BASDAI > 0 at baseline.
[d]Excludes question 3 of the BASDAI.
Unadjusted p-values as noted: *p < 0.001, ** p < 0.01



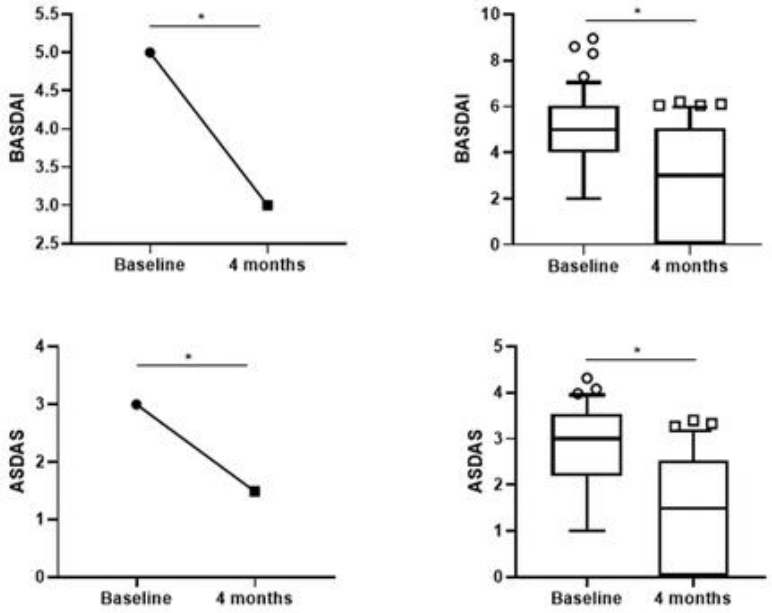
*p<0.001; †p<0.01; ‡p<0.05

Deodhar, Atul et al.The Lancet 2020
Mease PJ, et al The Lancet. 2020

IL-23 in PsA

Real-life data

- 67 PsA patients with axial involvement (Subjective + XR OR MR)
  - Received anti-IL-23 for 4 months
  - In 27 patients
    - MRIs before and after
  - Significant BASDAI and ASDAS improvement
  - MRI: ⇩ > 0.80 score SI was observed in 70.3% of pts
    - Paralleled clinical improvement



Ruscitti et al Rheumatology (Oxf) 2024

Τι θα άλλαζε αν η ασθενής μας:

- **Quantiferon (+)** ακτινογραφία θώρακος χωρίς παθολογικά ευρήματα

Ισονιαζίδη για 6-12 μήνες συνολικής θεραπείας ή συνδυασμός ισονιαζίδης/ριφαμπικίνης για 3-4 μήνες

Έναρξη bDMARD 1 μήνα μετά την έναρξη αγωγής κατά της φυματίωσης.

Anti-IL-17 ή etanercept

Fragoulis GE, et al. Ann Rheum Dis 2023
M Ward et al Arhtritis & Rheum 2019
Evangelatos G et al Ther Adv M Dis 2020

Table 6. Comparative presentation of active tuberculosis (TB) incidence rates (IR) between different biologic and targeted synthetic DMARDs.

Drug	Disease	Study type	IR§	Reference
Infliximab	RA, AS, PsA, PsO, CD, UC	LTE, RLS	52.5–2558.0	Askling *et al.*[2]; Seong *et al.*[6]; Wolfe *et al.*[8]; Dixon *et al.*[9]; Gomez-Reino *et al.*[10]; Souto *et al.*[27]; Tubach *et al.*[28]
Certolizumab	RA	LTE	474.29	Souto *et al.*[27]
Adalimumab	RA, AS, PsA, PsO, CD, UC	LTE, RLS	90.0–215.0	Dixon *et al.*[9]; Souto *et al.*[27]; Tubach *et al.*[28]
Golimumab	RA, AS, PsA	LTE	172.13	Souto *et al.*[27]
Etanercept	RA, AS, PsA, PsO	RLS, LTE	9.3–80.0	Askling *et al.*[2]; Dixon *et al.*[9]; Souto *et al.*[27]; Tubach *et al.*[28]
Apremilast	PsA, PsO	RCT, LTE, RLS	0.0	Cutolo *et al.*[35]; Edwards *et al.*[36]; Kavanaugh *et al.*[37]; Wells *et al.*[38]; Crowley *et al.*[39]; Abignano *et al.*[40]; Favalli *et al.*[41]
Tofacitinib	RA	RCT, LTE	200.0–210.0	Winthrop *et al.*[47]; Cohen *et al.*[49]
Baricitinib	RA	RCT, LTE	150.0–230.0	Smolen *et al.*[56]; Chen *et al.*[57]
Ustekinumab	PsA, PsO, CD	RCT, LTE, RLS	0.0–22.12	Ghosh *et al.*[76]; Lopez-Ferrer *et al.*[77]; Tsai *et al.*[78]; Hsiao *et al.*[79]
Secukinumab	AS, PsA, PsO	RCT, LTE	0.0–5.0	Deodhar *et al.*[95]; van de Kerkhof *et al.*[96]
Ixekizumab	PsA, PsO	RCT	0.0	Mease *et al.*[98]; Romiti *et al.*[99]

Τι θα άλλαζε αν η ασθενής μας:

- HBcAb (+), HBsAg (-)

- HBV DNA (+) ή HBV DNA (-)

Rheumatology key messages

- The use of anti-IL-17, anti-IL-12/23, anti-IL-23 and JAK-inhibitors in patients with chronic hepatitis B (HBV) infection comes with a significant risk for HBV reactivation and anti-viral pre-emptive therapy should be considered
- In patients with resolved HBV infection, the risk of HBV reactivation is low under anti-IL-17, anti-IL-12/23, anti-IL-23 and JAK-inhibitors treatment
- The choice of drug between anti-IL-17, anti-IL-12/23, anti-IL-23 and JAK-inhibitors does not come with different HBV reactivation risk

Androutsakos T. et al Rheumatolo

Τι θα άλλαζε αν η ασθενής μας;

- Επιθυμούσε εγκυμοσύνη

L. Rüegg et al. Ann Rheum Dis 00 (2025) 1–17

Table 2
Antirheumatic drugs in pregnancy

Drugs compatible with pregnancy		Drugs may be used if needed to effectively control maternal disease		Drugs to treat severe, refractory maternal disease, or if no alternative medication can be used		Drug to be discontinued prior to conception due to teratogenicity		Drugs that should be avoided due to insufficient data	
Drug	**LoE/GoR**	**Drug**	**LoE/GoR**	**Drug**	**LoE/GoR**	**Drug**	**LoE/GoR**	**Drug**	**LoE/GoR**
hydroxychloroquine (HCQ) chloroquine (CQ)	2a/B HCQ 2c/B CQ	IL12/23i: ustekinumab	2b/B	IV methylprednisolone	4/C	cyclophosphamide+	2a/B	apremilast	5/D
sulfasalazine	2a/B	IL-6i: tocilizumab sarilumab	4/C	IVIG	3b/C	mycophenolate+	2a/B	avacopan	5/D
azathioprine 6-mercaptopurine	2a/B	IL-1i: anakinra canakinumab	4/C	sildenafil	4/C	methotrexate	2a/B	JAKi: tofacitinib, baricitinib, upadacitinib, filgotinib	4/C-5/D
cyclosporine (CyC) tacrolimus (TAC)	2a/B CyC 2b/B TAC	IL17i: secukinumab, ixekizumab	4/C	C5i: eculizumab	4/C			bosentan	5/D
colchicine	2b/B	anti-T cell: abatacept	4/C	IL-5i: mepolizumab	4/C			leflunomide (stop 5 half-lives prior to conception or washout)	2b/B
TNFi: adalimumab certolizumab etanercept golimumab infliximab	2a/B	anti-B cell: rituximab belimumab	4/C	IL-23i: guselkumab risankizumab	5/D			voclosporin	5/D
NSAIDs# prefer ibuprofen (IBU), diclofenac (DIC); (only intermittent use, stop after 28 GW)	2a/B IBU, DIC 2b/C COX2i			IFNAR1i: anifrolumab	5/D				
prednisone, prednisolone# (aiming at ≤ 5 mg/d)	2a/B								

Τι θα άλλαζε αν ο ασθενής μας:

- Ιστορικό κακοήθειας προ 3ετίας.

2024 EULAR points to consider on the initiation of targeted therapies in patients with inflammatory arthritis and a history of cancer

Eden Sebbag ,[1] Kim Lauper ,[2] Juan Molina-Collada ,[3] Daniel Aletaha ,[4] Johan Askling ,[5] Karolina Gente,[6] Heidi Bertheussen,[7] Samuel Bitoun ,[8] Ertugrul Cagri Bolek ,[9] Gerd R Burmester ,[10] Helena M Canhão,[11] Katerina Chatzidionysiou ,[5] Jeffrey R Curtis,[12] Francois-Xavier Danlos ,[13,14] Vera Guimarães,[15] Merete Lund Hetland ,[16,17] Florenzo Iannone ,[18] Marie Kostine ,[19] Tue Wenzel Kragstrup ,[20,21] Tore K Kvien ,[22] Anne Constanze Regierer ,[23] Hendrik Schulze-Koops ,[24] Lucía Silva-Fernández,[25] Zoltan Szekanecz,[26] Maya H Buch ,[27] Axel Finckh ,[2] Jacques-Eric Gottenberg [1]

4. *Appropriate targeted antirheumatic treatment can be initiated without delay in patients with cancer in remission (LoE 4; LoA 9.4 (0.9)).*

6. *When targeted antirheumatic therapy is indicated in patients with a history of solid cancer (this PTC does not concern melanoma), TNF inhibitors may be preferred over other treatment options (LoE 4; LoA 9.2 (1.3)).*

5. *In patients with a history of cancer, JAK inhibitors and abatacept may be used with caution, and only in the absence of therapeutic alternatives (LoE 5; LoA 8.9 (1.1)).*

Contents lists available at ScienceDirect

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journal homepage: www.elsevier.com/locate/semarthrit

Malignancy in psoriatic disease: Results from prospective longitudinal cohorts

Ari Polachek[a], Anastasiya Muntyanu[b], Ker-Ai Lee[c], Justine Y. Ye[b], Vinod Chandran[b,d,e,f], Richard J. Cook[c], Dafna D. Gladman[b,d,f,*]

[a] Department of Rheumatology, Tel Aviv Sourasky Medical Center, Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel
[b] Center for Prognostic Studies in the Rheumatic Diseases, Krembil Research Institute, University Health Network, Toronto, ON Canada
[c] Department of Statistics and Actuarial Science, University of Waterloo, Waterloo, ON Canada
[d] Department of Medicine, University of Toronto, Toronto, ON Canada
[e] Institute of Medical Science, University of Toronto, Toronto, ON Canada
[f] Department of Laboratory Medicine and Pathobiology, University of Toronto, Toronto, ON Canada

- PsA patients followed prospectively since 1978
- PsC patients followed since 2006
- Malignancies were recorded prospectively and linkages with Cancer Care Ontario and the Death Registry
- Presence and type of malignancy up to December 2016

Table 1
Characteristics of study populations.

Characteristic	PsA (*N*=1413)	PsC (*N*=571)
Sex: Male	794 (56.2%)	326 (57.1%)
Age at first visit*	43.9 (13.0)	45.7 (13.6)
Age at Psoriasis*	28.5 (14.6)	30.3 (15.9)
Age at PsA*	37.7 (13.5)	–
Smoker	630 (47.4%)	319 (55.9%)
Alcohol use	959 (73.0%)	415 (72.7%)
Married	873 (61.8%)	334 (58.5%)
Employed	880 (62.3%)	462 (80.9%)
Education ≥ College	888 (62.8%)	469 (82.1%)
Deceased	216 (15.3%)	12 (2.1%)
Actively inflamed (swollen or tender) joints at first visit*	9.3 (10.0)	NA
Swollen joints at first visit*	2.3 (3.8)	NA
Damaged joints at first visit*	2.6 (6.7)	NA
Dactylitis at first visit	387 (27.5%)	NA
Enthesitis at first visit	224 (15.9%)	NA
Axial disease ? at first visit	467 (35.5%)	NA
PASI at first visit*	3.8 (7.1)	5.6 (6.0)
Nail lesions	1178 (84.4%)	340 (59.6%)
Depression	271 (19.2%)	69 (12.1%)
Obesity	477 (33.8%)	192 (33.6%)
Cardiovascular disease	115 (8.1%)	29 (5.1%)
Diabetes	171 (12.3%)	65 (11.4%)
No medications	78 (5.5%)	347 (60.8%)
NSAIDs**	206 (14.6%)	58 (10.2%)
DMARDS**	573 (40.6%)	88 (15.4%)
Biologics**	556 (39.3%)	78 (13.7%)

* mean (SD).
** strongest level of medication.

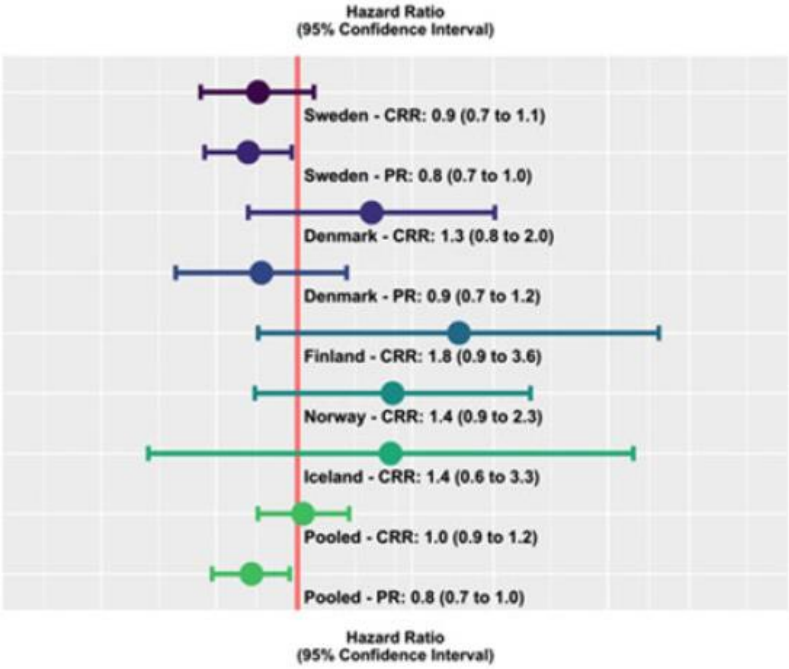
Table 4
Cause-specific standardized incidence ratio (SIR) of psoriatic disease (PsD) compared to general population, stratified by sex and years (1981–2012).

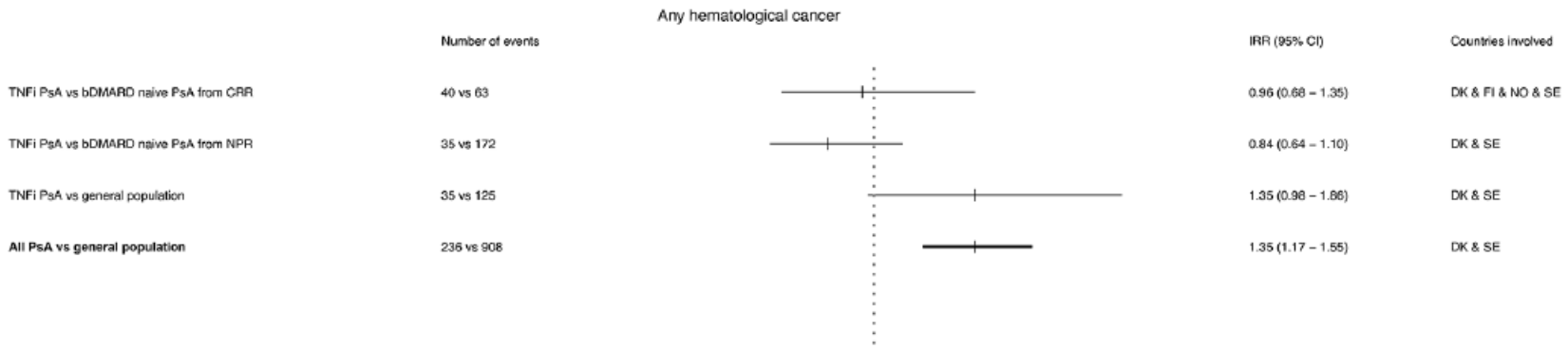
	Overall		Female		Male	
	Crude Rate (Per 1000 Persons)	SIR (95% CI)	Crude Rate (Per 1000 Persons)	SIR (95% CI)	Crude Rate (Per 1000 Persons)	SIR (95% CI)
Brain	0.16	1.68 (0.35–4.91)	0.25	3.02 (0.36–10.90)	0.10	0.89 (0.02–4.97)
Breast	-	-	2.40	1.46 (0.88–2.28)	-	-
Endocrine	-	-	0.13	0.46 (0.01–2.54)	-	-
Gastrointestinal	0.66	0.48 (0.25–0.84)	0.63	0.55 (0.18–1.27)	0.67	0.44 (0.18–0.92)
Gynecology	-	-	1.26	1.66 (0.80–3.05)	-	-
Hematological	0.87	1.49 (0.85–2.43)	0.63	1.27 (0.41–2.97)	1.06	1.62 (0.81–2.90)
Lung	0.49	0.57 (0.26–1.08)	0.76	1.07 (0.39–2.33)	0.29	0.29 (0.06–0.86)
Male Reproductive	-	-	-	-	1.06	0.58 (0.29–1.03)
Oral	0.11	0.67 (0.08–2.41)	0.13	1.33 (0.03–7.39)	0.10	0.45 (0.01–2.48)
Urinary	0.66	1.34 (0.69–2.34)	0.38	1.43 (0.30–4.19)	0.87	1.31 (0.60–2.49)
Skin[1]	0.77	3.37 (1.84–5.66)	0.63	3.19 (1.03–7.44)	0.87	3.49 (1.60–6.62)

[1] Skin includes melanoma and soft tissue without SSC and BCC.

Αιματολογικές κακοήθ
ΨΑ > Γενικό πληθυσμό

- Δεδομένα από 5 σκανδιναβικά registries (~60.000py)
  - TNF-treated patients
    - Χωρίς αυξημένο κίνδυνο για συμπαγείς καρκίνους
      - Οποιουδήποτε τύπου
    - Χωρίς αυξημένο κίνδυνο για αιματολογικές κακοήθειες.
  - PsA patients
    - Μεγαλύτερο ρίσκο





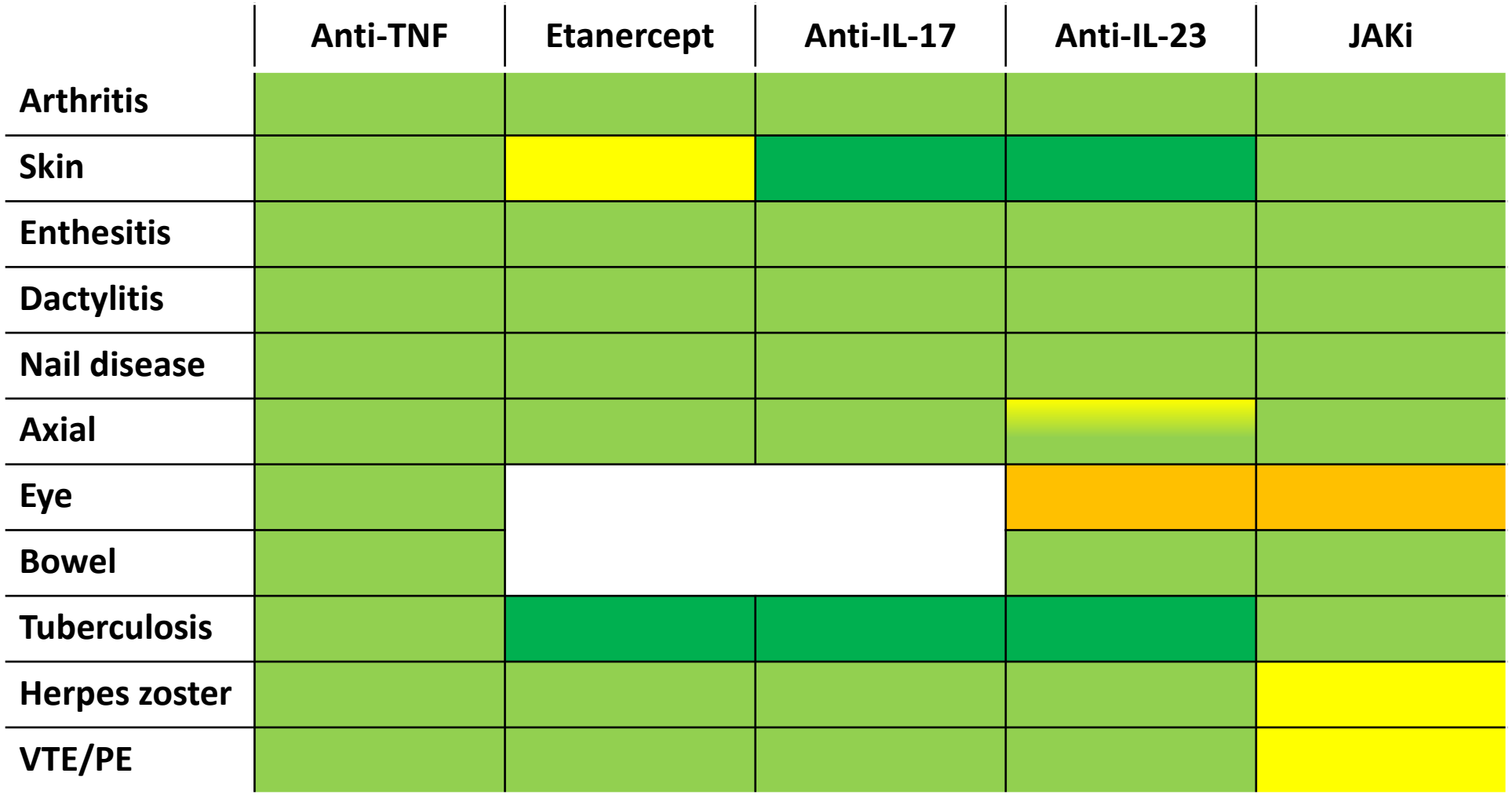
Hellgren, et al. Rheumatology. 2022 Jun 20;keac358

MGUS PsA

- Toronto PsA cohort (2008-2011)
- 361pts: 9.7% had MGUS (1.5-3% in the general population)
  - Older (mean Age 61 years old)
  - Higher disease duration of PsA

Eder, et al. J

Θεραπευτικές επιλογές στην ΨΑ



Gialouri et al MJR

Ευχαριστώ πολύ για την προσοχή σας