

[OP-0083] CLINICAL REMISSION IS ASSOCIATED WITH THE GREATEST IMPROVEMENT IN PATIENT-REPORTED OUTCOMES IN EARLY ACTIVE RHEUMATOID ARTHRITIS OVER THE FIRST TWO YEARS

J. Kekow¹, P. Emery², M. Leirisalo-Repo³, T. Sheeran⁴, D. Robertson⁵, A. Singh⁶, A. Koenig⁵, B. Freundlich⁵, S. Yang⁶, R. Sato⁶. ¹*Klinik für Rheumatologie, Otto-von-Guericke-Universität im, Vogelsang, Germany;* ²*Rheumatology, University of Leeds, Leeds, United Kingdom;* ³*Rheumatology, Helsinki University Central Hospital, Helsinki, Finland;* ⁴*Rheumatology, Cannock Chase Hospital, Cannock, United Kingdom;* ⁵*Medical Affairs;* ⁶*Global Health Outcomes Assessment, Wyeth Research, Collegeville, United States*

Background: Improvement in physical functioning, pain, fatigue and overall health status has been reported as an important goal for treatment in rheumatoid arthritis (RA) patients. However, there have been few data on the extent of patient-reported outcome (PRO) improvement that can be expected when the ultimate goal of clinical remission and radiographic non-progression is achieved.

Objectives: To evaluate the PRO improvement associated with achieving clinical remission and/or radiographic non-progression.

Methods: Data from the COMET (Combination of Methotrexate and Etanercept in Active Early Rheumatoid Arthritis) trial was used. Patients were categorized into 4 groups according to whether they had achieved clinical remission (DAS28

Results: 360 subjects had evaluable clinical and radiographic endpoints. At baseline, patients had active disease (mean DAS28=6.5, SD=0.96) with median mTSS of 3.5 (interquartile range: 1.0-8.0). Mean disease duration was 8.8 months. 81% (150/185) of patients who achieved clinical remission also achieved radiographic non-progression at the end of year 2. Patients who achieved clinical remission had almost two-fold greater improvement in PROs than patients without clinical remission. No difference was observed between patients who achieved clinical remission and radiographic non-progression compared with those achieving only clinical remission.

| Adjusted mean improvement* in PROs from baseline to end of year 2 | | | | | |
|---|---|--|--------------------------------------|---|---------------------|
| Change | No remission + progression (n=47) | No remission + non-progression (n=128) | Remission + progression (n=35) | Remission + non-progression (n=150) | Overall P value* |
| HAQ | -0.79 | -0.75 | -1.29 | -1.31 | <0.0001 |
| Pain VAS | -28.3 | -30.0 | -51.6 | -50.3 | <0.0001 |
| Fatigue VAS | -16.1 | -19.8 | -39.4 | -36.2 | <0.0001 |
| EQ-5D utility | 0.26 | 0.26 | 0.47 | 0.44 | <0.0001 |
| EQ-5D VAS | 18.3 | 21.3 | 39.7 | 37.6 | <0.0001 |
| SF-36 PCS | 10.0 | 9.7 | 17.6 | 19.4 | <0.0001 |
| SF-36 MCS | 4.1 | 5.5 | 11.9 | 9.1 | <0.0001 |

*ANCOVA model adjusted for gender and baselines scores.

Conclusion: Clinical remission should be the goal of therapy in early active RA, in part, because it is associated with the greatest improvement in multiple dimensions of PROs, including physical function, pain, fatigue, mental health, and overall health. Clinical remission appears to have a greater immediate effect on PROs than radiographic progression in early active RA. Given the known association of radiographic progression with later functional deterioration, this relationship may be expected to change with longer follow-up.

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[Close Window](#)

[OP-0149] CLINICAL REMISSION AND INHIBITION OF RADIOGRAPHIC PROGRESSION WITH COMBINATION ETANERCEPT-METHOTREXATE THERAPY VERSUS MONOTHERAPY IN ACTIVE, EARLY RHEUMATOID ARTHRITIS: 2-YEAR RESULTS FROM THE COMET TRIAL

P. Emery¹, F. Breedveld², D. van der Heijde², G. Ferraccioli³, M. Dougados⁴, D. Robertson⁵, R. Pedersen⁵, A.S. Koenig⁵, B. Freundlich⁵. ¹Rheumatology, University of Leeds, Leeds, United Kingdom; ²Rheumatology, Leiden University Medical Center, Leiden, Netherlands; ³Rheumatology, Catholic University of the Sacred Heart-CIC, Rome, Italy; ⁴Rheumatology, Cochin Hospital, Descartes University, Paris, France; ⁵Medical Affairs, Wyeth Research, Collegeville, United States

Background: Management strategies in rheumatoid arthritis (RA) are changing, with recognition of the importance of earlier treatment and benefits of potent biologic agents. Although traditional DMARDs are often effective in reducing disease activity, they may not be optimal to halt radiographic progression of joint damage.¹⁻³ Treatment efficacy is increasingly determined by both clinical and radiographic evidence of disease control.

Objectives: Assess how continuation of and alterations to the original etanercept-plus-methotrexate combination therapy and methotrexate monotherapy regimens affected clinical and radiographic outcomes in the second yr of the COMET trial.

Methods: Subjects were randomized at baseline; those who completed 1 yr of treatment with combination or methotrexate monotherapy entered yr 2 (n=411). The original combination group either continued combination (EM/EM; n=111) or received etanercept monotherapy (EM/E; n=111) in yr 2; the original methotrexate monotherapy group either received combination (M/EM; n=90) or continued monotherapy (M/M; n=99). Efficacy endpoints included clinical remission (DAS28

Results: Yr-2 LOCF analyses included 398 subjects for clinical and 360 for radiographic endpoints; the combined yr-1 and -2 NRI analysis included 528 subjects. At yr 2, the % of subjects achieving clinical remission was significantly greater in the continued combination therapy and delayed combination therapy groups than in the continued methotrexate monotherapy group (P

| Clinical and Radiographic Outcomes by Treatment Group at Year 2 | | | | |
|---|-------------------------|-------------------------|-------------------------|------------|
| Endpoint | % of Subjects EM/EM | EM/E | M/EM | M/M |
| Clinical Remission (LOCF) | 57* (n=108) | 50 (n=108) | 58* (n=88) | 35 (n=94) |
| Clinical Remission (NRI) | 46 [†] (n=131) | 38 [†] (n=134) | 37 [†] (n=133) | 24 (n=130) |
| Radiographic Nonprogression (LOCF) | 90** (n=99) | 75 (n=99) | 75 (n=79) | 68 (n=83) |

*P[†]P[†]P

Conclusion: Sustained combination therapy was consistently superior to continuous methotrexate monotherapy in providing clinical remission and radiographic non-progression over 2 years, without significant additional risk. Although delayed combination therapy was significantly more effective than methotrexate monotherapy with regard to clinical remission, it was not more effective in inhibiting progression of joint damage.

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Disclosure of Interest: P. Emery: Wyeth, Consultant, Research Support
 F. Breedveld: Pfizer, Abbott, Wyeth, Schering Plough, Consultant
 D. van der Heijde: Amgen, Abbott, BMS, Centocor, Roche, Wyeth, UCB, Consultant
 G. Ferraccioli: Wyeth, Research Support
 M. Dougados: Wyeth, Abbott, Roche, UCB, BMS, Consultant, Research Support
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[Close Window](#)

[OP-0014] SHORT-TERM SYMPTOMATIC EFFICACY OF ETANERCEPT IN REFRACTORY HEEL ENTHESITIS RELATED TO SPONDYLOARTHRITIS: RESULTS OF A DOUBLE BLIND PLACEBO CONTROLLED TRIAL

M. Dougados¹, B. Combe², J. Braun³, R. Landewé⁴, J. Sibilia⁵, A. Cantagrel⁶, V. Leblanc⁷, I. Logeart⁷.
¹Rheumatology B, Hopital Cochin, Paris; ²Rheumatology, Lapeyronie Hospital, Montpellier, France;
³Rheumazentrum Ruhrgebiet, Universitätsmedizin, Herne, Germany; ⁴Rheumatology, University Medical Center, Maastricht, Netherlands; ⁵Rheumatology, Hautepierre Hospital, Strasbourg;
⁶Rheumatology, Larrey Hospital, Toulouse; ⁷Rheumatology, Wyeth Pharmaceuticals France, Paris La Défense, France

Background: Heel enthesitis is a common feature of spondyloarthritis which might become disabling because of the persistence of the symptoms despite local treatment.

Objectives: To investigate the short-term symptomatic (patient's global, pain, functional impairment) efficacy of etanercept in this condition.

Methods: *Study design:* Prospective, randomized, 12-week duration, placebo controlled trial. *Study treatments:* etanercept 50 mg once a week versus placebo. *Patients:* adult (>18 years old) spondyloarthritis (Amor criteria) with heel enthesitis (inferior and/or posterior heel pain and presence at MRI of bone edema in the calcaneum adjacent to the insertion of either Achilles tendon or fascia plantaris), refractory to NSAIDs and appropriate local treatment, active (patient's global ≥ 40 mm on a 0-100 VAS scale). *Outcome variables:* patient's global assessment (0-100 VAS)(primary variable), pain (0-100 VAS), function (WOMAC function sub-scale, normalized unit 0-100).

Results: Of the 24 enrolled patients (males: 67%, age: 37 ± 12 years old, B27 positive: 71%), 12 received etanercept and 12 placebo. There was no significant difference in the symptomatic activity of the disease between the 2 groups at baseline (patient's global: 70 ± 17 , heel pain: 68 ± 16 , functional impairment: 47 ± 20). During the study, 5 patients discontinued the study treatment (4 in the placebo group because of inefficacy and 1 in the etanercept group because of severe infection). The mean changes in patient's global during the 12 weeks of the study (normalized net incremental area under the curve: primary variable) was -29 ± 11 and -11 ± 12 in the etanercept and placebo groups respectively ($p=0.029$). Moreover, the absolute changes between final and baseline visits showed also a statistically significant inter-group difference in favor of etanercept for the 3 main domains: -38 ± 19 versus -12 ± 19 [$p=0.007$], -37 ± 22 versus -13 ± 22 [$p=0.022$] and -23 ± 14 versus -8 ± 14 [$p=0.024$] in the etanercept versus placebo group for patient's global, heel pain and WOMAC function respectively. Such effect appeared as soon as week 2 and reached a statistically significant difference at week 8 for patient's global and heel pain and at week 12 for function. During the study, 8 patients complained of infection (mainly in the upper respiratory tract: 3 in the placebo and 5 in the etanercept group). All of them resolved after therapy and one of them (etanercept group) required hospitalization because of a foot cellulitis and a discontinuation of the study drug.

Conclusion: This study (to our knowledge, the first one using a prospective, placebo controlled design in enthesiopathy related to spondyloarthritis) demonstrates a symptomatic clinically relevant and statistically localized significant effect of etanercept in patients suffering from a refractory disabling heel enthesitis.

Disclosure of Interest: This study was sponsored by Wyeth Pharmaceuticals France.

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[Close Window](#)

[OP-0019] LOWER RATES OF UVEITIS WITH ETANERCEPT OR SULPHASALAZINE VERSUS PLACEBO IN CLINICAL STUDIES IN PATIENTS WITH ANKYLOSING SPONDYLITIS

J. Sieper¹, A.S. Koenig², S. Baumgartner³, C. Wishneski², J. Foehl², B. Vlahos², B. Freundlich².
¹Charité Medical University, Campus Benjamin Franklin, Berlin, Germany; ²Global Medical Affairs, Wyeth, Collegeville; ³Medical Affairs, Amgen, Inc, Thousand Oaks, United States

Background: Uveitis is reported in about 40% of subjects with ankylosing spondylitis (AS)^{1,2}. Anti-TNF agents used in the treatment of AS have shown a numerical decrease in the risk of uveitis³.

Objectives: Assess the incidence of inflammatory eye disease (IED) events such as uveitis in subjects with AS from placebo (PBO), active comparator, and long-term trials of etanercept (ETN).

Methods: Clinical trials of ETN in subjects with AS (4 double-blind [DB], placebo-controlled [PC]⁴⁻⁷; 1 double-blind, active comparator⁸; and 3 open-label extensions)^{4,9,10}; were examined for occurrences of IEDs. Events were categorized as new or recurrent (flare). All subjects included in the analysis received at least 1 dose of study drug. Confidence intervals (CI) and between-group differences in IED rates were calculated.

Results: In DB PBO-controlled trials, the estimated IED rate (95% CI) for ETN (8.63 [4.46, 14.15]) was lower than that for PBO (19.28 [11.02, 29.81]; p=0.03). In the active comparator trial, the IED rates for ETN and sulphasalazine (SSZ) were similar (10.73 [5.54, 17.59] and 14.72 [6.36, 26.54], respectively; p=0.49). The long-term IED rate for ETN, estimated from both the DB and OL extension studies was 11.96 (10.04, 14.06). Events were generally mild-to-moderate in severity, and all but one (0.63%) event resolved with topical therapy. There were no serious adverse events or study discontinuations because of IED.

Table 1. Incidence And Rates Of Inflammatory Eye Disease

| | Treatment | N | Study duration | Subjects with new events | Subjects with flare events | Total events | Exposure | Rate/100 pt yr |
|---|-----------|------|----------------|--------------------------|----------------------------|--------------|----------|----------------------|
| | | | weeks | n | n | n | pt yr | (95% CI) |
| Double-blind, placebo-controlled studies ⁴⁻⁷ | PBO | 249 | 12-24 | 1 | 10 | 16 | 83.00 | 19.28 (11.02, 29.81) |
| | ETN | 508 | 12-24 | 0 | 9 | 12 | 139.06 | 8.63 (4.46, 14.15) |
| Double-blind, active-controlled study ⁸ | SSZ | 187 | 16 | 3 | 4 | 8 | 54.34 | 14.72 (6.36, 26.54) |
| | ETN | 379 | 16 | 6 | 5* | 1288 | 111.88 | 10.73 (5.54, 17.59) |
| Open-label extension studies ^{4,9,10} | ETN | 1074 | 24-252 | 21 | 55 | 136 | 1136.85 | 11.96 (10.04, 14.06) |

*Includes 2 subjects with an event during screening and 1 subject with an event during post-study follow up;

**Includes 1 subject with an event during screening and an event post study.

Conclusion: In double-blind studies of subjects with AS, the rate of inflammatory eye disease with etanercept was similar to SSZ and significantly lower than PBO.

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[Close Window](#)

[OP-0264] REPAIR OF EROSIONS OCCURS PREFERENTIALLY IN PATIENTS TREATED WITH ANTI-TNF THERAPY AND IN JOINTS WITH CLINICAL IMPROVEMENT

C. Lukas¹, D. van der Heijde², S. Fatenejad³, R. Landewé⁴. ¹*Immuno-Rheumatology, Lapeyronie Hospital, Montpellier, France;* ²*Rheumatology, Leiden University Medical Center, Leiden, Netherlands;* ³*Wyeth Research, Wyeth Pharmaceuticals, Collegeville, United States;* ⁴*Internal Medicine, Division of Rheumatology, University Hospital Maastricht, Maastricht, Netherlands*

Background: Negative radiographic change scores obtained under strictly blinded time-sequence conditions have raised the impression that repair of previously damaged joints may indeed occur. It is likely that – if it truly exists – repair is preferentially seen in joints with clinical improvement and in patients treated with TNF-blocking drugs. We tested this hypothesis in the TEMPO trial.

Methods: Radiographs from patients of the TEMPO trial were scored twice by two readers using the Sharp/van der Heijde method, blinded to both treatment and true time sequence. Single-joint change scores in erosions were calculated and matched with single joint swelling scores. Factors expected to increase the likelihood of occurrence of both worsening and improvement of erosion over time were tested by GEE modelling (2 different models were built). The independent influence of clinical response in single joints and treatment (methotrexate, etanercept, or combination of both drugs) on 'progression' and 'repair' in single joints was investigated while adjusting for within-reads correlation.

Results: Multivariate analyses showed that worsening of erosion score in a joint was significantly increased if that joint was already damaged at study entry, clinical swelling was still persistent at the end of trial and MTX was used instead of etanercept (or combination) (data not shown), while repair was independently associated with clinical improvement of that joint and treatment with etanercept or combination ($p \leq 0.007$ for all associations).

| Likelihood of single joint 'repair' in patients participating in the TEMPO trial | | | |
|--|------------------|------------------|-------|
| Compared conditions | | OR [95% CI] | p |
| Treatment | MTX | 1 (reference) | |
| | ETA | 1.28 [1.07-1.53] | 0.007 |
| | MTX+ETA | 1.33 [1.12-1.58] | 0.001 |
| Swelling | Worse/Persistent | 1 (reference) | |
| | Improvement/None | 1.57 [1.16-2.14] | 0.004 |

Conclusion: Repair of erosions preferentially occurs in joints that show an adequate clinical response on anti-TNF treatment, while progression is seen more frequently in joints with persistent swelling, and in those receiving MTX monotherapy, preferentially if damage is already present.

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[FRI0206] SAFETY AND EFFICACY OF UP TO 10 CONTINUOUS YEARS OF ETANERCEPT THERAPY IN PATIENTS WITH RHEUMATOID ARTHRITIS IN NORTH AMERICA AND EUROPE

*L. Klareskog¹, S.B. Cohen², J.R. Kalden³, M.E. Weinblatt⁴, M.C. Genovese⁵, J.M. Bathon⁶, J.M. Kremer⁷, R.M. Fleischmann², M.H. Schiff⁸, J. Wajdula⁹, G.S. Park¹⁰, Y. Chon¹⁰, S.W. Baumgartner¹⁰.
¹Rheumatology Unit Department of Medicine, Karolinska Institutet at Karolinska University Hospital Solna, Stockholm, Sweden; ²UT Southwestern Univ Hosp, Dallas, United States; ³Univ Erlangen-Nuernberg, Erlangen, Germany; ⁴Division of Rheumatology, Brigham and Women's Hospital, Boston; ⁵Division of Immunology and Rheumatology, Stanford University Med Ctr, Palo Alto; ⁶Division of Rheumatology, Immunology and Allergy, Johns Hopkins Univ, Baltimore; ⁷The Center for Rheumatology, Albany; ⁸Univ Colorado, Denver; ⁹Wyeth Pharmaceuticals, Collegeville; ¹⁰Amgen Inc., Thousand Oaks, United States*

Background: Some patients with rheumatoid arthritis (RA) have been treated with etanercept (ETN) for over 10 continuous years. Analyses of large global datasets provide valuable insight into the long-term safety and efficacy of ETN in patients with RA.

Objectives: To assess the long-term safety and efficacy of ETN in a global RA population.

Methods: European and North American patients with DMARD-refractory RA or North American patients with early RA (disease duration less than or equal to 3 years) were eligible to enroll in open-label extensions (OLE) of double-blind controlled trials. Data from the double-blind controlled studies and the OLEs were included in this analysis. Safety assessments in all patients receiving at least 1 dose of ETN included serious adverse events (SAEs), serious infectious events (SIEs), opportunistic infections (OIs), sepsis, malignancies, lymphomas, and deaths. Standard incidence ratios (SIRs) of malignancies compared with the general population were calculated using age- and sex-matched data from the SEER database (1998–2002). The numbers of expected deaths were calculated using National Vital Statistics Reports (Kochanek, 2001). Efficacy was assessed for up to 6 continuous years in European DMARD-refractory patients, and 10 continuous years in North American DMARD-refractory patients and North American early RA patients.

Results: A total of 2055 patients and 10,495 patient-years (pt-yrs) of ETN exposure were included in this analysis without imputation for missing data. Kaplan-Meier analyses estimated 65–71% of all patients continued to receive ETN at 3 years and 37–39% of patients continued at 10 years in the North American studies. The overall North American rates of SAEs for ERA patients (0.12/pt-yr) and DMARD-refractory patients (0.18/pt-yr) were similar to rates of controls or placebo/MTX (0.11–0.20/pt-yr) from the double-blind phase of the RCTs. The overall rates of SIEs for ERA patients (0.02/pt-yr), North American DMARD-refractory patients (0.04/pt-yr), and European DMARD-refractory patients (0.06/pt-yr) were similar to rates of control or placebo/MTX (0.03–0.05/pt-yr). Reports of OIs were rare. The SIR (95% CI) for malignancies was 1.00 (0.80, 1.23); the SIR for lymphoma was 3.69 (1.97, 6.31). It is currently unknown if the higher-than-expected rate of lymphoma is related to TNF inhibition or if it reflects the elevated risk of lymphoma in patients with RA (Askling, 2005; Baecklund, 2006). A total of 64 deaths were reported; 115 were expected. Proportions of North American DMARD-refractory and ERA patients achieving ACR 20, 50, and 70 responses were 76–80%, 56%, and 31–39%, respectively, after 10 years of continuous therapy.

Conclusion: These global data indicate the safety and efficacy profile of ETN therapy is maintained with long-term continuous use for up to 10 continuous years in patients remaining on treatment in North American studies and up to 6 continuous years in patients remaining on treatment in European studies.

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[Close Window](#)

[SAT0264] CLINICAL EFFICACY OF ETANERCEPT VERSUS SULFASALAZINE IN ANKYLOSING SPONDYLITIS PATIENTS WITH PERIPHERAL JOINT INVOLVEMENT

J. Braun¹, K. Pavelka², C.R. Remus³, A. Dimic⁴, B. Vlahos⁵, A.S. Koenig⁵, B. Freundlich⁵. ¹Rheumatology Medical Center, Ruhrgebiet, Herne, Ruhr-University, Bochum, Germany; ²Institute, Rheumatology, Prague, Czech Republic; ³Unidad de Investigacion en Enfermedades Cronico Degenerativas, Guadalajara, Mexico; ⁴Rheumatology Institut, Niska Banja, Serbia; ⁵Global Medical Affairs, Wyeth, Collegeville, United States

Background: Etanercept (ETN) is a fully human tumor necrosis factor soluble receptor that is effective in the treatment of ankylosing spondylitis (AS).[1, 2] Current guidelines for the management of AS recommend sulfasalazine (SSZ) for AS patients with peripheral arthritis.[3]

Objectives: This study compared the efficacy of ETN with SSZ in subjects with AS, including those with peripheral joint involvement.

Methods: A post hoc analysis compared the efficacy of ETN 50 mg once weekly with SSZ up to 3 g daily in subjects with and without swollen peripheral joint involvement from a 16-week randomized, double-blind study in subjects with AS [4]. Study design and eligibility criteria have been published [4]. Efficacy endpoints assessed in this analysis included ASAS 20, ASAS 5/6, partial remission, and BASDAI; physical function and mobility were assessed using BASFI and BASMI. LOCF was used for imputation of missing values.

Results: Of a total of 566 subjects included in the study [4], 181 (ETN 121; SSZ 60) had ≥1 swollen peripheral joint and 364 (ETN 250; SSZ 124) had none. Regardless of swollen joint involvement, subjects receiving ETN showed significantly greater improvement than subjects receiving SSZ in all efficacy assessments, including physical function and spinal mobility (Table).

Table 1. Efficacy at Week 16 (LOCF)

| | All Patients | | | Patients With Swollen Joints at Baseline | | | Patients With No Swollen Joints at Baseline | | |
|-------------------|----------------------|----------------------|-----------|--|----------------------|-----------|---|----------------------|-----------|
| | ETN | SSZ | P value** | ETN | SSZ | P value88 | ETN | SSZ | P value** |
| | n/N (% Improvement) | n/N (% Improvement) | | n/N (% Improvement) | n/N (% Improvement) | | n/N (% Improvement) | n/N (% Improvement) | |
| ASAS 20 | 287/378 (75.9) | 99/187 (52.9) | <0.001 | 83/121 (68.6) | 30/60 (50.0) | 0.020 | 197/249 (79.1) | 68/124 (54.8) | <0.001 |
| ASAS 5/6 | 166/365 (45.5) | 38/179 (21.2) | <0.001 | 48/119 (40.3) | 10/56 (17.9) | 0.002 | 115/239 (48.1) | 28/121 (23.1) | <0.001 |
| Partial Remission | 126/379 (33.3) | 29/187 (15.5) | <0.001 | 42/121 (34.7) | 9/60 (15.0) | 0.006 | 82/250 (32.8) | 19/124 (15.3) | <0.001 |
| | Mean (% Improvement) | Mean (% Improvement) | | Mean (% Improvement) | Mean (% Improvement) | | Mean (% Improvement) | Mean (% Improvement) | |
| BASDAI | 27.2 (54.1) | 39.4 (33.4) | <0.001 | 31.1 (51.9) | 43.8 (28.1) | 0.001 | 25.7 (55.2) | 37.6 (36.1) | <0.001 |
| BASFI | 28.7 (47.8) | 39.4 (28.5) | <0.001 | 32.2 (43.5) | 42.4 (25.9) | 0.011 | 27.2 (50.0) | 37.9 (30.2) | <0.001 |
| BASMI | 2.8 (25.0) | 3.3 (6.9) | <0.001 | 2.4 (31.7) | 3.1 (6.0) | 0.001 | 3.0 (23.6) | 3.3 (7.8) | <0.001 |

**ETN vs SSZ. Cochran-Mantel-Haenszel Test for ASAS criteria and partial remission; ANCOVA model for BASDAI, BASFI and BASMI.

Conclusion: In this post hoc analysis, etanercept was significantly more effective than SSZ at improving the clinical symptoms of AS in subjects with and without swollen joints at baseline. These findings support the role of etanercept as a key therapy for the management of subjects with AS with or without associated peripheral joint involvement.

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CRR, AD: Wyeth, grant research support.
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[Close Window](#)

[SAT0265] IMPACT OF ETANERCEPT ON PATIENT-REPORTED OUTCOMES: RESULTS FROM A RANDOMIZED, DOUBLE-BLIND STUDY OF PATIENTS WITH ANKYLOSING SPONDYLITIS

J. Sieper¹, R. Guzman², M. Hammoudeh³, A. Singh⁴, A. Koenig⁵, B. Vlahos⁵, D. Robertson⁵, B. Freundlich⁵, R. Sato⁴. ¹Rheumatology, Charité, Campus Benjamin Franklin, Berlin, Germany; ²Rheumatology, Clinica Salucoop, Bogota, Colombia; ³Rheumatology, Hamad Medical Corporation, Doha, Qatar; ⁴Global Health Outcomes Assessment; ⁵Medical Affairs, Wyeth Research, Collegeville, United States

Background: Patients with ankylosing spondylitis (AS) are generally young, have few substantive treatment options, and tend to report impaired health-related quality of life.

Objectives: To evaluate the impact of etanercept (ETN) compared with suphasalazine (SSZ) on patient-reported outcomes (PROs) among patients with AS.

Methods: PROs were assessed using the Short Form-36 (SF-36, range 0-100), a generic health-related quality-of-life (QoL) measure consisting of 8 domains, at baseline and at week 16 as part of a double-blind, randomized trial in which patients received either ETN 50 mg once weekly (n=379) or SSZ up to 3 g daily (n=187). Eligible patients had active AS based on 1) BASDAI VAS ≥30; 2) morning stiffness VAS ≥30; and 3) VAS ≥30 for at least two of the following: patient global assessment of disease activity; pain; or BASFI. Mean changes from baseline in the SF-36 scores were analyzed using analysis of covariance in the intention-to-treat population. In addition, correlations between SF-36 and clinical parameters at week 16 were determined.

Results: The mean age was 41 years, 74% were male, and the average disease duration was 7.6 years. Overall, 354 in the ETN group and 165 in the SSZ group had evaluable SF-36 scores. The two groups had similar baseline SF-36 scores with substantially impaired QoL. Baseline scores were notable in that all 8 domains were impaired. In particular, the physical function domain score at baseline (see table) in this AS population was comparable or lower than that reported in patients with diabetes (67.7), congestive heart failure (47.5), and hypertension (73.4).¹ All SF-36 domains improved after treatment at week 16. There was a significantly greater improvement in the ETN group than the SSZ group in all the domains, with the exception of role-limitations emotional. The Pearson correlation coefficient of SF-36 domains ranged from -0.43 to -0.71 for BASDAI, -0.45 to -0.78 for BASFI, and -0.15 to -0.48 for BASMI. Improvement in SF-36 scores was the greatest in patients achieving ASAS70 response for all 8 domains (mean improvement ranged from 15 to 51 points) and virtually no change was observed in patients who did not reach an ASAS20 response.

| Mean (% improvement) at baseline and week 16 | | | | |
|--|----------|------|--------------|------------|
| SF-36 Domain | Baseline | | Week | |
| | ETN | SSZ | ETN | SSZ |
| Physical function | 51.3 | 49.1 | 67.6 (32%)* | 60.7 (24%) |
| Vitality | 41.6 | 41.5 | 57.0 (37%)** | 48.8 (18%) |
| Social functioning | 58.0 | 58.3 | 73.8 (27%)** | 65.3 (12%) |
| Mental health | 61.5 | 63.0 | 71.9 (17%)** | 66.2 (5%) |
| Role-limitations physical | 23.8 | 24.6 | 54.0 (127%)* | 43.9 (79%) |
| Bodily pain | 32.8 | 33.2 | 59.1 (80%)** | 47.9 (44%) |
| Role-limitations emotional | 47.8 | 49.8 | 68.2 (43%) | 62.0 (25%) |
| General health | 38.1 | 37.5 | 52.5 (38%)** | 43.9 (17%) |

*P<0.001.

Conclusion: In this study, etanercept treatment significantly improved multiple dimensions of PROs compared with SSZ. There was a relationship between PROs and clinical status, with the greatest PRO benefit in patients who achieved greater clinical improvement.

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Quality Metric Incorporated, 1993.

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[Close Window](#)

[SAT0366] IMPROVEMENT IN PSORIATIC ARTHRITIS, INCLUDING ARTHRITIS SYMPTOMS AND PHYSICAL FUNCTION WITH ETANERCEPT IN PATIENTS WITH PSORIASIS AND PSORIATIC ARTHRITIS (PRESTA TRIAL)

S. Schewe¹, J. Prinz¹, L. Puig², R. Burgos-Vargas³, R. Boggs⁴, D. Robertson⁴, R. Pedersen⁴, C. Molta⁴, B. Freundlich⁴. ¹*Abteilung Rheumatology, Ludwig-Maximilian-Universitaet, Munchen, Germany;* ²*Dermatology, Universitat Autònoma de Barcelona, Barcelona, Spain;* ³*Rheumatology Department, Universidad Nacional Autónoma de México, Mexico City, Mexico;* ⁴*Global Medical Affairs, Wyeth, Collegeville, United States*

Background: Etanercept (ETN) 25 mg twice wkly (BIW) (or 50 mg once-wkly [QW]) has demonstrated significant benefit in psoriasis (PsO) and both skin and joint manifestations of psoriatic arthritis (PsA) subjects. Although ETN at an induction dose of 50 mg BIW is more effective than 50 mg QW in treating PsO, it has not been previously evaluated in PsA subjects.

Objectives: Assess the efficacy of 2 ETN regimens on the PsA response criteria (PsARC), arthritic symptoms, and physical function of subjects with PsO and PsA over 24 wks.

Methods: A 12-wk randomised double-blind study, followed by a 12-wk open-label extension; subjects received ETN 50 mg BIW or 50 mg QW during the double-blind period followed by 50 mg QW during the open-label period. Eligibility criteria included: age >18 y; stable, moderate-to-severe plaque PsO and PsA, with ≥10% body surface area (BSA) affected; Physician Global Assessment (PGA) of PsO status of moderate or worse (≥3 on a scale of 0-5); and ≥2 swollen/painful joints. Arthritis endpoints assessed were change from baseline in PGA of arthritis and subject global assessments (SGA) of joint pain, arthritis activity, and stiffness at wks 12 and 24; physical function was assessed using the Health Assessment Questionnaire (HAQ). Last-observation-carried-forward (LOCF) was used for imputation of missing values.

Results: At baseline, subjects (n=752) had a mean age 47 y, were 63% male, 89% white and had a mean BMI of 28. Mean duration of PsO and PsA was 19 and 7 years, respectively; mean PGA of PsO was 3.6 (median=4.0), and BSA 30.8%. Baseline arthritis PGA, HAQ and SGA of joint pain, arthritis activity, and stiffness were not different between the 2 groups (Table). The % of PsO PGA responders (clear or almost clear) at Wk 12, was 46% for the ETN 50 mg BIW group vs 32% for the 50 mg QW group (P

| Key Arthritis and Physical Function Assessments at Weeks 12 and 24 | | | | | | |
|--|----------------------|----------------------------|-------------|---------------------|----------------------------|-------------|
| Endpoint | ETN 50 mg BIW, N=379 | | | ETN 50 mg QW, N=373 | | |
| | Wk 0 | Wk 12 | Wk 24 | Wk 0 | Wk 12 | Wk 24 |
| | | Mean score (% Improvement) | | | Mean score (% Improvement) | |
| PGA of arthritis | 50.6 | 18.7 (63.0) | 13.5 (73.3) | 49.9 | 19.0 (62.0) | 13.2 (73.7) |
| HAQ | 0.9 | 0.5 (46.7) | 0.44 (51.1) | 0.93 | 0.49 (47.3) | 0.43 (53.8) |
| SGA | | | | | | |
| Joint pain | 63.2 | 27.9 (55.7) | 27.0 (57.1) | 61.9 | 30.5 (50.8) | 25.4 (59.0) |
| Arthritis activity | 63.9 | 27.9 (56.4) | 26.9 (58.0) | 61.7 | 28.5 (53.8) | 25.1 (59.3) |
| Stiffness | 143.5 | 53.6 (62.8) | 51.8 (64.0) | 141.0 | 49.1 (65.3) | 44.2 (68.7) |

Conclusion: Etanercept 50 mg BIW for 12 wks followed by 50 mg QW for 12 wks was associated with similar improvements when compared with etanercept 50 mg QW for 24 weeks as assessed by the PsARC and assessments of arthritis symptoms in subjects with both PsO and PsA. Each regimen effectively improved the arthritis symptoms in these subjects. If rapid skin clearing is required, then initial treatment with etanercept 50 mg BIW may offer additional benefit.

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[Close Window](#)