

INNOVATIONS IN DIAGNOSIS AND TREATMENT

DIAGNOSIS

Is it psoriatic arthritis or rheumatoid arthritis plus psoriasis?

Psoriatic arthritis is grouped with other forms of arthritis labelled "sero-negative". By this we mean that tests in the serum for rheumatoid factor are negative. There is a problem about this in that rheumatoid factor can be found in a number of other diseases, such as systemic lupus erythematosus, and even in illnesses quite unrelated to arthritis such as the tropical disease, Kala-Azar, to mention but one example.

Moreover, rheumatoid arthritis is a common disease with a prevalence of 1-2% of the population. Similarly psoriasis affects 1-2% of the population and therefore it is bound to happen from time to time that a patient has both diseases. There are some forms of psoriatic arthropathy which closely resemble rheumatoid arthritis, particularly when it presents with symmetrical joint swelling of the hands and feet.

So far the convention has been that if a patient has arthritis, psoriasis and a positive rheumatoid factor, they should not be included in a group of patients labelled as having psoriatic arthropathy. Of course from time to time patients are seen whose arthritis is so

obviously that associated with psoriasis on clinical and x-ray grounds that rheumatologists feel forced to make an exception to the rule but this is never satisfactory particularly in selecting patients for drug trials or other research. Happily there is now a new investigation – anti-CCP antibodies. This new antibody test is extremely specific for rheumatoid arthritis and its sensitivity, ie, the proportion of patients with rheumatoid arthritis it picks up, is similar to that of conventional rheumatoid factor tests. It appears likely that this test will clarify the diagnosis in patients with psoriatic arthritis eliminating many of the false positive tests for rheumatoid arthritis which currently give rise to confusion.

This test is available already in the private sector and it is hoped that it will be adopted by NHS hospitals before long.

TREATMENT

A biological agent tailored to psoriasis?

I know from letters and e-mail enquiries passed on to me to answer that there is great interest in the use of anti-TNF alpha agents both in treating the skin and the joints. Although these agents are very effective they are at present very costly and can have the disadvantage

of stirring up latent infections such as tuberculosis. Therefore new agents of a biological type, which are more specific to disease mechanisms and, we hope, therefore safer, are very welcome.

Lebwohl, Christophers and others of Mount Sinai School of Medicine, New York, USA, writing in Archives of Dermatology, June 2003, have described their results with Alefacept. This agent is involved in modifying the function to particular types of lymphocyte. The agent binds to CD2 molecules on the surface of a class of lymphocyte called activated T-cells and moreover it targets in particular cells called memory effector T-cells (CD45 RO+). More than three quarters of the T-cells in plaques of psoriasis are of this type.

Lebwohl, and his colleagues studied 507 patients with chronic plaque psoriasis in an international, randomised, double-blind, placebo controlled trial. The quality of evidence obtained by this type of study, using large numbers of patients, is particularly good. They also used both 10mg and 15mg doses of Alefacept given by intramuscular injection, weekly for twelve weeks, comparing these groups with patients given a placebo injection, ie, one which does not contain any of the active agents. They then followed up all the cases for

three months after finishing the treatment.

The result of the study was that a greater percentage of the patients having the larger 15mg dose showed a significant reduction in their psoriasis skin score compared with placebo. Of those who took 15mg per week and achieved 75% improvement in their score at observation two weeks after the last dose, 71% maintained at least half of that improvement through the following three months of observation.

In no case was there any evidence of latent infections being rekindled. It is of note also that none of the cases who responded well had a rebound with increased psoriasis during the three months after the trial.

It is unlikely that this treatment will be available outside of trial situations in the USA in the short term and its availability in the UK will have to await the outcome of further trials here and abroad, licensing by the European equivalent of the FDA in America, our Medicines

Control Agency in the UK itself and the opinion of the National Institute of Clinical Excellence, but it is a very interesting pointer to the future customisation of biological agents to much more precise disease mechanisms than has been possible before.

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