The Switch: From One TNF inhibitor to another in PsA

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Tumor necrosis factor inhibitors have transformed the treatment of psoriatic arthritis. However, switching TNF inhibitors two or three times is not uncommon.

Tumor necrosis factor (TNF) inhibitors have transformed the treatment of psoriatic arthritis, with substantial evidence that they reduce disease activity. However, some patients do not tolerate or respond well to TNF inhibitors at first, and may need to switch to a second or even a third TNF inhibitor.

Early diagnosis and implementation of highly effective treatment with TNF inhibitors helps psoriatic arthritis patients achieve better outcomes. Tight control with frequent adjustments to medications and a treat-to-target approach can maintain low disease activity. Treatment strategies to deal with refractory disease include TNF inhibitor switching and the use of novel disease-modifying therapies.

One study examined the efficacy of TNF inhibitor switching in patients with psoriasis previously treated with a different TNF inhibitor. The review of 15 studies found response rates to a second TNF inhibitor were lower than for a first one, but a substantial proportion of patients achieved treatment success. Up to three-quarters of patients had a week 24 response rate for a second TNF inhibitor for a 75% improvement in Psoriasis Area and Severity Index score, and up to 70% achieved a good Physician Global Assessment score. Dermatologic quality of life scores improved, and, in general, patients who experienced secondary failure achieved better responses than patients with primary failure.

A new study examined TNF inhibitor adherence, discontinuation, switching, and restarting among 2707 Medicare recipients who were psoriasis patients found low biologic adherence and high discontinuation rates. Only 8% of patients switched to another biologic, and 9% restarted biologic treatment with either the index biologic or an alternate. The odds of switching to a new biologic within 90 days of discontinuing the index biologic were higher among disabled beneficiaries, females, and those who switched low-income subsidy status during the study period.

The researchers noted that patients using etanercept were less likely to be adherent and those using adalimumab and ustekinumab, both self-administered biologics, were more likely to discontinue compared with those on infliximab, which was administered under the supervision of a physician. All biologic agents, including ustekinumab, had high levels of nonadherence and discontinuation, they stated.

Switching TNF inhibitors also works in rheumatoid arthritis. Studies show that adult patients with rheumatoid arthritis who discontinued TNF inhibitor therapy and switched to an alternative TNF inhibitor incurred lower healthcare costs than patients who switched to a non-TNF inhibitor biologic. And patients who switch TNF inhibitors have higher pre-treatment disease activity score (DAS28) and higher overall costs than patients who received the same TNF inhibitor as either single or interrupted therapy.

Switching in Psoriatic Arthritis

(Continued on next page.)

Switching in Psoriatic Arthritis

A recent cohort study of the effectiveness and feasibility associated with switching to a second or third TNF Inhibitor in psoriatic arthritis found moderate response rates in 217 first-time TNF inhibitor switchers and inferior response rates in 57 second-time switchers.

The study showed “the response to a third anti-TNF treatment course to be markedly lower than to a first or second treatment, suggesting that switching to biological DMARD with other mode of actions should be more beneficial when 2 trials of anti-TNF agents have been tried unsuccessfully.” Likewise, drug survival rates were superior for patients receiving the second course of anti-TNF compared with the third course,” stated the researchers.

They also found, as have other researchers, that when switching to a second TNF inhibitor, a better response is predicted by elevated baseline DAS28 values, and lower health assessment questionnaire values are associated with prolonged drug survival.

The results illustrate that adhering to drug withdrawal is important, especially when studying late responses among those with poor drug survival, for example, a 6-month response in second-time switchers.

Other therapeutic options can be considered after two TNF inhibitors have failed. Refractory patients pose a challenge, but strategies to overcome treatment failure exist, such as implementing alternative therapies. Therapies with new modes of action, including interleukin 12/23 inhibition as well as phosphodiesterase 4 inhibition, have been approved for psoriatic arthritis treatment, providing reasonable alternatives to TNF inhibitor therapy. Also, abatacept has been proven effective in psoriatic arthritis patients.

Psoriatic arthritis patients who are well controlled on treatment may be able to taper or discontinue therapy. But patients who fail their first TNF inhibitor may need a treatment with another mechanism of action. New and potentially effective therapies currently in advanced stages of development may provide other clinical options to TNF inhibitor switching.
In this slideshow, we highlight five of the top concerns and questions physicians have about switching patients from one biologic to another in psoriatic arthritis. Click on the image to view the slideshow.

References:


Kristensen LE, et al. “Effectiveness and Feasibility Associated with Switching to a Second or Third TNF Inhibitor in Patients with Psoriatic Arthritis: A Cohort Study from Southern Sweden.” The Journal of Rheumatology Published online before print December 1, 2015, doi: 10.3899/jrheum.150744


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