PostScript

MATTERS ARISING

Etanercept is effective in patients with rheumatoid arthritis with no response to infliximab therapy

We read the recent article by van Vollenhoven *et al*[1] on the efficacy of one tumour necrosis factor α antagonist (infliximab or etanercept) when the other has failed with great interest. The authors concluded that infliximab is efficacious in a significant proportion of patients who have not responded to etanercept. No conclusive results were reported when they analysed the opposite situation, probably because 11 of the 13 patients who switched from infliximab to etanercept did so owing to adverse events rather than inefficacy.

We recently studied 12 patients with rheumatoid arthritis (11 women) who were switched from infliximab to etanercept because of inefficacy.[2] Infliximab was used for a mean (SD) of 15.6 (8.6) months (range 2–29). Most patients had a satisfactory clinical response to infliximab at the start of treatment with a later reduction in efficacy despite increased doses of infliximab and/or frequency of infusions. They were switched to etanercept and after 6 months of treatment, 10/12 (83%) patients had a good (2 patients) or moderate (8 patients) therapeutic response according to the EULAR criteria, in comparison with the response at the end of infliximab treatment. The Disease Activity Score, DAS28, improved from a mean (SD) of 5.63 (1.1) to 4.30 (0.8) ($p = 0.019$) and the percentage of patients with DAS28>5.1 was reduced from 75% at the end of infliximab treatment to 8% ($p = 0.009$). Figure 1 shows the DAS28 scores during treatment. Interestingly, the four patients who never achieved a response to infliximab, showed an impressive response to etanercept; similar results were recently reported by Buch *et al*.[3] There were no serious adverse events with the etanercept treatment.

Few reports are available on this subject.[3–6] Based on available data and our results, we suggest that etanercept is effective in a significant proportion of patients with a poor or non-sustained response to infliximab.

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References

1 **van Vollenhoven R**, Harju A, Brannemark S, Klareskog L. Treatment with infliximab (Remicade) when etanercept (Enbrel) has failed or vice versa: data from the STURE registry showing that switching tumour necrosis factor α blockers can make sense. *Ann Rheum Dis* 2003;**62**:1195–8.
2 **Sanmarti R**, Gómez-Puerta JA, Rodríguez-Cros JR, Albaladejo C, Muñoz-Gómez J, Cañete JD. Etanercept in rheumatoid arthritis patients with a poor therapeutic response to infliximab. *Med Clin (Barc)* 2004;**122**:321–4.
3 **Buch MH**, Bingham SJ, Bejarano V, White J, Emery P. Do patients with rheumatoid arthritis demonstrate an improvement on etanercept following an inadequate response to infliximab? [abstract]. *Arthritis Rheum* 2003;**48**(suppl):S325.
4 **Brocq O**, Plubel Y, Breuil V, Grisot C, Flory P, Mousnier A, *et al*. Etanercept-infliximab switch in rheumatoid arthritis 14 out of 131 patients treated with anti TNF alpha. *Presse Med* 2002;**31**:1836–9.
5 **Herbert TS**, Helfgott S. Do the clinical responses and complications following etanercept or infliximab therapy predict similar outcomes with the other tumor necrosis factor-α antagonist in patients with rheumatoid arthritis? *J Rheumatol* 2003;**30**:2315–18.
6 **Haraoui PB**, Keystone EC, Thorne JC, Pope JE, Asare C, Leff J. The Canadian biologic observational switchover survey (BOSS): functional status of patients with rheumatoid arthritis after switching from infliximab to etanercept therapy [abstract]. *Ann Rheum Dis* 2003;**62**(suppl I):S223.

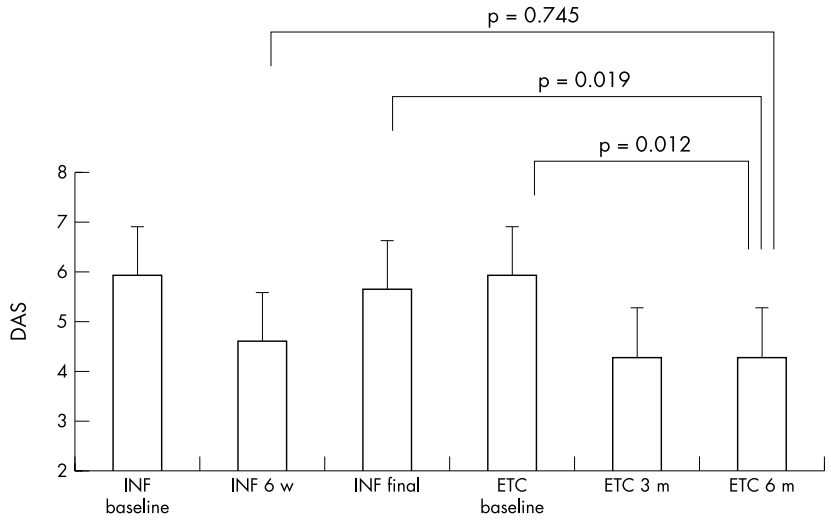

Figure 1 Disease activity according to DAS28 in 12 patients with RA treated with infliximab and switched to etanercept. Mean DAS values are shown for infliximab (INF; baseline, 6 weeks of treatment, last infusion) and etanercept (ETC; baseline, 3 and 6 months of treatment). Comparison was made using a non-parametric test (Wilcoxon). m, months; w, weeks.

FORTHCOMING EVENTS

First European Course: Capillaroscopy and Rheumatic Diseases

10–12 September 2004; Genova, Italy
Contact: Scientific Secretariat: Professor Maurizio Cutolo, Division of Rheumatology, DIMI, University of Genova, Italy
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Tel: +39 02 281 72300
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Fourth International Congress on Spondyloarthropathy

7–9 October 2004; Gent, Belgium
Contact: Medicongress, Waalpoel 28/34, B-9960 Assenede, Belgium
Tel: +32 (0)9 344 39 59
Fax: +32 (0)9 344 40 10
Email: congresses@medicongress.com
Website: www.medicongress.com

ACR/ARHP 68th Annual Scientific Meeting

16–21 October 2004; San Antonio, Texas, USA
Website: www.rheumatology.org/annual/index.asp

XIth International Conference on Behçet's Disease

27–31 October 2004; Antalya, Turkey
Contact: Congress Secreteriat, Figur Congress and Organization Services Ltd. STI, Ayazmaderesi Cad. Karadut Sok. No: 7 80888 Dikilitas, Istanbul, Turkey
Tel: +90 (0212) 258 6020
Fax: +90 (0212) 258 6078
Email: behcet2004@figur.net
Website: www.behcet2004.org

4th International Congress on Autoimmunity

3–7 November, 2004; Budapest, Hungary
Contact: 4th International Congress on Autoimmunity, Kenes International—Global Congress Organisers and Association Management Services, 17 rue du Cendrier, PO Box 1726, CH-1211 Geneva 1, Switzerland
Tel: +41 22 908 0488
Fax: +41 22 732 2850
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