Conference call

The role of biologics in rheumatoid arthritis, how pharmacists can safeguard patients on anticoagulants against the risk of bleeding and the misdiagnosis of contact dermatitis were subjects considered at two recent conferences, as **Christine Clark** reports

Biologics improve RA management

The introduction of biologics for rheumatoid arthritis has been associated with considerable improvements in its management, Robert Moots, professor of rheumatology at the University of Liverpool, told an EAHP satellite symposium sponsored by Pfizer.

Citing the COMET study, he said that 25 per cent of patients treated with methotrexate alone (the previous gold standard treatment) had given up work after one year, compared with fewer than 10 per cent in the group treated with combined etanercept and methotrexate. It appears, he said, that early use of biologics can prevent disease progression and improve productivity.

Dose escalation is a phenomenon that has been observed in RA patients treated with biologics. The formation of anti-drug antibodies means that an increasing dose is required to maintain efficacy.

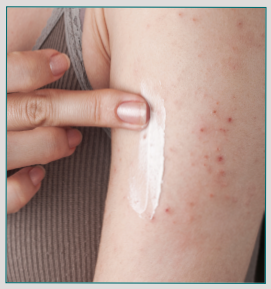
The effect is particularly marked with infliximab but occurs infrequently with etanercept. Dose escalation is also associated with increased costs, not only for the biologic itself but also for other disease-related costs.

In Italy research has shown dose escalation patterns similar to those seen elsewhere, the greatest being with infliximab and least with etanercept. Up to 18 per cent of patients switch from one biologic to another in the first year of treatment and persistence with treatment diminishes over a four-year period for all biologics. By the end of the fourth year of follow-up only 29 and 32 per cent of patients on adlimumab and infliximab respectively are continuing to take the drugs, compared with 45 per cent of those taking etanercept.

Treatment cost evaluations should therefore take into account the complex real-world patterns of usage, including dose escalation and tapering, treatment switches and persistence, rather than be based on acquisition cost alone, Dr degli Esposti (ceo of CliCon, Italy) commented.

• *See also CPD module, p25.*

Allergic contact dermatitis often misdiagnosed



Allergic contact dermatitis is often misdiagnosed, delegates at the European Academy of Dermatology and Venereology spring symposium in Valencia were told. Magnus Bruze, professor of occupational dermatology at Lund University, Sweden told the symposium of one woman, who had been treated for atopic dermatitis for 50 years, but turned out to have contact allergy to a dye named disperse blue.

Another patient in Sweden had been diagnosed with mycosis fungoides (a form of cutaneous T-cell lymphoma), but the correct diagnosis only came to light after he had watched the UK television programme, *Watchdog*. After seeing a feature on contact dermatitis apparently caused by leather sofas (due to the dimethylfumarate used as a dessicant), the patient asked to be tested by his dermatologist. He was found to be allergic to dimethylfumarate and not to have mycosis fungoides after all.

Another lady, who was a nurse in an intensive therapy unit, had experienced numerous bouts of severe eczema and eventually had been prescribed oral prednisolone 35mg daily. She turned out to have an allergy to hair dye. Once the use of the dye was discontinued, her eczema cleared up. After discussing the cases, Professor Bruze concluded that patch testing should be undertaken more often.

Safeguard against the risk of bleeding

Safeguarding patients on anticoagulants against the risk of bleeding is a key role for pharmacists, Peter Verhamme of the Centre for Molecular and Vascular Biology at the University of Leuven in Belgium, told the EAHP conference.

The prevention of stroke outweighs the risk of bleeding with anticoagulant treatment but the risk of bleeding and the lack of an antidote to the new oral anticoagulants (NOACs) is often seen as a barrier to use.

Studies that compared NOACs with vitamin K antagonists (VKAs) for stroke prevention in patients with atrial fibrillation show that the overall risk of bleeding is reduced with NOACs.

There is less risk of intracranial bleeding and major bleeding but the risk of gastrointestinal bleeding is increased, he said. The most likely explanation is that these patients are particularly frail, but these are the patients who benefit most from NOACs (because of the reduced risk of bleeding).

The management of NOAC-associated bleeding differs from VKA-assisted bleeding because there is no antidote at present. In fact, for minor bleeds no action is required. The main message is not to stop taking the anticoagulant.

"In these patients we prioritise stroke prevention over nuisance bleeds," Professor Verhamme said, adding that it is also important to review concomitant medication in case changes can be made.