Rhumatologie

Quoi de neuf?

Céline BRASSEUR

Rhumatologue

CHR Haute-Senne

1. Sur le plan moléculaire

1.1 Nouvelles molécules

Polyarthrite rhumatoïde

Anti-JAK : Baricitinib (Olumniant®)

Tofacitinib (Xeljanz®)

Arthrite psoriasique

Inhibiteurs de la phosphodiesterase 4:

Apremilast (Otezla®)

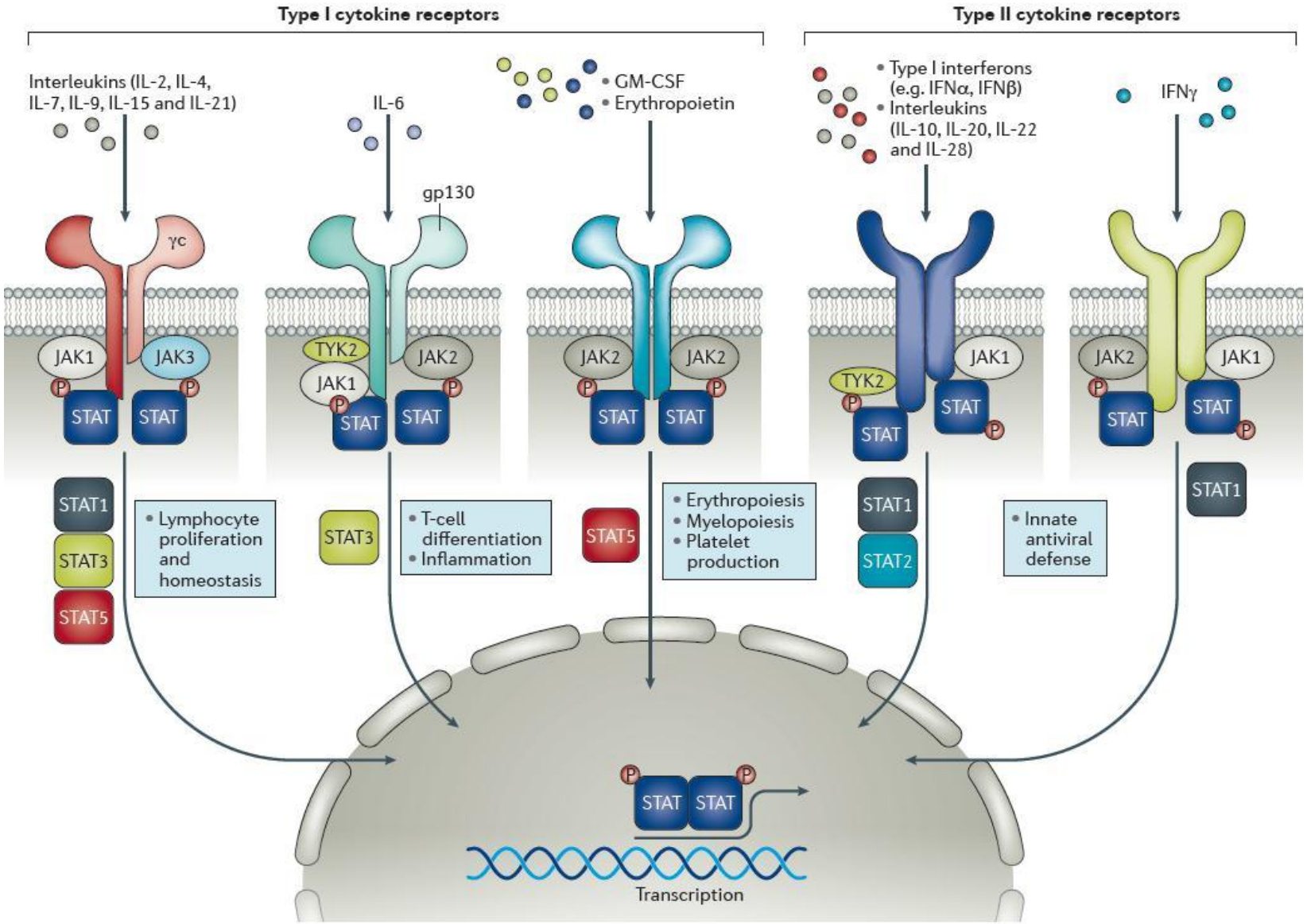
Spécificités

- Petites molécules => traitement oral

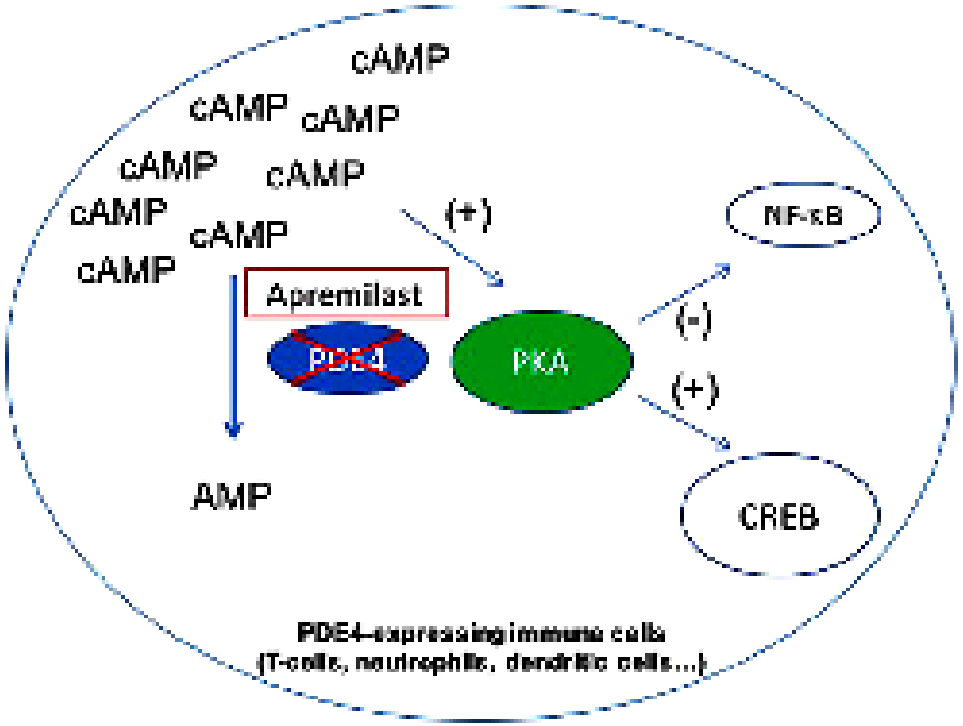
  T 1/2 court

- ≠ biothérapie
  - Précautions d'emploi
  - Tolérance et toxicité

Anti-JAK


Type I cytokine receptors
Type II cytokine receptors
Interleukins (IL-2, IL-4, IL-7, IL-9, IL-15 and IL-21)
IL-6
GM-CSF
Erythropoietin
Type I interferons (e.g. IFNα, IFNβ)
Interleukins (IL-10, IL-20, IL-22 and IL-28)
IFNγ
gp130
γc
JAK1
JAK3
TYK2
JAK2
STAT
STAT1
STAT3
STAT5
STAT2
Lymphocyte proliferation and homeostasis
T-cell differentiation
Inflammation
Erythropoiesis
Myelopoiesis
Platelet production
Innate antiviral defense
Transcription

Apremilast



Pro-inflammatory mediators

↓ TNF-α, IL-8
↓ IL-23, IL-2, IFN-γ

Anti-inflammatory mediators

↑ IL-10

1.2 Nouveaux patients

Révolution des immunothérapies oncologiques

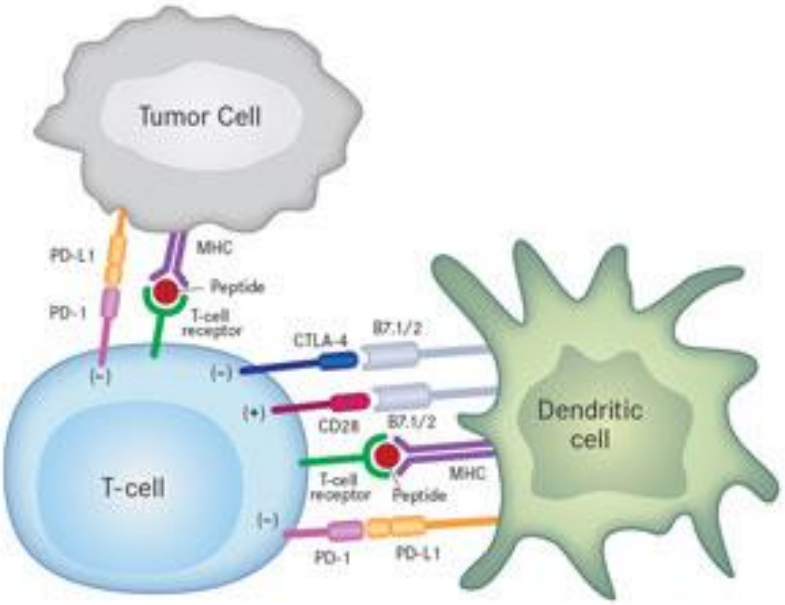
= Inhibiteurs de check-point

1ère génération = Ipilimumab

= anti CTLA 4

OR Abatacept (Orencia)

= CTLA 4-Ig



1.2 Nouveaux patients

<u>Effets secondaires des thérapies inhibiteurs de check-point</u>

Nombreux, auto-immunitaires

Cutané, gastro, hépato, pulmonaire, endocrino

Quid des effets secondaires rhumato?

1.2 Nouveaux patients

<u>Effets secondaires des thérapies inhibiteurs de check-point</u>

Quid des effets secondaires rhumato?

Arthralgies 1 - 57%

Connectivites, myosites 0,7%

Quid des patients présentant une pathologie pré-existante?

Guidelines de PEC : BSMO - SRBR (09/2018)

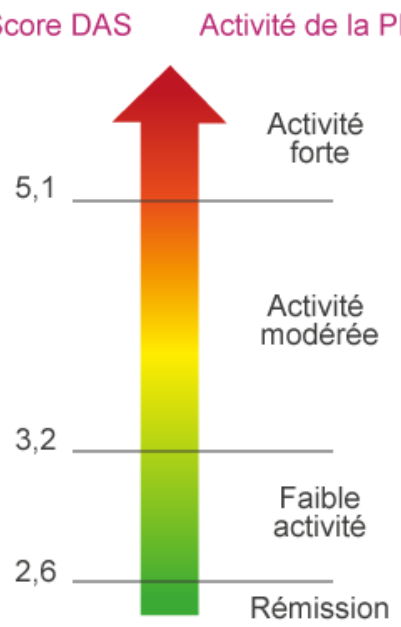
www.bsmo.be/immunomanager

- PEC en fonction de la sévérité

- Traitement :
  - Traitement symptomatique
  - Corticothérapie
  - DMARDs et biothérapies

2. En consultation

Treat-to-target: exemple de la PR



De l'importance de la métrologie

Scores d'activité :

- DAS (AD/AG/EVA-P/VS ou CRP)
- SDAI (AD/AG/EVA-P/EVA-M/CRP)
- CDAI (AD/AG/EVA-P/EVA-M)

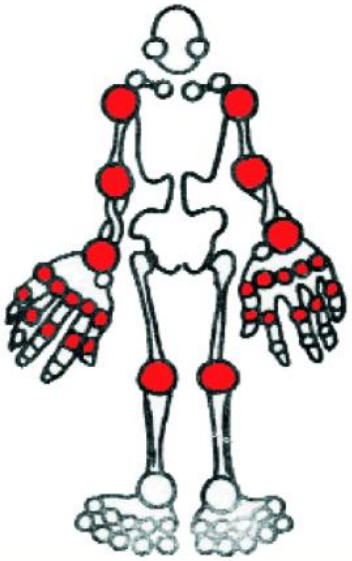
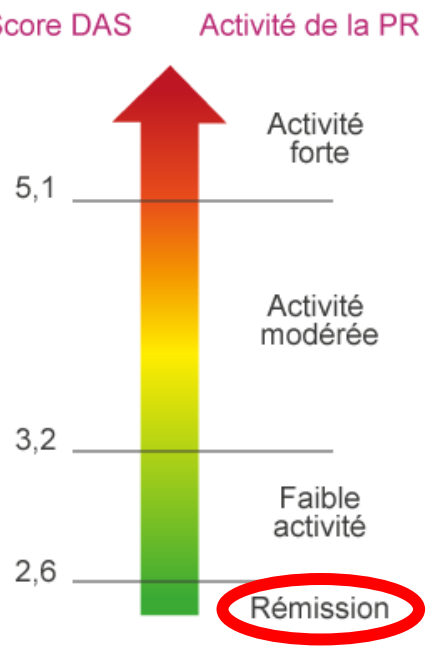


Figure 1. Représentation schématique des 28 articulations évaluées dans le DAS28

Treat-to-target: exemple de la PR



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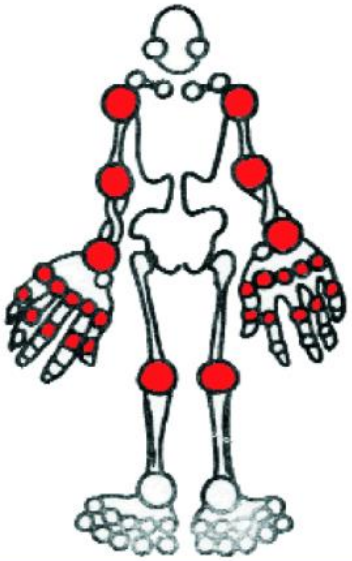

Figure 1. Représentation schématique des 28 articulations évaluées dans le DAS28

Treat to target strategy in early rheumatoid arthritis versus routine care - A comparative clinical practice study.

Brinkmann GH[1], Norvang V[2], Norli ES[3], Grøvle L[4], Haugen AJ[4], Lexberg ÅS[5], Rødevand E[6], Bakland G[7], Nygaard H[8], Krøll F[8], Widding-Hansen IJ[9], Bjørneboe O[10], Thunem C[11], Kvien T[2], Mjaavatten MD[2], Lie E[2].

OBJECTIVE:

To assess the 2-year effect on disease activity and health-related quality of life (HRQoL) of implementing a clinical practice treat-to-target (T2T) strategy in patients with rheumatoid arthritis (RA).

METHODS:

Patients in the Norwegian Very Early Arthritis Cohort 2.0 (NOR-VEAC 2.0), included 2010-2015, were treated according to T2T principles with visits at baseline, 3, 6, 9, 12 months, then every 6 months plus monthly visits until DAS28 <2.6. These patients were compared to a pre-T2T cohort of patients included in the Norwegian Disease Modifying Anti-Rheumatic Drug (NOR-DMARD) register 2006-2009. Both groups had a clinical diagnosis of RA (≤1 year) and were DMARD naïve. Disease activity and HRQoL outcomes were analysed, and the primary outcome was SDAI remission (≤3.3) at 2 years.

RESULTS:

The T2T cohort included 293 patients (mean (SD) age 54 (13) years, 66% females, disease duration median (25,75 perc) 98 (57,164) days) and the routine care cohort 392 patients (age 54 (13) years, 68% females, 4 (0,30) days since diagnosis). At 2 years, the proportion of patients achieving SDAI remission was 46% in the T2T cohort compared to 31% in the routine care cohort. EQ-5D was similar at baseline, but differed significantly between groups at 2 years (median (25,75 perc) 0.77 (0.69, 0.85) vs 0.73 (0.59, 0.80), $p < 0.001$). Methotrexate monotherapy was the dominant DMARD regimen used to achieve SDAI remission in both cohorts.

CONCLUSION:

Higher remission rates and better HRQoL were achieved in patients following a T2T strategy in clinical practice compared to routine care.

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OBJECTIVE:

Comparer la stratégie de traitement « treat-to-target » à une PEC conventionnelle

METHODS:

293 patients norvégiens comparés à une cohorte de 392 patients

PR précoce (< 1 an), naïfs de traitement

RESULTS:

Après 2 ans: taux de rémission = **46%** vs **31%**

Meilleure qualité de vie

(A noter que le Methotrexate en monotherapie est le régime thérapeutique dominant dans les 2 cohortes)

CONCLUSION:

Intérêt de la stratégie de traitement « treat-to-target »

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3. Mais le patient, ce n’est pas que des molécules et des mesures…

… et la prise en charge thérapeutique n’est pas que médicamenteuse

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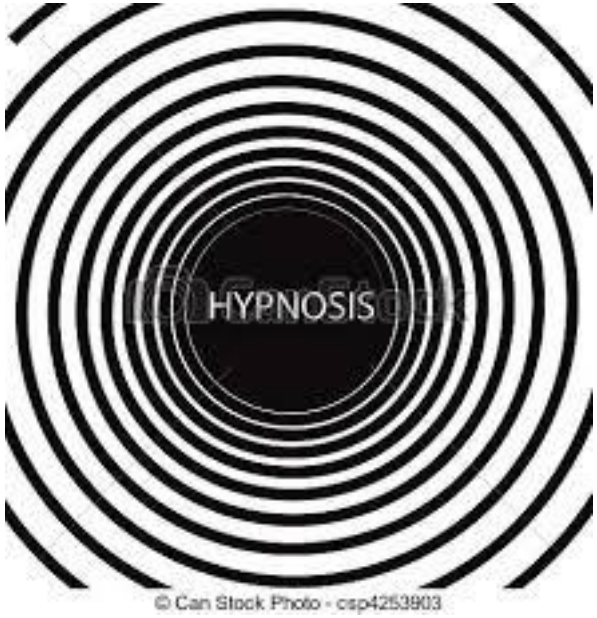

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