LETTERS

Infliximab in refractory psoriatic arthritis with severe psoriasis: a 2-year experience

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Infliximab was shown to be effective and safe in controlled trials of psoriatic arthritis (PsA).^{1–4} In an open-label study, we reported a notable clinical benefit accompanied by clearing and healing of psoriatic skin lesions.⁵ Thus, we conducted this study to evaluate the efficacy and safety of infliximab in patients with active PsA and recalcitrant psoriasis in whom treatment with disease-modifying antirheumatic drugs had failed. Thirty two patients who had a negative purified protein derivative skin test and normal chest radiographs were included. All had an active disease, defined as ≥ 6 tender or swollen joints count, psoriasis area and severity index (PASI) score ≥ 10 ,⁶ and erythrocyte sedimentation rate ≥ 28 mm Hg/h or C reactive protein concentration ≥ 10 mg/l. The end points were the percentage of patients who achieved the psoriatic arthritis response criteria (PsARC)⁷ and improvement in PASI. Patients were treated with infliximab (5 mg/kg weight) at weeks 0, 2 and 6 and every 8 weeks thereafter for a period of 2 years. If the clinical response was insufficient, the interval between infusions was shortened to 6 or 4 weeks. The clinical response according to the American College of Rheumatology (ACR) criteria,⁸ and the disease activity for 28-joint indices score were recorded.⁹

Table 1 shows the clinical and laboratory data. After the first year of treatment, PsARC was achieved by 26 of 32 (81.25%) patients, PASI 70% by 27 of 32 (84.4%) patients, and PASI 90% by 26 of 32 (81.25%) patients. After the second year, PsARC was achieved by 23 of 32 (71.9%) patients, and PASI 70% and 90% by 24 of 32 (75.0%) patients. The response to treatment was rapid, and, after 6 months of infliximab treatment, in most of the patients the skin lesions were cleared and healed. This clinical improvement was sustained for 2 years (fig 1). A similar clinical response was seen on applying the ACR

response criteria. A significant reduction in disease activity for 28-joint indices score and acute-phase reactants was noted. After the first year of treatment, 84.4% of patients continued with infliximab. This rate was 75% after the second year. Eight patients discontinued infliximab treatment: five patients due to allergic reactions, one due to lack of efficacy and two were lost to follow-up.

These results are in agreement with previous studies.^{1–4} However, our results differ somewhat from those of other investigators, who assessed primarily the articular component of the disease and, to a lesser extent, the cutaneous manifestations. In addition, no infliximab survival rates have been

Figure 1 A 49-year-old man with extensive skin lesions of plaque psoriasis with thickness and hyperkeratosis and nail involvement affecting the lower extremities (feet and toes) (A). After 2 years of treatment with infliximab, the skin was entirely cleared and healed, and the nails were cleared (B). Reproduced with permission from the patient.

Table 1 Demographic, clinical and laboratory data of 32 patients with psoriatic arthritis treated with infliximab

Variable	Number
Age (years), mean (SD)	51.4 (16.4)
Female/male, n (%)	12/20 (37.5/62.5)
Arthritis disease duration (years), mean (SD)	8.8 (6.4)
Psoriasis disease duration (years), mean (SD)	13.3 (11.2)
Swollen joints, mean (SD)	7.5 (1.2)
Tender joints, mean (SD)	7.8 (1.8)
Disease activity for 28-joint indices score, mean (SD)	6.1 (1.1)
PASI, mean (SD)	48.8 (10.5)
Methotrexate and ciclosporin A intake, n (%)	20 (62.5)
Methotrexate and leflunomide intake, n (%)	7 (21.9)
Ciclosporin A and leflunomide intake, n (%)	5 (15.6)
Prednisone intake (5 mg/day), n (%)	10 (31.2)
Erythrocyte sedimentation rate (mm/1st h), mean (SD)	33.9 (10.5)
C reactive protein (mg/l), mean (SD)	16.1 (5.1)

PASI, psoriasis area and severity index.

Abbreviations: ACR, American College of Rheumatology; PASI, psoriasis area and severity index; PsA, psoriatic arthritis; PsARC, psoriatic arthritis response criteria

reported so far. Our study is the first in which only patients with severe PsA with recalcitrant psoriasis were included. We showed considerable improvement of PsARC and ACR clinical response with healing of the psoriatic skin lesions, which was sustained for 2 years. Another point is the high rate of infliximab survival after treatment. This is probably related to the combination treatment, especially the use of methotrexate and ciclosporin.¹⁰ We conclude that infusions of infliximab in severe PsA with recalcitrant psoriasis led to a marked clinical response which was sustained over 2 years, and the infliximab survival rate was 75%.

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Prevalence and risk factors of discordance in diagnosis of osteoporosis using spine and hip bone densitometry

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Dual x ray absorptiometry is the reference method to measure bone mineral density (BMD) accurately and reproducibly. The World Health Organization defines osteoporosis on the basis of the T score (which is the difference between the measured BMD and the mean value of young adults, expressed in standard deviations for a normative population of the same ethnicity).¹ Although the BMD at different anatomical regions is correlated, the agreement between sites is low when it comes to classifying individual subjects as having osteoporosis.² Various studies have analysed the prevalence and effect of T score discordance on the management of osteoporosis.^{3–7} However, most of these studies did not evaluate risk factors for this phenomenon. Thus, we aimed to evaluate the presence and risk factors for T score discordance in a large sample of patients.

Participants in this study were 3015 people who underwent bone densitometry in our department (Rheumatology and Physical Rehabilitation Department, Military Hospital Mohammed V, Rabat, Morocco). BMD was determined by a Lunar Prodigy Vision DXA System (Lunar, Madison, Wisconsin, USA). The phantom precision expressed as the coefficient of variation (%) was 0.08. Reproducibility assessed in clinical practice showed a smallest detectable difference of 0.04 g/cm² (spine) and 0.02 g/cm² (hips).^{8,9} Patients' BMD was measured at the lumbar spine (L1–L4) and at the femur. Using the Moroccan normative data for lumbar spine and hip,¹⁰ and the

World Health Organization criteria, each patient was categorised as having (only) one of the following: concordance (osteoporosis, osteopenia or normal BMD at both sites), minor discordance (osteoporosis at one site and osteopenia at the other site or osteopenia at one site and normal at the other site) and major discordance (osteoporosis at one site and normal at the other site).

Major discordance was observed in BMD results of 129 (4.3%) participants (table 1). Minor discordance was observed in 1250 (41.5%) participants, and T score categories of two measurement sites in the remaining 1636 (54.3%) participants were concordant. In multivariate analysis (table 2), menopausal participants and those with obesity and a history of fractures were more likely to show major T score discordance.

Our study confirms that T score discordance between the spine and hip testing sites is a commonly observed phenomenon. The discordance may be related to the skeleton's natural adaptive reaction to normal external and internal factors and forces (eg, overweight), or to the difference in bone loss velocity between trabecular and cortical bone (eg, menopause or steroid use); secondary to a disease leading to a falsely increased spine T score (vertebral osteophytosis, facet sclerosis, syndesmophytes or aortic calcification); artefactual when dense synthetic substances are within the region of interest of the test; and

Abbreviation: BMD, bone mineral density