Secukinumab Use in Psoriatic Arthritis

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A 76 years old male, non smoker, non alcoholic, was diagnosed as psoriatic arthritis 3 years back on the basis of psoriatic skin rash, asymmetrical polyarthritis including distal interphalangeal joints and asymmetric sacroilitis with raised inflammatory markers. He was allergic to sulphasalazine and intolerant to methotrexate. He was given leflunomide 20 mg daily but he did not responded well to it and therefore anti-TNF agent subcutaneous injection etanercept 50 mg weekly was added to it. He responded well and remains stable for about 2.5 years but any attempt to taper anti TNF resulted in recurrence of symptoms and signs, so patient was continued on same dose.

Inspite of regular and adequate dose of etanercept and leflunomide, patient developed skin rash on dorsum of both hands associated with gradually increasing inflammatory type of low back pain and polyarthralgia from last 3 months. On examination his tender joint count (TJC) was 15/68, swollen joint count (SJC) was 0/66, without any deformity. Patient’s pain score was 6/10 score, patient global assessment score was 8/10, with increase in CRP-32 mg/L, ESR-41 mm/h. Disease Activity in Psoriatic Arthritis (DAPSA)-32.2 (High activity). Secondary anti-TNF Failure was considered and etanercept was stopped. Patient was shifted to subcutaneous injection Secukinumab 300 mg every weekly for 4 weeks than monthly, he responded very well within one month, with disappearance of rash and improvement in back pain without any side effect. His DAPSA score significantly improved from 32.2 (high activity) to 2.3 (remission) with marked dermatological improvement (Figures 1, 2, 3).

Secukinumab is a fully human monoclonal antibody that selectively neutralizes circulating IL-17a. Research suggests that IL-17a may play an important role in driving the body’s immune response in psoriasis, psoriatic arthritis and ankylosing spondylitis.¹,² Even though many patients with psoriatic arthritis benefit from anti-TNF therapy but many do not respond to Anti-TNF agents, therefore unmet needs remain, including an unacceptable side-effect, lack of primary efficacy (primary failure), loss of efficacy (secondary failure), and immunogenicity with these agents in some patients.³-⁵ Secukinumab showed efficacy among patients who had received previous anti-TNF therapy and especially in above mentioned situations.

References


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A 27 year male presented with multiple, itchy, erythematous, concentric plaques over groins since 3 months. Patient consulted a physician (non-dermatologist) and was prescribed topical preparation containing potent topical corticosteroids (clobetasol) in combination with clotrimazole. Initially there was a quick response in itching which prompted him to apply the product continuously for few weeks. After application of topical steroids morphology of lesion changed from annular to concentric plaques. We performed potassium hydroxide mount which showed hyphae and on culture Trichophyton rubrum was grown.

These days dermatologist across India, have been seeing such cases in dermatology outdoor on a very regular basis. This condition is named as Tinea pseudoimbricata, which is essentially a form of tinea incognito characterised by presence of multiple concentric rings within a lesion of dermatophytosis.1 It resembles tinea imbricata caused by Trichophyton concentricum, 2 but latter has many more concentric circles and is usually generalized. Injudicious use of topical steroids is probably the major reason for development of this distinct clinical presentation of tinea. Such cases are resistant to conventional treatment and often require prolonged therapy with systemic antifungals like Itraconazole. As many of these cases of tinea initially present to general physician we want to share this case to make them aware of pitfalls of use of topical corticosteroids and combination products (antifungal with steroids) in cases of tinea.

References