This policy statement is approved by Southport and Formby and South Sefton, CCGs

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PAN MERSEY APC

PAN MERSEY AREA PRESCRIBING COMMITTEE
PRESCRIBING POLICY STATEMENT
APC BOARD DATE: 26 JUL 2017

NHS
Pan Mersey
Area Prescribing Committee

MONOARTHRITIS or OLIGOARTHRITIS, inflammatory: TNF alpha inhibitors (anti-TNF)

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The Pan Mersey Area Prescribing Committee recommends the prescribing of anti-TNF (adalimumab, certolizumab, etanercept, golimumab, infliximab) by specialists only, for inflammatory monoarthritis or oligoarthritis as specified below.

Patients may be considered for treatment with anti-TNF in line with the following:

> Severe inflammatory monoarthritis or oligoarthritis (2 joints) involving a large joint or moderately large joint (knee, hip, ankle, shoulder, elbow) despite an adequate trial of two standard DMARDs, appropriate injectable steroids, and NSAIDs. (Adequate trial of DMARD defined as being usually of at least 6 months duration with at least 2 months at standard dose).

> Anti-TNF therapy should be reviewed at 3 months to assess efficacy response. In case of adequate response, therapy will continue with 6-monthly re-assessments in rheumatology clinic. In reactive arthritis, anti-TNF can be stopped at 6 months of remission. In others, treatment may be continued and clinician can make a decision on tapering and stopping treatment as deemed clinically appropriate.

> In case of inadequate response (primary inefficacy) or loss of response (secondary inefficacy), a second anti-TNF may be considered but discontinued if no effect. If side-effects, a switch to an alternate anti-TNF may be considered.

> For details of criteria for assessing response and further information refer to accompanying treatment pathway
https://www.panmerseyapc.nhs.uk/media/2126/monooligoarthritis_pathway.pdf

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Note: Patients who are not eligible for treatment under this statement may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. In this situation, follow locally defined processes.

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Review date: Apr 2025
(or earlier if there is significant new evidence relating to this recommendation)

MONOARTHRITIS or OLIGOARTHRITIS, inflammatory: TNF alpha inhibitors (anti-TNF)

EFFECTIVENESS	**SAFETY**
Small trials and case series have shown improvement in outcome[1,2] but there is a lack of randomised controlled trials investigating the use of anti-TNF therapies in oligoarthritis[3]. Although the inclusion criteria for most clinical trials could have included patients with 3 or 4 active joints, the vast majority of patients had polyarticular disease with around 20 active joints[3]. The only large randomised controlled trial to give information about the proportion of patients with oligoarticular disease was an adalimumab study[4], where 25% had an oligoarticular presentation at baseline but separate sub-analyses of the efficacy of adalimumab in this cohort are not available. The British Society for Rheumatology recommends that anti-TNF therapies should be considered in patients with severe persistent oligoarthritis (less than 3 tender/3 swollen joints), that has a major demonstrable influence on well-being and who have failed treatment with at least two conventional DMARDs and appropriate intra-articular therapy (3).	anti-TNF are contra-indicated in active tuberculosis or other severe infection, and in Class III or IV heart failure. Caution should be exercised as anti-TNF increase risk of infections, and they should be used with caution in patients with history or at increased risk of tuberculosis, hepatitis B, malignancies and lymphoproliferative disorders, skin and other cancers, heart failure, blood dyscrasias, demyelinating disease – see individual product SPCs for further details. Most common side-effects are infection, skin cancer, blood dyscrasias, hypersensitivity, increased lipids, electrolyte disturbances, mood alterations, headache, paraesthesias, visual disturbance, vertigo, tachycardia, hypertension, flushing, breathlessness, cough, GI pain, elevated LFTs, rash, worsening of psoriasis, muscle pain, renal impairment, injection site reaction, oedema and pyrexia. See individual product SPCs for further details.
COST	**PATIENT FACTORS**
Costs per 100,000 population in Pan Mersey: assuming 50% of patients on biosimilar etanercept and 50% on alternative biologic at mean cost of alternatives, for 19 patients is £175,000 in Pan Mersey area = £11,150 per 100,000 population. Actual cost will be lower due to commercial in confidence discounts available.	British Society for Rheumatology and British Health Professionals in Rheumatology rheumatoid arthritis guidelines on safety of anti-TNF therapies 2010 recommend monitoring for infection, and full blood count should be undertaken regularly[5]. Renal impairment, hepatic impairment and paediatric patients – no data available on dose adjustment. No dosage adjustment necessary for elderly patients. See individual product SPCs for further details.

PRESCRIBING INFORMATION See individual product SPCs**.**

IMPLEMENTATION NOTES Prescribing should be retained by the specialist. Administered (often self-administered) by subcutaneous injection via prefilled syringe (except infliximab administered by intravenous infusion), usually by “home care” arrangement. Patients should be given the special alert card.

REFERENCES

1. Scand J Rheumatol. 2013; 42(5):369-72.
2. Scand J Rheumatol. 2015; 44(3):192-99
3. Rheumatology 2013; 52(10): 1754-57
4. Arthritis Rheum 2005; 52(10): 3279-89
5. Rheumatology 2010; 49 (11): 2217-2219.