PsA Risk Found for Ustekinumab; Psoriasis Linked to Kidney Disease

By RheumatologyNetwork Staff [2]

Small case study reveals psoriatic arthritis risk with ustekinumab use for psoriasis. Also: Regulators toughen up on painkiller labeling, but is it enough?

Last week's articles on rheumatology topics in the major non-rheumatology journals.

Ustekinumab Associated With Flares of Psoriatic Arthritis
JAMA Dermatology, October 16, 2013

A small group of patients treated with ustekinumab for plaque psoriasis developed psoriatic arthritis (PsA), according to a case report.

The four patients were switched to ustekinumab after inadequate results with methotrexate, narrowband UV-B, etanercept and adalimumab. Two had previous PsA and two did not.

After two patients discontinued ustekinumab, the “failed” anti-tumor necrosis factor drugs were effective again. A previously published case series of three patients on ustekinumab also reported PsA flares.

In the original phase II and III studies reporting improvement of PsA with ustekinumab, patients had continued methotrexate.

These cases “raise concern that ustekinumab may unmask or aggravate joint disease in selected patients,” the authors warned.

Risk of moderate to advanced kidney disease in patients with psoriasis: population based cohort study
BMJ, October 15, 2013

UK researchers noted a link between moderate to severe psoriasis and advanced chronic kidney disease (CKD), independent of traditional risk factors for renal dysfunction.

However, there was no association with mild disease, according to a cohort study of 143,883 patients and nearly 700,000 controls culled from a patient record database.

Patients who received phototherapy, oral medication or biologics were defined as having severe disease. Severe psoriasis doubled the risk of CKD and quadrupled the risk of end-stage renal disease requiring dialysis.

Patients with ≥3% of body surface area affected should be monitored closely, and nephrotoxic drugs should be used with caution.

FDA Tightens Indications for Using Long-Acting and Extended-Release Opioids to Treat Chronic Pain
JAMA, October 16, 2013

The US Food and Drug Administration is tightening the indications for long-acting and extended-release opioid pain medications. The amended labeling will specify that these drugs
are reserved for patients who cannot tolerate or obtain adequate relief from other treatments, and to specify the risks of addiction, abuse and death, even at recommended doses.

The main goal of the labeling change is to curb the “epidemic” of prescription drug abuse and overdoses. Between 1999 and 2010, painkiller prescriptions increased by 300%, accompanied by a fivefold increase in women (and nearly a fourfold increase in men) who died from painkiller overdose.

Andrew Kolodny, chief medical officer at Phoenix House, a national substance abuse treatment program, said that most opioid prescribing is for chronic noncancer pain conditions including fibromyalgia and low back pain. These drugs may not be effective or appropriate for these diseases, he observed, arguing for even greater restrictions.

Also, these case studies of interest ...

Churg-Strauss Syndrome: An Uncommon Cause of Intracerebral Hemorrhage
JAMA Neurology, October 14, 2013.

A patient with Churg-Strauss syndrome (CSS) had brain involvement, consisting of right homonymous hemangiopsia, intracranial hemorrhage, eosinophilic vasculitis in brain tissue and diffuse alveolar hemorrhage.

He improved with cyclophosphamide and methylprednisone, and was discharged.

About 6% to 10% of patients with CSS have brain involvement, most commonly cerebral infarction and encephalopathy.

A difficult case of atopic eczema
BMJ, October 14, 2013

A patient with lifelong eczema and asthma developed iatrogenic Cushing’s syndrome from the cumulative absorption of topical, inhaled and oral steroids.

She had been using 1% hydrocortisone cream, betamethasone valerate ointment, a beclomethasone dipropionate inhaler and oral prednisolone.

“Red flags” are skin atrophy, striae, telangiectasias, purpura, acne or rosacea, and hair thinning, along with cushingoid features.

She was weaned off steroids with azathioprine, but then developed adrenal insufficiency, which can be fatal if untreated.

... and a semantic and historical clarification.

Bechet vs Behet: The Name Is Not the Same
JAMA Dermatology, October 2013

Confusion persists over the names of two prominent 20th century clinicians.


Hulsi Behet (1889-1948) described a syndrome of of recurrent oral aphthous ulcers, genital ulcers, and eye lesions, in 1937 at the Istanbul Dermatological Society. After World War II, the syndrome, often associated with severe ischemic vasculitis, was named Behet disease.

Additionally, Benediktos Adamantiades (1875-1962), a Greek ophthalmologist practicing in Athens, described a case of recurrent iritis, oral and genital ulcers and arthritis in 1930. The syndrome should be called Adamantiades-Behet disease, but because of political rivalries
Adamantiades was not given proper recognition.

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