Letters to the Editors

Golimumab treatment for complicated uveitis

Sirs,

Juvenile idiopathic arthritis (JIA) and HLA-B27 associated uveitis can be associated with severe ocular complications and poor visual outcome (1, 2). Golimumab, a new human monoclonal antibody to TNF-α, was approved for patients with rheumatoid arthritis, psoriatic arthritis and anklylosing spondilitis (3–4).

We retrospectively evaluated the efficacy of subcutaneous injections of golimumab in 6 patients with JIA and 4 patients with HLA-B27 associated uveitis who had an inadequate response to previous TNF-α blockers or other biologic drugs in controlling uveitis and/or arthritis. Patients attended the Paediatric Rheumatologic Unit at the “Istituto Ortopedico G. Pini”, Milan. Inclusion criteria were: inadequate control of uveitis and/or arthritis to one or more TNF-α blockers (etanercept, infliximab or adalimumab), or other biologics (rituximab, abatacept). Golimumab was given subcutaneously at the dose of 50 mg monthly from March 2011 to March 2012. Data collected included: age, gender, age at onset of uveitis and arthritis, ocular complications, JIA category (ILAR classification) (5), previous systemic immunosuppressant/corticosteroid therapies, and follow-up.

Primary outcome measures were: response to treatment (decrease in uveitis activity), visual acuity improvement, reduction of concomitant systemic corticosteroids, occurrence of adverse events. Disease activity was graded in accordance with the standardisation uveitis nomenclature (SUN) criteria also for adults JIA patients (6).

Ten patients (5 females; 5 males; 20 affected eyes), with a mean age of 34.2 ± 10.3 (SD) years with uveitis were treated. Four patients were treated with golimumab for active uveitis and arthritis, six for active uveitis. Demographic data, clinical features and treatment details are shown in the Table. Mean age at onset of uveitis was 5.1 ± 3.5 (SD) years (JIA group), 27 ± 6 (SD) years (B27 group).

Mean ocular disease duration was 21.3 ± 6.6 (SD) years. All patients had bilateral uveitis (4 anterior, 7 panuveitis). Ocular complications at the beginning of golimumab were: macular oedema (6 eyes), cataract (6 eyes), glaucoma (4 eyes). Visual acuity remained stable in 15 eyes, improved in 4 eyes and worsened in one eye (patient n. 8). Cataract extraction was performed in two patients (n. 1, n. 9) three months after initiation of golimumab. Patient n. 9 had severe macular oedema and visual loss after surgical intervention necessitating pericocular corticosteroid injections. The mean uveitis activity before treatment was 2 ± 0.7 (SD) cells and 0.5 ± 0.8 (SD) cells at end of follow-up. The mean systemic prednisolone dose was 13.75 mg/day before and 6 mg/day after golimumab treatment. At end of follow-up, 7 patients were still on daily systemic low-doses of prednisolone (5–12.5 mg). Methotrexate was the only associated disease-modifying anti-rheumatic drug at end of follow-up in 4 patients. The mean follow-up time on golimumab was 8.2 ± 2.3 (SD) months.

At last visit uveitis was inactive in 8 patients, and active in the two patients that underwent cataract extraction. Decrease in uveitis activity was evident around the second week after the injection of golimumab with rapid reduction of anterior chamber cells. No serious adverse events were encountered.

Little is known about the use of golimumab in ophthalmology, with only one article reporting favourable results on uveitis (7). Studies from the rheumatologic experience suggest that switching patients from one TNF-α inhibitor to golimumab is effective and well tolerated for active rheumatoid arthritis (3, 4).

Although biologics are effective in controlling uveitis, their use remain mostly “off label” and several patients do not adequately respond to treatment (8–10). Therefore, it’s becoming more frequently important to have a wide range of effective therapeutic options available to treat the most serious uveitis cases with more convenient dosing schedule.

Golimumab may be a new therapeutic option for patients with severe uveitis who have not previously responded to biologics. To date, this is the largest case series on golimumab in uveitis patients.

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References


Table I. Patient demographics, clinical features and treatment data.

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<tr>
<th>Patient number</th>
<th>Gender</th>
<th>Age (yrs)</th>
<th>Associated rheumatic disease</th>
<th>Biologics used before Golimumab</th>
<th>Immunosuppressive treatment at last visit</th>
<th>Systemic steroids (at beginning of Golimumab and at last visit) (prednisolone mg/day)</th>
<th>Follow-up (Golimumab) Visual Acuity (at first injection Golimumab) (at end follow-up)</th>
<th>Visual Acuity (at last visit) OD</th>
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