Dr. Cohen replies

To the Editor:

We thank Dr. Koumakis and colleagues for their interest in our report[1].

A few cases of spondyloarthritis (SpA) treated by tocilizumab have been published. The report of Koumakis and colleagues is interesting for many reasons: (1) they described the case of a woman with a severe radiographic ankylosing spondylitis (AS) on spine and sacroiliac joints; (2) for the first time, tocilizumab was administered because of recurrent infections [under 2 anti-tumor necrosis factor (TNF)] and not inefficacy; (3) the clinical response was rapid; and (4) the spinal inflammation studied by magnetic resonance images decreased, in contrast to other cases[2,3].

This new successful case of tocilizumab in SpA provided the opportunity to address the following issues: (1) the difference in the efficacy of tocilizumab between patients refractory or intolerant to anti-TNF; (2) the efficacy of tocilizumab as first-line biologic, as reported[3,4]; and (3) the necessity to adapt the frequency of infusions as in juvenile idiopathic arthritis for the systemic form compared to the polyarticular form.

Unfortunately, in addition to recent and disappointing case series reports with (at least) axial SpA[5,6], the development of tocilizumab in AS has been interrupted by Roche because the NCT01209702 study, a randomized, double-blind, placebo-controlled study including patients refractory to nonsteroidal antiinflammatory drugs, failed to show the efficacy of tocilizumab.

Actually, the role of interleukin 6 (IL-6) in SpA does not seem unequivocal[7,8,9]. Finally, the absence of efficacy of tocilizumab demonstrated in a placebo-controlled study suggests that there is not a pathogenic role of IL-6 in SpA as in rheumatoid arthritis. Recent reports on inadequate response in peripheral SpA[10] and psoriatic arthritis[11] follow this hypothesis.

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