Combination Therapy of Abatacept and Anakinra in Children with Refractory Systemic Juvenile Idiopathic Arthritis: A Retrospective Case Series

JESSICA L. RECORD, TIMOTHY BEUKELMAN and RANDY Q. CRON

J Rheumatol 2011;38;180-181
http://www.jrheum.org/content/38/1/180

1. Sign up for TOCs and other alerts
   http://www.jrheum.org/alerts

2. Information on Subscriptions
   http://jrheum.com/faq

3. Information on permissions/orders of reprints
   http://jrheum.com/reprints_permissions

The Journal of Rheumatology is a monthly international serial edited by Earl D. Silverman featuring research articles on clinical subjects from scientists working in rheumatology and related fields.
Combination Therapy of Abatacept and Anakinra in Children with Refractory Systemic Juvenile Idiopathic Arthritis: A Retrospective Case Series

To the Editor:

Novel biological agents have provided improved treatment options for children with systemic juvenile idiopathic arthritis (sJIA). Anakinra, an interleukin 1 receptor antagonist, has been shown to effectively treat sJIA1,2,3,4,5; however, some patients may require multiple painful daily injections to control their disease. Another biologic, abatacept, selectively modulates the CD80/CD86:CD28 costimulatory signal necessary for T cell activation6 and has been shown to be effective in treating patients with sJIA who have a polyarticular course7. Rheumatologists are generally hesitant to combine biologics because of studies involving adults with rheumatoid arthritis showing no improvement when combining anti-cytokine biologics and an increased risk of infection8,9. However, Weinblatt, et al actually reported a lower incidence of severe adverse events in a small group of patients receiving anakinra and abatacept than in patients receiving anakinra and placebo, although the efficacy of this combination has not been formally evaluated6.

Based on the available literature regarding the effectiveness of anakinra and abatacept in the treatment of sJIA independently, we have begun using these agents concurrently in selected patients with refractory disease. The mechanism of action of abatacept (costimulatory blockade) was deemed notably different from cytokine inhibition, and we postulated that combination therapy would have an additive or synergistic benefit for these steroid-dependent patients with refractory sJIA because of its unique mechanism of action. We performed a retrospective review of children with difficult-to-treat sJIA treated simultaneously with anakinra and abatacept to report the efficacy and safety of this combination.

All patients at the Children’s Hospital of Alabama, Birmingham, AL, USA, diagnosed with sJIA by a treating board-certified pediatric rheumatologist and receiving combination therapy with abatacept and anakinra were eligible for this study. After receiving institutional review board approval, 4 patients were identified and their records were reviewed. Data were collected on a standard form regarding demographics, laboratory values, joint count, and any infectious or other adverse effects. All 4 patients are female, and 2 are siblings. Three are African American and 1 is of European descent.

Table 1. Clinical summary of patients with sJIA treated with abatacept and anakinra.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age at First Symptoms</th>
<th>Time to Abatacept*</th>
<th>Response Following Abatacept</th>
<th>Total Months of Abatacept Therapy</th>
<th>Treatment Regimen at Abatacept Initiation†</th>
<th>Treatment Regimen at Last Followup†</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8 mo</td>
<td>46 mo</td>
<td>Fever improved; ESR normalized; requires dosing every 3 wks for greater arthritis control</td>
<td>17</td>
<td>Ank 11 mg/kg/day CS 1.1 mg/kg/day MTX 0.8 mg/kg/wk</td>
<td>Ank 0.9 mg/kg/day CS 0.9 mg/kg/day MTX 0.7 mg/kg/wk Abt 18 mg/kg every 3 wks</td>
</tr>
<tr>
<td>2</td>
<td>10 yrs</td>
<td>18 mo</td>
<td>Stopped prednisone at 2 mo; cushingoid symptoms have resolved; no disease flares or MAS</td>
<td>8</td>
<td>Ank 8.9 mg/kg/day CS 4.2 mg/kg/day Cyclosporine 4.4 mg/kg/day IV CYC 466 mg/m² every 4 wks IVIG 1.7 g/kg every 3 wks</td>
<td>Ank 2.3 mg/kg/day CS 0.2 mg/kg/day Abt 18 mg/kg every 4 wks</td>
</tr>
<tr>
<td>3</td>
<td>2 yrs</td>
<td>66 mo</td>
<td>Improved arthritis; ESR began to normalize at 2 mo</td>
<td>13</td>
<td>Ank 5.1 mg/kg/day CS 0.8 mg/kg/day MTX 0.9 mg/kg/wk</td>
<td>Ank 3.5 mg/kg/day CS 0.5 mg/kg/day MTX 0.6 mg/kg/wk Abt 10 mg/kg every 4 wks</td>
</tr>
<tr>
<td>4</td>
<td>2 yrs</td>
<td>40 mo</td>
<td>Improved arthritis; ESR began to normalize at 3 mo</td>
<td>9</td>
<td>Ank 11 mg/kg/day CS 0.8 mg/kg/day MTX 0.8 mg/kg/wk</td>
<td>Ank 8.4 mg/kg/day CS 0.6 mg/kg/day Abt 13 mg/kg every 4 wks</td>
</tr>
</tbody>
</table>

* Months since onset of initial sJIA symptoms to start of abatacept. † Corticosteroid dosing was converted into prednisone equivalent and calculated as mg/kg/day. Ank: anakinra; CS: corticosteroids; MTX: methotrexate (subcutaneous); Abt: abatacept; IVIG: intravenous immunoglobulin; MAS: macrophage activation syndrome; ESR: erythrocyte sedimentation rate; sJIA: systemic juvenile idiopathic arthritis; CYC: cyclophosphamide.
was added to that treatment regimen 3 years after initial symptoms in response to persistent arthritis and inflammation. Her arthritis went from 6 affected joints to none at last followup, and her ESR, which averaged 60 mm/h prior to abatacept, began to steadily decrease 3 months after abatacept initiation and was 29 mm/h at last followup, the lowest it has been since diagnosis.

To our knowledge, ours is the first description of the concurrent use of anakinra and abatacept in children with sJIA. This combination therapy appears to be beneficial in these 4 steroid-dependent patients with refractory sJIA, allowing dose reduction of both anakinra and corticosteroids while improving arthritis joint count, as well as controlling systemic features of disease (Table 1). With 8–17 months of followup since initiation of abatacept, no infusion reactions, significant infections, or other notable adverse effects have been observed in any of the patients. Although the evidence is anecdotal at present, a controlled clinical trial to assess the efficacy and safety of this combination therapy in children with refractory sJIA is warranted.

Jessica L. Record, BS; Timothy Beukelman, MD, MSCE, Assistant Professor; Randy Q. Cron, MD, PhD, Professor, Children’s Hospital of Alabama, University of Alabama at Birmingham, Department of Pediatrics, Division of Pediatric Rheumatology. Address correspondence to Dr. R.Q. Cron, Children's Hospital of Alabama/University of Alabama at Birmingham, Children’s Park Place, Ste. 210, 1601 4th Avenue South, Birmingham, AL 35233, USA. E-mail: rcron@peds.uab.edu

REFERENCES


J Rheumatol 2011;38:1; doi:10.3899/jrheum.100726