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Letter

Apremilast Use in Oligoarticular Psoriatic Arthritis

To the Editor:

We read with interest the article published in *The Journal of Rheumatology* by Ogdie et al[1] in which apremilast monotherapy showed more benefit in a specific subset of the psoriatic arthritis (PsA) population (oligoarticular pattern), compared to methotrexate (MTX) and biologic disease-modifying antirheumatic drugs (bDMARDs). The authors collected baseline and follow-up data (6-month period) regarding the clinical response to either MTX, apremilast, or bDMARD, all in monotherapy. A total of 150 patients with oligoarticular PsA (≤ 4 swollen joints) fulfilled inclusion criteria and were enrolled in the Corrona Psoriatic Arthritis/Spondyloarthritis (PsA/SpA) Registry.[2] The authors found higher levels of clinical involvement and patient-reported outcome measures among patients who received apremilast compared to those who received MTX or bDMARD. Despite these data, apremilast (n = 34) showed better numerical clinical outcomes than both MTX and bDMARD in oligoarticular PsA (no statistical tests were performed). Accordingly, Mekhail et al showed that an oligoarticular PsA subpattern is a prognostic factor of good response to apremilast, whereas high disease activity is a prognostic factor of poor response.[3] MTX is the most commonly used conventional synthetic DMARD (csDMARD) treatment for PsA, despite little available published evidence; however, in the study by Ogdie et al,[1] the MTX-treated group was the least numerically represented group in monotherapy (n = 15).

The European Alliance of Associations for Rheumatology (EULAR) recommendations consider "mild PsA" for those patients with oligoarticular involvement (< 5 involved joints).[4] The same recommendations suggest the use of apremilast after failure of MTX, leflunomide, and/or sulfasalazine. In our opinion, when considering the definition of mild PsA, we might balance not only the absolute number of involved joints but also the presence of mild yet active psoriasis (PsO). Whatever the case may be, EULAR recommendations for the treatment of mild PsA run into the best potential scenario in which apremilast may show highest response rates, which actually is a very frequent PsA presentation (1–5 involved joints, affects ~50% of patients with PsA).[4,5] It is still unclear how different subsets or clinical combinations of oligoarticular PsA (eg, enthesitis, dactylitis, distal interphalangeal involvement, nail domain, PsO subtype) would, according to the EULAR definition of mild PsA,[4] respond to apremilast. This response might be clarified at the end of the currently ongoing trial assessing apremilast efficacy in early oligoarticular PsA (ClinicalTrials.gov: NCT03747939). The burden of disease seems to be higher in polyarticular PsA based on functional and quality of life assessment, but there is still a need for similar use of bDMARD among both oligo- and polyarticular PsA, as observed by Gladman et al.[5] This use of bDMARD in oligoarticular PsA would eventually be significantly reduced when tight controls and treat-to-target regimens are applied, as suggested by Coates et al .[6]

Interestingly, Ogdie et al[1] found their results in a population with high frequency of obesity, more frequent among apremilast users (> 64.7%). This is noteworthy, since several currently approved bDMARD might be more effective at higher dosages.[4] Based on the authors' observations, apremilast appears to show similar efficacy regardless of the patient's weight/BMI.[1]

We aim to present our limited data on our experience with apremilast for the treatment of oligoarticular PsA, which is very similar to those reported by Ogdie et al.[1] Ethics approval was obtained from Hospital Comarcal Alt Penedès-Garraf (CSAPG Ethics Committee 2021-001R).

Two out of 3 cases showed clinical benefit after introducing apremilast when MTX showed either inefficacy or intolerance, in clinical practice settings, as shown in Table 1. We initiated apremilast before bDMARD therapy because of an appropriate suitability for the oligoarticular subtype of patients with PsA, according to EULAR recommendations. The 2 responders both reached minimal disease activity, and skin domain improved significantly. One of the patients who showed good response had high BMI. The patient who failed to control her PsA also failed to 5 previous different bDMARD and several intraarticular injections.

In our opinion, since the approval of several therapies for a very heterogeneous disease such as PsA, it is mandatory to find a specific profile for each type of patient and treatment. Apremilast looks to have a very reasonable profile for the treat-

Table 1. Sociodemographic characteristics and clinical data (at baseline and 6-month follow-up) of patients with oligoarticular PsA treated with apremilast.

	Patient 1	Patient 2	Patient 3
Age, yrs	37	42	44
Female sex	Yes	Yes	Yes
BMI, kg/m^2	36	26	32
Duration since PsA diagnosis, yrs	1	3	4
Prior non-bDMARD use	MTX	MTX	MTX
Prior biologic use	No	No	No
SJC (0–66)[a]	4/1	5/0	3/3
TJC (0–68)[a]	5/1	3/0	3/2
Dactylitis[a]	0/0	0/0	0/0
cDAPSA[a]	21/8	26/9	20/18
BSA[a]	2/2	5/1	4/4
PASI[a]	7/5	8/2	10/10
VAS[a], mm	8/4	6/0	8/8

[a] Values at baseline/after 6 months of treatment are shown. bDMARD: biologic disease-modifying antirheumatic drug; BSA: body surface area; cDAPSA: Clinical Disease Activity Index for Psoriatic Arthritis; MTX: methotrexate; PASI: Psoriasis Area Severity Index; PsA: psoriatic arthritis; SJC: swollen joint count; TJC: tender joint count; VAS: visual analog scale.

ment of oligoarticular PsA as monotherapy when csDMARD shows intolerance and/or inefficacy. Further studies are needed to confirm this hypothesis.

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The authors declare no conflicts of interest relevant to this article.

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