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Irish Society for Rheumatology Spring Meeting 2013



22 March, 2013
Royal Marine Hotel,
Dun Laoghaire, Dublin

Brochure kindly sponsored by MSD



Bristol-Myers Squibb





IN DMARD-IR AND TNF-IR RA PATIENTS,
WHEN COMBINATION WITH MTX IS NOT AN OPTION...

ROACTEMRA
STANDS OUT¹

RoACTEMRA[®]
tocilizumab

RoACTEMRA, in combination with methotrexate (MTX), is indicated for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have either responded inadequately to, or who were intolerant to, previous therapy with one or more disease-modifying anti-rheumatic drugs (DMARDs) or tumour necrosis factor (TNF) antagonists. In these patients, RoACTEMRA can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate. RoACTEMRA has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function when given in combination with methotrexate.²

ABRIDGED PRESCRIBING INFORMATION (For full prescribing information, refer to the Summary of Product Characteristics [SmPC]) RoACTEMRA[®] (Tocilizumab) 20mg/ml Concentrate for Solution for Infusion

Indications: (i) In combination with methotrexate (MTX), for the treatment of adult patients with moderate to severe active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more DMARDs or TNF antagonists. In these patients, RoACTEMRA can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate. RoACTEMRA has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function when given in combination with methotrexate. (ii) As monotherapy (in case of intolerance to MTX or where treatment with MTX is inappropriate) or in combination with MTX, for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients ≥ 2 years of age, who have responded inadequately to previous therapy with NSAIDs and systemic corticosteroids. **Dosage and Administration:** Treatment should be initiated by healthcare professionals experienced in the diagnosis and treatment of RA or sJIA and all patients should be given the Patient Alert Card. **RA Patients:** Recommended posology is 8mg/kg diluted to a final volume of 100ml, given once every 4 weeks by iv infusion over 1 hour. For patients weighing > 100 kg, doses > 800 mg per infusion are not recommended. No data on doses above 1.2g. **Dose adjustments:** Dose modification, interruption or in some cases discontinuation of RoACTEMRA recommended in the event of raised liver enzymes, low absolute neutrophil count (ANC) or low platelet count (see SmPC for details). In patients not previously treated with RoACTEMRA, initiation not recommended in patients with an ANC below $2 \times 10^9/l$. Closely monitor renal function in patients with moderate to severe renal impairment as RoACTEMRA has not been studied in these patients. No data in patients with hepatic impairment. **sJIA Patients:** No data in patients < 2 years of age. Posology: 8mg/kg for patients ≥ 30 kg or 12mg/kg for patients < 30 kg once every 2 weeks by iv infusion over 1 hour. Check patient's weight at each visit – refer to SmPC. In the event of raised liver enzymes, low ANC or low platelet count, interrupt/discontinue RoACTEMRA dose or modify/stop concomitant MTX and other medications where appropriate. - see SmPC for details. Reduction of RoACTEMRA dose due to laboratory abnormalities not studied in sJIA patients. Clinical improvement is generally seen within 6 weeks of starting RoACTEMRA, reconsider continued therapy if no improvement seen in this timeframe. **Contraindications:** Hypersensitivity to any component of the product; active, severe infections. **Warnings and Precautions:** Serious (sometimes fatal) infections reported in patients receiving immunosuppressive agents including RoACTEMRA. Do not initiate in patients with active infection. If serious infection develops interrupt therapy until infection controlled. Caution in patients with history of recurring/chronic infections, or other underlying conditions (e.g. diverticulitis, diabetes and interstitial lung disease) which may predispose patients to infection. Vigilance for the timely detection of serious infection recommended. Advise all patients and parents/guardians of sJIA patients to contact their healthcare professional immediately when symptoms suggestive of an infection appear. Screen for latent TB prior to starting therapy. Treat latent TB with standard anti-mycobacterial therapy before initiating RoACTEMRA. Viral reactivation (e.g. hepatitis B) reported with biologic therapies for RA. Patients screening positive for hepatitis excluded from clinical trials. Events of diverticular perforations as complications of diverticulitis reported uncommonly with RoACTEMRA in RA patients. Exercise caution in patients with a history of intestinal ulceration or diverticulitis. Evaluate patients with symptoms of complicated diverticulitis promptly. Serious hypersensitivity reactions reported - may be more severe and potentially fatal in patients who have experienced hypersensitivity reactions during previous infusions even if they have received premedication with steroids and anti-histamines. Appropriate treatment should be available for immediate use in the event of an anaphylactic reaction with RoACTEMRA. If an anaphylactic reaction or other serious hypersensitivity/serious infusion related reaction occurs, stop administration of RoACTEMRA immediately and discontinue therapy permanently. Use with caution in patients with active hepatic disease or hepatic impairment. Not recommended in patients with baseline ALT or AST $> 5 \times$ ULN; use with caution in patients with ALT or AST $> 1.5 \times$ ULN. Monitor ALT and AST levels for RA and sJIA patients according to SmPC - other liver function tests including bilirubin should be considered where indicated. If raised, follow dosage recommendations in SmPC for RA and sJIA patients. Risk of neutropenia may be increased in patients previously treated with a TNF antagonist. Continued therapy not recommended in patients who develop an ANC $< 0.5 \times 10^9/l$ or platelet count $< 50 \times 10^9/l$. In patients not previously treated with RoACTEMRA, initiation not recommended where ANC is below $2 \times 10^9/l$. Caution in patients with low platelet count: monitor neutrophils and platelets in RA and sJIA patients according to SmPC. If reduced, follow dosage recommendations in SmPC for RA and sJIA patients. Elevations in lipid parameters seen - refer to SmPC. Assess lipid parameters according to SmPC, if elevated, manage patients according to local guidelines for hyperlipidaemia. Potential for central demyelination with RoACTEMRA currently unknown; physicians should be vigilant for symptoms of new onset disease. Immunomodulatory medicines may increase malignancy risk in RA patients. Do not give live and live attenuated vaccines concurrently with RoACTEMRA as safety not established - refer to SmPC for further details on immunisations. RA patients should have CV risk factors managed as part of usual standard of care. Not recommended for use with other biological agents. Macrophage activation syndrome (MAS) is a serious life-threatening disorder that may develop in sJIA patients - RoACTEMRA has not been studied in patients during an active MAS episode. Advise patients experiencing dizziness not to drive or use machines until dizziness resolved. Product contains 26.55mg sodium per 1200mg. **Drug Interactions:** In RA patients, levels of simvastatin (CYP3A4) were decreased by 57% one week following a single dose of tocilizumab to levels similar to or slightly higher than those observed in healthy subjects. Monitor patients taking medicines which are individually adjusted and metabolised by CYP450 3A4, 1A2 or 2C9 when starting or stopping RoACTEMRA, as doses may need to be increased to maintain therapeutic effect. The effect of tocilizumab on CYP450 enzyme activity may persist for several weeks after stopping therapy. Refer to SmPC for further details on the effects of RoACTEMRA on cytochrome CYP450. **Fertility, Pregnancy and Lactation:** No adequate data from use in pregnant women. Animal study showed an increased risk of spontaneous abortion/embryo-fetal death at high dose. RoACTEMRA should not be used during pregnancy unless clearly necessary. Women of childbearing potential should use effective contraception during and up to 3 months after treatment. No lactation data in humans. A decision on whether to continue/discontinue breastfeeding or RoACTEMRA therapy should be made taking into account the relative benefits to the child and mother. **Side Effects and Adverse Reactions:** RA: ADRs occurring in patients with RA receiving tocilizumab as monotherapy or in combination with MTX or other DMARDs: Very Common ($\geq 1/10$): upper respiratory tract infections and hypercholesterolaemia. Common ($\geq 1/100$ - $< 1/10$): cellulitis, pneumonia, oral herpes simplex, herpes zoster, abdominal pain, mouth ulceration, gastritis, rash, pruritus, urticaria, headache, dizziness, hepatic transaminases increased, weight increased, total bilirubin increased, hypertension, leucopenia, neutropenia, peripheral oedema, hypersensitivity reactions, conjunctivitis, cough and dyspnoea. sJIA: In general, the ADRs were similar to those seen in RA patients. Infections - Serious infections of varicella and otitis media reported. Infusion reactions - Hypersensitivity reactions requiring treatment discontinuation occurred in $< 1\%$ of patients. Other events occurring within 24 hours of infusion in 16% of patients included, but were not limited to rash, urticaria (considered serious), diarrhoea, epigastric discomfort, arthralgia and headache. IgG - decreased levels during therapy. Other - decreases in neutrophil and platelet counts, hepatic transaminase elevations, lipid parameter increases and anti-tocilizumab antibodies observed. **Serious or Potentially Serious:** active tuberculosis, invasive pulmonary infections, interstitial lung disease (including pneumonitis and pulmonary fibrosis), gastrointestinal perforations (as complications of diverticulitis), serious hypersensitivity reactions. Refer to SmPC for a complete listing of adverse events for RA and sJIA. **Legal Category:** Limited to sale and supply on prescription only. **Presentations and Marketing Authorisation Numbers:** 80mg of tocilizumab in 4ml (20mg/ml) pack of 1 (EU/1/08/492/001); 200mg of tocilizumab in 10ml (20mg/ml) pack of 1 (EU/1/08/492/003); 400mg of tocilizumab in 20ml (20mg/ml) pack of 1 (EU/1/08/492/005). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, United Kingdom. RoACTEMRA is a registered trade mark. Further information is available from Roche Products (Ireland) Limited, 3004 Lake Drive, Citywest, Naas Road, Dublin 24. Telephone: (01) 4690700. Fax: (01) 4690791. **Date of Preparation:** June 2012; p05/07/12. Copyright © 2012 by Roche Products (Ireland) Ltd. All rights reserved. **References:** 1. Nisar MK et al. The role of tocilizumab monotherapy in the management of rheumatoid arthritis: a review. Int. J. Clin. Rheumatol. (2012) 7(1): 9-19. 2. SmPC: RoACTEMRA (tocilizumab) Summary of Product Characteristics, 25 May 2012.





WELCOME

Dear Colleagues and Friends

I am delighted as President of The Irish Society for Rheumatology to welcome you all to our Spring Meeting in the very picturesque surroundings here in the Royal Marine hotel in Dunlaoire. I hope that you will find the occasion both interesting and stimulating and that you will have the opportunity of renewing old acquaintances and maybe forging some new ones.

Once again our academic organizing team from Connolly Hospital, namely Maurice Barry, Eithne Murphy and Trevor Duffy have done the Society proud by putting together a really diverse programme.

I am really looking forward to hearing Prof John Isaacs from Newcastle who will present on the topical area of "Biosimilars in Rheumatic Diseases". John is Director of the innovative Wilson Horne Immunotherapy Centre in Newcastle University. I look forward to hearing John who is renowned worldwide as a speaker of international repute.

On a similar vein Prof Piet van Riel comes to us from the University Medical Centre in Nijmegen in the Netherlands. Piet was for many years chair of the EULAR standing committee for International Clinical Studies, which included Therapeutic Trials. As a vastly experienced and active member of ACR, BSR and the Dutch Society of Rheumatology, Piet is an expert in biologics and inflammatory arthritis.

I would like to extend a warm welcome to our "local speakers" Dr Anne Gilleece, Dr Etaoin O'Keeffe and Dr Andrew McCann giving the meeting a sense of balance and their presentations range from the social aspects of medicine to relevant clinical updates.

Once again we owe a debt of gratitude to our friends in industry particularly in these challenging economic times and in particular our major sponsors for their continued support of our meetings. I would ask you to visit the stands and to recognize this ongoing financial contribution.

I would also like welcome members of the Health Professional Society who are joining us here today.

I hope that you all enjoy the meeting and I look forward to meeting with many of you in the course of the day.

Dr Gary Wright,
ISR President

Dr Gary Wright

Dr Wright qualified from Queens University in 1987 and was appointed Consultant Rheumatologist at the Royal Victoria Hospital and Musgrave Park Hospitals in Belfast in 1998. He is an Honorary Clinical lecturer at Queen's University Belfast.

He trained in Rheumatology in Belfast and spent a further year as Honorary Senior Registrar in Nottingham with Professor Mike Doherty.

His Research interests include the genetics of

osteoarthritis and crystal disease, early diagnosis and treatment of inflammatory arthritis and musculoskeletal ultrasound in rheumatic disorders. He is the Royal College of Physicians of London Northern Ireland Regional Advisor for Training.



ISR Presidents

Dr Gary Wright 2012 - Present
Belfast

Prof. G. Cunnane 2010 – 2012
Dublin

Dr. R. Kavanagh 2008-2010
Galway

Dr. J. Lee 2006-2008
Craigavon

Dr. P. O'Connell 2004-2006
Dublin

Prof. O. Fitzgerald 2002-2004
Dublin

Dr. A. Taggart 2000-2002
Belfast

Dr. D. Raman 1998-2000
Sligo

Dr. A. Bell 1996-1998
Belfast

Prof. B. Bresnihan 1994-1996
Dublin

Prof. M. Molloy 1992-1994
Cork

Dr. E. Casey 1990-1992
Dublin

Dr. S. Roberts 1988-1990
Belfast

Dr. C. Barry 1985-1987
Dublin

Dr. D. Roden 1983-1985
Dublin

Dr. W. Boyd 1981-1983
Belfast

Dr. T. Gregg 1979-1981
Dublin

Dr. J. Molony 1977-1979
Dublin

Dr. M. McMahon 1975-1977
Cork

Dr. T. O'Reilly 1973-1975
Dublin



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OUR NAME HAS CHANGED. OUR COMMITMENT TO RHEUMATOLOGY ENDURES.

The partner you once called Abbott is now AbbVie. Our name has changed but our commitment to join you in improving patient care does not. We stand by our promise to develop and deliver innovative medicines and work with you to elevate the standard of care in the treatment of rheumatic diseases.

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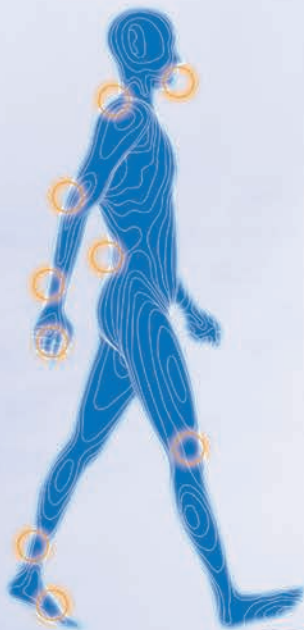
PROGRAMME ISR Spring Meeting
22nd March 2013, Royal Marine Hotel, Dun Laoghaire, Dublin

FRIDAY 22nd March

8.00a.m.	Pfizer symposium
10.00a.m.	Introduction & Welcome ISR President – Dr Gary Wright
10.10a.m.	1st Session Chair: Dr Eithne Murphy Vaccination and Biologic Agents Dr Anne Gilleece Microbiologist, Connolly Hospital, Dublin
10.55a.m.	Tea/Coffee
11.15a.m.	Biosimilars in Rheumatic diseases Prof John Isaacs Clinical Rheumatology and Director of the Wilson Horne Immunotherapy Centre, Newcastle University, United Kingdom
12.00p.m.	2nd Session Chair: Dr Claire Sheehy Foetal Medicine and the Rheumatologist Dr Etaoin Kent Research Fellow, The Rotunda Hospital, Dublin
12.45p.m.	LUNCH
2.00p.m.	3rd Session Chair: Dr Trevor Duffy Making welfare supports easier for your patients Dr Andrew McCann, Development Manager, Fingal Citizens' Information Service, Swords, Co. Dublin
2.45p.m.	Biologic dose reduction in inflammatory arthritis Prof P Van Riel Head of Department of Rheumatology, University Medical Centre Nijmegen, The Netherlands
3.45p.m.	Close of meeting

All the Sessions are kindly sponsored by AbbVie, MSD, Pfizer & Roche

DEMONSTRATED POWERFUL PAIN RELIEF^{1,a}



For the symptomatic relief of¹

Osteoarthritis^b **30-60mg**
once daily

Rheumatoid Arthritis **90mg**
once daily

Ankylosing Spondylitis **90mg**
once daily

For the short-term treatment of¹

Postoperative Moderate Dental Surgery Pain **NEW**
90mg
once daily,
maximum 3 days.

Acute Gouty Arthritis **120mg**
once daily,
maximum 8 days.

ARCOXIA® (etoricoxib) ABRIDGED PRODUCT INFORMATION

Refer to Summary of Product Characteristics before prescribing

PRESENTATION Tablets: 30mg, 60 mg, 90 mg and 120 mg tablets each containing 30mg, 60 mg, 90 mg or 120 mg of etoricoxib respectively. **USES** Symptomatic relief of osteoarthritis, rheumatoid arthritis (RA), ankylosing spondylitis (AS) and the pain and signs of inflammation associated with acute gouty arthritis. The short-term treatment of moderate pain associated with dental surgery. Base the decision to prescribe a selective COX-2 inhibitor on an assessment of the individual patient's overall risks. **DOSAGE AND ADMINISTRATION** Take orally with or without food. Onset of action may be faster when administered without food, and should be considered when rapid relief is needed. *Osteoarthritis*: 30 mg once daily. In some patients with insufficient relief from symptoms, an increased dose of 60 mg once daily may increase efficacy. *Rheumatoid arthritis*: 90 mg once daily. *Ankylosing spondylitis*: 90 mg once daily. For acute pain conditions, etoricoxib should be used only for the acute symptomatic period. *Acute gouty arthritis*: 120 mg once daily limited to a maximum of 8 days. *Postoperative dental surgery pain*: 90 mg once daily, limited to a maximum of 3 days. Some patients may require additional postoperative analgesia. Each dose above is the maximum recommended dose for each condition and should not be exceeded. As the cardiovascular risks of etoricoxib may increase with dose and duration of exposure, use for the shortest duration possible and use the lowest effective daily dose. Re-evaluate periodically the patient's need for symptomatic relief and response to therapy, especially in osteoarthritis patients. **Hepatic insufficiency**: mild (Child-Pugh score 5-6): regardless of indication, do not exceed a dose of 60 mg daily; moderate (Child-Pugh score 7-9): regardless of indication, do not exceed 30 mg once daily. **Renal insufficiency**: No dosage adjustment necessary for patients with creatinine clearance ≥ 30 ml/min. **CONTRA-INDICATIONS** History of hypersensitivity to any component of this product. Active peptic ulceration or gastro-intestinal (GI) bleeding. Patients who have experienced bronchospasm, acute rhinitis, nasal polyps, angioneurotic oedema or urticaria or allergic type reactions after aspirin or NSAIDs including COX-2 inhibitors. Pregnancy and lactation. Severe hepatic dysfunction (serum albumin < 25 g/l or Child-Pugh score ≥ 10). Estimated creatinine clearance < 30 ml/min. Children and adolescents under 16 years of age. Inflammatory bowel disease. Congestive heart failure (NYHA II-IV). Patients with hypertension whose blood pressure is persistently elevated above 140/90 mmHg and has not been adequately controlled. Established ischaemic heart disease, peripheral arterial disease and/or cerebrovascular disease. **PRECAUTIONS** Gastro-intestinal effects Upper GI complications (perforations, ulcers or bleedings), some with fatal outcome have occurred in patients taking etoricoxib. Caution is advised in patients most at risk of developing a GI complication with NSAIDs: elderly, those on other NSAID or aspirin concomitantly, or those with a prior history of GI disease. There is a further increase in the risk of GI adverse effects (GI ulceration or other GI complications) when etoricoxib is taken together with aspirin (even at low doses). A significant difference in GI safety between selective COX-2 inhibitors + acetylsalicylic acid vs NSAIDs + acetylsalicylic acid has not been demonstrated in long-term clinical trials. **Cardiovascular** Clinical trials suggest that the selective COX-2 inhibitor class of drugs may be associated with a risk of thrombotic events (especially MI and stroke), relative to placebo and some NSAIDs. As the cardiovascular risks of etoricoxib may increase with dose and duration of exposure, use for the shortest duration possible and use the lowest effective daily dose. Re-evaluate periodically the patient's need for symptomatic relief and response to therapy, especially in those with osteoarthritis. Patients with significant risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking) should only be treated with etoricoxib after careful consideration. COX-2 selective inhibitors are not a substitute for acetylsalicylic acid for prophylaxis of cardiovascular thromboembolic diseases because of their lack of antiplatelet effect. Therefore antiplatelet therapies should not be discontinued. **Renal effects** Consider monitoring renal function in patients with pre-existing significantly impaired renal function, uncompensated heart failure, or cirrhosis. **Fluid retention, oedema and hypertension** Exercise caution in patients with a history of cardiac failure, left ventricular dysfunction, or hypertension and pre-existing oedema from any other reason, as fluid retention, oedema and hypertension have been observed in patients taking etoricoxib. All Nonsteroidal Antiinflammatory Drugs (NSAIDs), including etoricoxib, can be associated with new onset or recurrent congestive heart failure. Take appropriate measures, including discontinuation of etoricoxib where there is clinical evidence of deterioration in the condition of these patients. Etoricoxib may be associated with more frequent and severe hypertension than some other NSAIDs and selective COX-2 inhibitors, particularly at high doses. Therefore, hypertension should be controlled before treatment with etoricoxib (see section 4.3) and special attention should be paid to blood pressure monitoring during treatment with etoricoxib. Blood pressure should be monitored within two weeks after initiation of treatment and periodically thereafter. If blood pressure rises significantly, consider alternative treatment. **Hepatic effects** Elevations of ALT and/or AST (> 3 times the upper limit of normal) have been reported in approximately 1% of patients treated in trials with etoricoxib 30mg, 60 mg and 90 mg for up to one year. Monitor any patient with symptoms/signs of liver dysfunction or in whom an abnormal liver function test has occurred. Discontinue etoricoxib if signs of hepatic insufficiency occur, or if persistently abnormal liver function tests (3 times the upper limit of normal) are detected. **General** Take appropriate measures and consider discontinuation, if during treatment, patients deteriorate in any of the organ system functions described above. Maintain appropriate medical supervision when treating the elderly and patients with renal, hepatic or cardiac dysfunction with etoricoxib. Use caution when initiating treatment in patients with considerable dehydration. Rehydrate patients prior to starting therapy with etoricoxib. Serious skin reactions, some of them fatal, including exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis have been reported very rarely, associated with the use of NSAIDs and some selective COX-2 inhibitors. Discontinue at the first signs of skin rash, mucosal lesions or any other signs of hypersensitivity as hypersensitivity reactions (anaphylaxis, angioedema) have been reported. Etoricoxib may mask fever. Use of etoricoxib is not recommended in women attempting to conceive. 'Arcoxia' tablets contain lactose: do not use in patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption. **Interactions (pharmacodynamic):** *Oral anticoagulants*: Exercise caution when coadministering with warfarin and other oral anticoagulants. Closely monitor the prothrombin time INR when therapy with etoricoxib is initiated or the dose changed in patients receiving oral anticoagulants or similar agents, particularly in the first few days. *Diuretics, ACE-inhibitors and Angiotensin II Antagonists*: NSAIDs may reduce the effect of diuretics and antihypertensive drugs. In some patients with compromised renal function, the co-administration of an ACE inhibitor or AIIA and cyclo-oxygenase inhibitors may result in further deterioration of renal function including possible acute renal failure, which is usually reversible. Administer cautiously, especially in the elderly. Patients should be adequately hydrated. Consider monitoring renal function at initiation of therapy and periodically thereafter. *Aspirin*: etoricoxib can be used concomitantly with aspirin at doses used for cardiovascular prophylaxis (low dose aspirin). However, concomitant administration of low dose aspirin with etoricoxib may result in an increased rate of GI ulceration or other complications compared to use of etoricoxib alone. Concomitant administration of etoricoxib with doses of aspirin above those for cardiovascular prophylaxis, or with other NSAIDs is not recommended. *Ciclosporin/tacrolimus*: monitor renal function when etoricoxib and either ciclosporin or tacrolimus is used in combination. **Interactions (pharmacokinetic)** The effect of etoricoxib on the pharmacokinetics of other drugs: Lithium: the plasma concentration of lithium is

increased by NSAIDs, therefore monitor and adjust blood lithium and lithium dosage if necessary. *Methotrexate*: adequate monitoring is recommended for methotrexate-related toxicity when etoricoxib and methotrexate are administered concomitantly. *Oral Contraceptives (OC)*: Administration of etoricoxib 60 mg with an OC containing 35 mcg ethinyl estradiol (EE) and 0.5 to 1 mg norethindrone for 21 days increased the steady state AUC_{0-24h} of EE by 37%. Administration of etoricoxib 120 mg with the same OC, concomitantly or separated by 12 hours, increased the steady state AUC_{0-24h} of EE by 50 to 60%. Consider this increase in EE concentration when selecting an oral contraceptive for use with etoricoxib. An increase in EE exposure can increase the incidence of adverse events associated with oral contraceptives. *Hormone Replacement Therapy*: 120 mg etoricoxib administered with 0.625 mg Premarin™ (Wyeth) for 28 days increased the mean steady state AUC_{0-24h} of unconjugated estrone (41%), equilin (76%) and 17- β -estradiol (22%). Although the clinical significance is unknown, take into consideration the increase in estrogenic concentration when selecting HRT as the increase in estrogen exposure might increase the risk of adverse events associated with HRT. *Digoxin*: Patients at high risk of digoxin toxicity should be monitored for an increase in digoxin C_{max} when etoricoxib and digoxin are administered concomitantly. *Effect of etoricoxib on drugs metabolised by sulfo-transferases*: Etoricoxib is an inhibitor of human sulfo-transferase activity, particularly SULT1E1 and has been shown to increase the serum concentrations of ethinyl estradiol. It may be prudent to exercise care when administering etoricoxib concurrently with other drugs primarily metabolised by human sulfo-transferases (e.g. oral salbutamol and minoxidil). *Effect of etoricoxib on drugs metabolised by CYP isoenzymes*: Based on in vitro studies, etoricoxib is not expected to inhibit cytochromes P450 (CYP) 1A2, 2C9, 2C19, 2D6, 2E1 or 3A4. In a study in healthy subjects, daily administration of etoricoxib 120 mg did not alter hepatic CYP3A4 activity as assessed by the erythromycin breath test. *Effects of other drugs on the pharmacokinetics of etoricoxib*: The main pathway of etoricoxib metabolism is dependent on CYP enzymes. CYP3A4 appears to contribute to the metabolism of etoricoxib in vivo. *Ketoconazole*: a potent inhibitor of CYP3A4, dosed at 400 mg once a day for 11 days to healthy volunteers did not have any clinically important effect on the single-dose pharmacokinetics of 60 mg etoricoxib (43% increase in AUC). *Voriconazole and Miconazole*: Co-administration of either oral voriconazole or topical miconazole oral gel, strong CYP3A4 inhibitors, with etoricoxib caused a slight increase in exposure to etoricoxib, but is not considered to be clinically meaningful based on published data. *Rifampicin*: Co-administration of etoricoxib with rifampicin, a potent inducer of CYP enzymes, produced a 65% decrease in etoricoxib plasma concentrations, an interaction which may result in recurrence of symptoms. *Antacids*: Antacids do not affect the pharmacokinetics of etoricoxib to a clinically relevant extent. **Pregnancy**: contra-indicated in the first, second and third trimesters of pregnancy. **Lactation**: contra-indicated. **SIDE EFFECTS** The following undesirable effects were reported at an incidence greater than placebo in clinical trials in patients with OA, RA, AS or chronic low back pain treated with etoricoxib 30 mg, 60 mg or 90 mg for up to 12 weeks, or in post-marketing experience: [Very common ($\geq 1/100$) Common ($\geq 1/100$ to $< 1/100$) Uncommon ($\geq 1/1000$ to $< 1/100$) Rare ($\geq 1/10,000$ to $< 1/1000$) Very rare ($< 1/10,000$) not known (cannot be estimated from the available data)] **Infections and infestations**: Common: alveolar osteitis Uncommon: gastroenteritis, upper respiratory infection, urinary tract infection. **Blood and lymphatic system disorders**: Uncommon: anaemia (primarily associated with gastrointestinal bleeding), leukopenia, thrombocytopenia. **Immune system disorder**: Very rare: hypersensitivity reactions including angioedema, anaphylactic/anaphylactoid reactions including shock. **Metabolism and nutrition disorders**: Common: oedema/fluid retention Uncommon: appetite increase or decrease, weight gain. **Psychiatric disorders**: Uncommon: anxiety, depression, mental acuity decreased. Very rare: confusion, hallucinations. **Nervous system disorder**: Common: dizziness, headache. Uncommon: dysgeusia, insomnia, paraesthesia/hypaesthesia, somnolence. **Eye disorders**: Uncommon: blurred vision, conjunctivitis. **Ear and labyrinth disorders**: Uncommon: tinnitus, vertigo. **Cardiac disorders**: Common: palpitations Uncommon: atrial fibrillation, congestive heart failure, non-specific ECG changes, angina pectoris, myocardial infarction*. **Not known**: tachycardia. **Vascular disorders**: Common: hypertension. Uncommon: flushing, cerebrovascular accident*, transient ischaemic attack. Very rare: hypertensive crisis. **Not known**: vasculitis. **Respiratory, thoracic and mediastinal disorders**: Uncommon: cough, dyspnoea, epistaxis. Very rare: bronchospasm. **Gastro-intestinal disorders**: Common: gastro-intestinal disorders (e.g. abdominal pain, flatulence, heartburn), diarrhoea, dyspepsia, epigastric discomfort, nausea. Uncommon: abdominal distention, acid reflux, bowel movement pattern change, constipation, dry mouth, gastrooduodenal ulcer, irritable bowel syndrome, oesophagitis, oral ulcer, vomiting, gastritis. Very rare: peptic ulcers including gastro-intestinal perforation and bleeding (mainly in the elderly). **Not known**: pancreatitis. **Hepatobiliary disorders**: Common: ALT increased, AST increased. Very rare: hepatitis. **Not known**: jaundice. **Skin and subcutaneous tissue disorders**: Common: ecchymosis Uncommon: facial oedema, pruritus, rash. Rare: erythema. Very rare: urticaria, Stevens-Johnson syndrome, toxic epidermal necrolysis. **Musculoskeletal, connective tissue and bone disorders**: Uncommon: muscular cramp/spasm, musculoskeletal pain/stiffness. **Renal and urinary disorders**: Uncommon: proteinuria, serum creatinine increased. Very rare: renal insufficiency, including renal failure, usually reversible upon discontinuation of treatment. **General disorders and administration site conditions**: Common: asthenia/fatigue, flu-like disease. Uncommon: chest pain. **Investigations**: Uncommon: blood urea nitrogen increased, creatine phosphokinase increased, hyperkalaemia, uric acid increased. Rare: blood sodium decreased. The following serious undesirable effects have been reported in association with the use of NSAIDs and cannot be ruled out for etoricoxib: nephrotoxicity including interstitial nephritis and nephrotic syndrome; hepatotoxicity including hepatic failure. * Based on analyses of long-term placebo and active controlled clinical trials, selective COX-2 inhibitors have been associated with an increased risk of serious thrombotic arterial events, including myocardial infarction and stroke. The absolute risk for such events is unlikely to exceed 1% per year based on existing data (uncommon). **PACKAGE QUANTITIES** 30 mg, 60 mg and 90 mg Tablets: packs of 28 tablets 120 mg Tablets: packs of 7 and 28 tablets **Marketing Authorisation numbers** Tablets 30 mg PA 1286/7/1 Tablet 60 mg PA 1286/7/2 Tablet 90 mg PA 1286/7/3 Tablet 120 mg PA 1286/7/4 **Marketing Authorisation holder** Merck Sharp & Dohme Ireland (Human Health) Limited Red Oak North, South County Business Park, Leopardstown, Dublin 18. Date of review: July 2012. © Merck Sharp & Dohme Ireland (Human Health) Limited 2012. All rights reserved. Legal Category: POM Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie. Date of preparation: January 2013. **References**: 1. Arcoxia SPC. a. Doses greater than those recommended for each indication have either not demonstrated additional efficacy or have not been studied. Due to cardiovascular risks, the shortest duration possible and the lowest effective daily dose of ARCOXIA® should be used. b. The recommended dose for osteoarthritis is 30 mg once daily. An increased dose of 60 mg once daily may increase efficacy. The dose for osteoarthritis should not exceed 60 mg daily.



Academic Organising Team: Connolly Hospital

Dr Maurice Barry

Dr Maurice Barry qualified in Medicine in Dublin in 1982. He trained in Internal Medicine in Dublin and in Rheumatology in Dublin and Cambridge, UK. He has been a Consultant Rheumatologist at Connolly Hospital Dublin since 1994. His main rheumatological interest is in the optimal use of biologic agents in inflammatory arthritis.



Dr Eithne Murphy

Dr Eithne Murphy qualified from UCD in 1991. She completed her SpR training in Rheumatology and General Internal Medicine in Dublin. After a brief period working as a Clinical Fellow in Addenbrooke's Hospital Cambridge she returned to take up her current position as Consultant Rheumatologist in Connolly Hospital Blanchardstown in 2002. She was awarded an MD from UCD in 2003 for her thesis entitled 'Periarticular and Axial Bone Loss in Early Inflammatory Arthritis'. Dr Murphy has recently been appointed as an Honorary Senior Clinical Lecturer with the Royal College of Surgeons in Ireland.



Dr Trevor Duffy

Consultant Rheumatologist, Connolly Hospital, Dublin 15. Graduated UCD & RCSI 2003, Rheumatology Research Fellow UCD 2000/04, Clinical Director, Connolly Hospital (Present), Senior Lecturer in Medicine RCSI, Chief Resident, SVUH 1999/2000, Chef de Clinique, University Hospital Geneva.



Speakers

Dr Anne Gilleece

Dr Anne Gilleece, MB BCH BAO, FRCPI, FRCPath, BSc (Hons) Graduated from University College Dublin Medical School in 1987. General professional training completed prior to commencing training in Clinical Microbiology. Trained in Clinical Microbiology in St James Hospital, St Vincents Hospital and National Virus Reference Laboratory. Also completed a year training in Infectious diseases in Beaumont Hospital during this time. Appointed as Consultant Microbiologist in Connolly Hospital, Blanchardstown in 2001 and remains in this post currently. In addition from 2007-2009 was Lecturer in Clinical Microbiology for the Graduate Entry Medical Programme in RCSI.

Professor John Isaacs

John Isaacs is Professor of Clinical Rheumatology and Director of the Wilson Horne Immunotherapy Centre at Newcastle University, and consultant rheumatologist at the Freeman Hospital.

He graduated from London University with a first class degree in Physiology and Medicine, followed by junior posts in London (Hammersmith Hospital) and Harvard (Beth Israel Hospital). He was subsequently registrar on the Hammersmith Renal Unit before moving to Cambridge with MRC funding, to read for his PhD in Immunology.

Over the past 20 years his work has focused on the potential of novel immunotherapies to treat rheumatoid arthritis, ranging from target identification to early and late stage clinical trials. He has performed several pioneering translational studies in patients with inflammatory disease, challenging existing dogma and informing the design of subsequent generations of therapeutic agents.

Currently his team is preparing for a first-into-man study, in rheumatoid arthritis patients, of a tolerogenic dendritic cell vaccine that has been developed in Newcastle. In 1999 he received the British Society for Rheumatology Michael Mason Medal, awarded for excellence in clinical or scientific research, and in 2010 presented to 'Heberden Round' to the Society.

John Isaacs moved to Newcastle University in 2002, where he developed the translational and innovative Wilson Horne Immunotherapy Centre for early phase studies of novel immunotherapeutics. Nationally he chairs the Arthritis Research Campaign's Clinical Study Group for Inflammatory Arthritis, developing an internationally competitive research strategy for the UK. He is also a member of the Committee for the Safety of Medicine's Expert Advisory Group on Clinical Trials.



ARTHRITIS IRELAND'S SERVICE INNOVATION & GRANTS PROGRAMME



Arthritis Ireland

2012 WINNERS

Arthritis Ireland's Service Innovation Awards and Grants Programme celebrates Arthritis Ireland's three decades of commitment and support to improving patient services as well as academic advancements in Ireland.

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1. Research Assistant Grant: *(Sponsored by Roche)*

Noirin Nealon Lennox, Waterford Regional Hospital

Subject: Acceptance and change in a rheumatology pain management programme

2. Innovation in Patient Healthcare: *(Sponsored by MSD)*

Dr Malik Aizad Mumtaz, Cork University Hospital

Subject: Establishment of video capillaroscopy service for early identification of patients with life-threatening features of scleroderma

3. Educational Project: *(Sponsored by Abbvie)*

a. **Oriel Corcoran**, Waterford Regional Hospital, &

Eimear Lyons, Our Ladies Hospice, Harold's Cross

Subject: Fit for Work Strategies and Solutions

b. **Dr Alan Barry**, **Dr Darragh O'Neill** & **Prof Oliver FitzGerald**

St Vincent's University Hospital

Subject: Development of a web-based rheumatology educational programme for GP trainees

4. Education Travel:

Alexander Businos & **Niall Halliday**, Beaumont Hospital

Subject: Integrated Hand Therapy Clinic



abbvie

Presentations will be made to each of the winners at the Irish Society for Rheumatology autumn conference.

For more details go to:
arthritisireland.ie/awards



Arthritis Ireland

Little Things make a Big Difference



Dr Etaoin Kent

Dr Kent is a Lecturer with the Royal College of Surgeons in Ireland at the Rotunda Hospital. She works in the perinatal unit with Prof Fergal Malone. She has interests in perinatal medicine, publishing research on topics including placental health, twin pregnancies and eclampsia. She teaches on the topic of prenatal diagnosis both in the RCSI and on the Trinity MSc in Clinical Chemistry.

Professor Piet van Riel

Prof. dr. Piet van Riel is Head of the Department of Rheumatology at the University Medical Centre Nijmegen, The Netherlands. After graduating in Medicine from the Catholic University of Nijmegen in 1978, Prof Dr van Riel trained in Internal Medicine at St. Radboud Hospital, Nijmegen. In 1983 he completed his PhD thesis and went on to receive rheumatology training at the Academic Hospital Nijmegen.



Prof. dr. van Riel is an active member of many professional societies, including the Dutch Society of Rheumatology, of which he was Chairman from 2003 up to 2009, the American College of Rheumatology and the British Society of Rheumatology. From 1999 to 2003 he was Chairman of the EULAR Standing Committee for International Clinical Studies Including Therapeutic Trials.

Prof. dr. van Riel's research interests include clinical research in rheumatology, clinical pharmacology and clinimetrics. He is on the editorial board of a number of journals, and has authored or co-authored several books and over 500 international publications with currently a h-index of 49 Clinimetrics in Rheumatology.

The development, validation and implementation of methods to assess the disease in different rheumatic diseases both in randomized clinical trials as well as in daily clinical practice.

Dr Andrew McCann

Andrew McCann has an in-depth knowledge of the taxation and social welfare systems in Ireland and is known nationwide for his clear, direct and relevant advice on all things related to social and civic entitlements and rights. Author of the well-known Know Your Rights: A Guide to Your Social and Civic Entitlements and Know Your Rights: A Practical Guide to Living in Challenging Times, Andrew is a frequent guest on national and local radio and TV3's Ireland AM. Andrew is also the development manager of the Fingal Citizens' Information Service in Swords, Co. Dublin.

ISR Board Members

Professor David Kane

Prof David Kane attended medical school at Trinity College, Dublin, Ireland and was conferred MB BCh BAO BA in 1991, PhD in 2002 and FRCPI in 2006. He has trained in rheumatology with Prof. Barry Bresnihan and Prof. Oliver FitzGerald at St. Vincent's University Hospital, Dublin, Ireland and with Prof Roger Sturrock, Prof Iain McInnes and Dr Peter Balint at Glasgow Royal Infirmary, Glasgow, United Kingdom. He was appointed as Senior Lecturer in Rheumatology at the University of Newcastle in 2003 and is currently working as Consultant Rheumatologist at the Adelaide and Meath Hospital and Clinical Professor in Rheumatology at Trinity College Dublin. His special interests are musculoskeletal ultrasound, spondyloarthritis and arthroscopy and synovial biology. He is a member of the European Working Party on Musculoskeletal Ultrasound and the OMERACT special interest group on musculoskeletal ultrasound, previous organiser of the BSR Musculoskeletal Ultrasound course and is Faculty member of the EULAR Musculoskeletal ultrasound course. He has served as a Board member of the Irish Osteoporosis Society and is currently Honorary Treasurer of the Irish Society for Rheumatology.



Dr Sinéad Harney

Dr Sinéad Harney graduated from UCG in 1994 and did her specialist training in Rheumatology and General Medicine in Dublin. She completed her training in Oxford in 2005 and was awarded a DPhil by thesis titled "Major Histocompatibility Genetics of Rheumatoid Arthritis". She was appointed to a Consultant Rheumatologist post in Cork University Hospital in 2005 and has worked there since. She completed a Masters in Sports and Exercise Medicine in UCC in 2007. Her research interests include – Genetics of inflammatory arthritis and occult cardiovascular disease in Rheumatoid Arthritis and she has over 40 publications. She is currently the secretary of the Irish Society of Rheumatology and a board member of the TUE committee of the Irish Sports Council



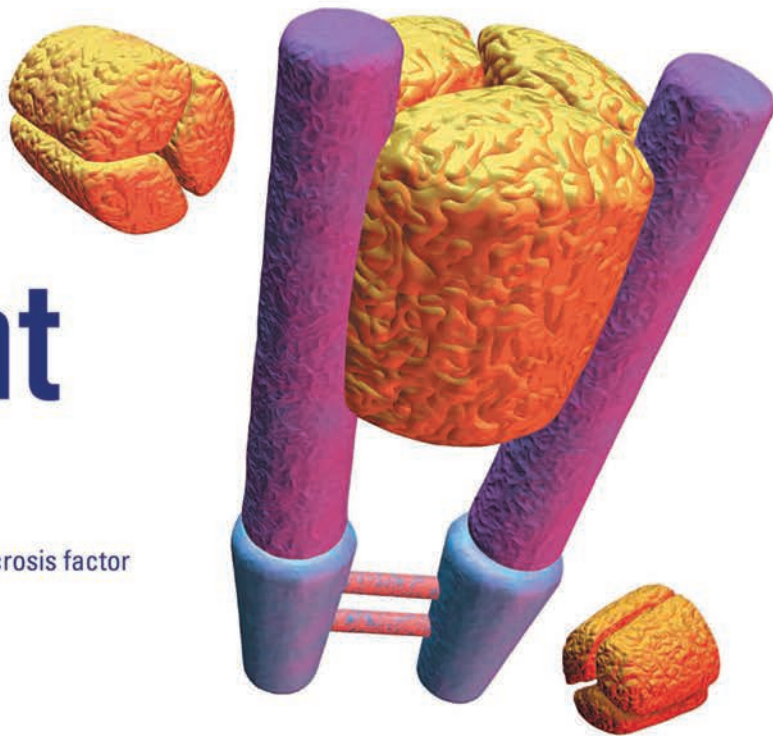
Professor Gaye Cunnane

PhD, MB, FRCPI

Gaye Cunnane is a Clinical Professor in Rheumatology at Trinity College Dublin (TCD) and a Consultant Rheumatologist at St James's Hospital. After graduating from TCD, she completed her basic clinical training and then undertook research studies examining key prognostic markers in early inflammatory arthritis under the guidance of Profs Barry Bresnihan and Oliver FitzGerald, in association with units in Zurich, Cambridge, Stockholm and Leiden. This was followed by a 3 year clinical and research Fellowship at the University of California San Francisco, USA. She then moved to the UK as Senior Lecturer at the University of Leeds. In 2003, she returned to Ireland to take up her current consultant post. Professor Cunnane has been the National Specialty Director in Rheumatology since 2005 and oversees a comprehensive



ENBREL is Different



A unique mechanism of action

- Enbrel is the only fully human soluble tumour necrosis factor (TNF) receptor^{1,2,3,4,5,6}
- It works differently than MAB's¹

No neutralising antibodies¹

- Enbrel is not associated with the production of neutralising antibodies in humans

Enbrel has a short half life (<3 days)¹

- The half-life of anti-TNF agents should be taken into account if a treatment break is required

Efficacy

- Registry data and Cochrane Review data support efficacy & safety of Enbrel^{7,8}



ABBREVIATED PRESCRIBING INFORMATION Before prescribing Enbrel® please refer to full Summary of Product Characteristics (SmPC).

Presentation: Enbrel Pre-filled Syringe: Enbrel 25 mg and 50 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains either 25 mg or 50 mg etanercept. Enbrel Pre-filled Pen (MYCLIC®): Enbrel 50 mg solution for injection in pre-filled pen. Each pre-filled pen contains 50 mg etanercept. Enbrel Powder: Enbrel 25 mg powder and solvent for solution for injection. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel Paediatric: Enbrel 10 mg powder and solvent for solution for injection for paediatric use. Each vial contains 10 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel 25 mg/ml powder and solvent for solution for injection for paediatric use. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml bacteriostatic water for injections. **Uses:** Adults: Moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, when response to DMARDs, including methotrexate (unless contraindicated), has been inadequate. Enbrel can be given as monotherapy in the case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Severe, active and progressive RA without prior methotrexate treatment. Enbrel alone or with methotrexate has been shown to reduce the rate of progression of joint damage measured by X-ray and to improve physical function. Patients with moderate to severe plaque psoriasis (PP) who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporin, methotrexate or PUVA. Active and progressive psoriatic arthritis (PsA) when response to DMARDs has been inadequate. Enbrel has been shown to improve physical function in PsA patients, and to reduce the progression rate of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of PsA. Severe active ankylosing spondylitis (AS) when response to conventional therapy has been inadequate. Children aged 2-17 years (25 mg only): Active polyarticular juvenile idiopathic arthritis (JIA) when inadequate response to, or intolerant of methotrexate. Children aged 6-17 years: Chronic severe psoriasis when inadequately controlled by, or intolerant to, other systemic therapies or phototherapies. **Dosage:** By subcutaneous injection. Adults: RA – 25 mg twice weekly or 50 mg once weekly PP – 25 mg twice weekly or 50 mg once weekly for up to 24 weeks, or 50 mg twice weekly for up to 12 weeks followed by 25 mg twice weekly or 50 mg once weekly for a further 12 weeks if needed. Continuous therapy may be appropriate for some adult patients. Discontinue if no response after 12 weeks. For re-treatment: 25 mg twice weekly or 50 mg once weekly for up to 24 weeks. AS and PsA – 25 mg twice weekly or 50 mg once weekly. Children aged 2-17 years: JIA in children aged 2-17 years – 0.4 mg/kg (maximum per dose 25 mg) twice weekly with an interval of 3 – 4 days. Discontinuation of treatment should be considered in patients who show no response after 4 months. Children aged 6-17 years: Plaque psoriasis in children aged 6-17 years – 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. Discontinue if no response after 12 weeks. For re-treatment: 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. **Contra-indications:** Hypersensitivity to any of the ingredients, sepsis or risk of sepsis, active infections. Enbrel Paediatric (25 mg): Must not be given to premature babies or neonates as the bacteriostatic water for injections contains benzyl alcohol. **Warnings and Precautions:** Enbrel should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA, JIA, PsA, AS, PP or Paediatric PP. Patients treated with Enbrel should be given the Patient Alert Card. Use carefully in patients predisposed to, or with history of, infection due to

underlying diseases other than RA (e.g. advanced or poorly controlled diabetes) or with history of blood dyscrasias, pre-existing or predisposition to demyelinating disease or congestive heart failure. Cases of active tuberculosis have been reported, therefore all patients should be evaluated for both active and inactive TB prior to being treated with Enbrel. If active TB is diagnosed, Enbrel should not be initiated. Caution should be used when administering Enbrel to patients identified as carriers of hepatitis B virus and there have been reports of worsening hepatitis C in patients receiving Enbrel. Use with caution in patients with a history of hepatitis C. Whether treatment with Enbrel might influence the development and course of active and/or chronic infections is unknown. Concurrent administration of Enbrel and anakinra has been associated with increased risk of serious infections and neutropenia, and is therefore not recommended. In clinical studies, concurrent administration of abatacept and Enbrel resulted in increased incidences of serious adverse events, and is therefore not recommended. Use caution when considering combination therapy with sulfasalazine. Reports of various malignancies have been received in the post-marketing period, therefore with current knowledge, a possible risk for the development of lymphomas, leukaemia or other haematopoietic or solid malignancies in patients treated with a TNF-antagonist cannot be excluded. Malignancies, some fatal, have been reported among children, adolescents and young adults (up to 22 years of age) treated with TNF-antagonists (initiation of therapy ≤ 18 years of age) in the postmarketing setting. Melanoma and non-melanoma skin cancer (NMSC) have been reported in patients treated with TNF-antagonists, including Enbrel. Post-marketing cases of Merkel cell carcinoma have been reported very infrequently in patients treated with Enbrel. Periodic skin examination is recommended for all patients, particularly those with risk factors for skin cancer. Enbrel has not been studied in combination with other systemic therapies or phototherapy for the treatment of psoriasis. Monitor closely if patient develops new infection during treatment. Discontinue treatment if serious infection or allergic reaction develops or if blood dyscrasias are confirmed. Caution should be used in patients who have moderate to severe alcoholic hepatitis and Enbrel should not be used in patients for the treatment of alcoholic hepatitis. Discontinue temporarily if significantly exposed to varicella virus. Live vaccines should not be given concurrently with Enbrel. Paediatric patients should have received all vaccines recommended in current immunization guidelines prior to starting Enbrel. Treatment with Enbrel may result in the formation of autoantibodies. Enbrel is not recommended for the treatment of Wegener's granulomatosis. There have been reports of hypoglycaemia in Enbrel patients receiving medication for diabetes, necessitating a reduction in anti-diabetic medication in some of these patients. There have been reports of Inflammatory Bowel Disease (IBD) in JIA patients being treated with Enbrel. Caution should be exercised when treating the elderly and with particular attention to occurrence of infections. Enbrel Paediatric (25 mg): Contains benzyl alcohol as an excipient, which may cause toxic and/or anaphylactic reactions in infants and children up to 3 years old. **Pregnancy & Lactation:** Enbrel is not recommended in pregnant or breast-feeding women. **Undesirable Effects:** Adults: The most commonly reported adverse reactions are injection site reactions, infections, allergic reactions, development of autoantibodies, itching, and fever. See SmPC for less commonly reported side effects. TNF-antagonists, such as Enbrel, affect the immune system and their use may affect the body's defenses against infection and cancer. Serious infections affect fewer than 1 in 100 patients treated with Enbrel. Reports have included fatal and life threatening infections and sepsis. Various

malignancies have also been reported with use of Enbrel, including cancers of the breast, lung, skin and lymph glands (lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia and very rare reports of aplastic anaemia. Central and peripheral demyelinating events have been seen rarely and very rarely, respectively, with Enbrel use. There have been rare reports of lupus, lupus-related conditions, and vasculitis. Rate of new malignancies was similar to that expected for the population studied. Fatalities associated with serious infections, pancytopenia, aplastic anaemia and interstitial lung disease have also been reported. Paediatrics: Generally as for adults, except the following were more common: headaches, nausea, vomiting and abdominal pain. In addition the following were reported as severe events: varicella, appendicitis, gastroenteritis, depression/personality disorder, cutaneous ulcer, oesophagitis/gastritis, group A streptococcal septic shock, type I diabetes mellitus and soft tissue and post operative wound infection. There have been post-marketing reports of IBD in JIA patients, including cases indicating a positive re-challenge. **Legal Category:** POM. **Package Quantities:** Enbrel Pre-filled Syringe: Each carton contains 4 pre-filled syringes containing either 25 mg or 50 mg of Enbrel and 4 alcohol swabs. Enbrel Pre-filled Pen (MYCLIC): Each carton contains 4 pre-filled pens containing 50 mg of Enbrel and 4 alcohol swabs. Enbrel Powder: Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (10 mg): Each carton contains 4 vials of Enbrel 10 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (25 mg): Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of bacteriostatic water for injections, 8 empty plastic syringes, 20 needles and 24 alcohol swabs. **European Marketing Authorisation Numbers:** Enbrel Pre-filled Syringe 25 mg: EU/1/99/126/013 Enbrel Pre-filled Syringe 50 mg: EU/1/99/126/017 Enbrel Pre-filled Pen (MYCLIC) 50 mg: EU/1/99/126/020 Enbrel Powder 25 mg: EU/1/99/126/003 Enbrel Paediatric 10 mg: EU/1/99/126/022 Enbrel Paediatric 25 mg: EU/1/99/126/012. **European Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ, UK. For full prescribing information see the Summary of Product Characteristics. **Further information is available on request from:** Pfizer Healthcare Ireland, 9 Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24, telephone: +353 1 467 6500. **Medical Information:** 1 800 633 363. **API Reference Number:** EN 3_0. **Date of Prescribing Information:** January 2012.

References: 1. Enbrel SPC July 2010 2. Remicade SPC 3. Humira SPC 4. Orencia SPC 5. Mabthera SPC 6. Simponi SPC 7. Singh J et al. CMAJ: 2009;DOI:10.1503 8. Hetland ML et al. Arthritis & Rheumatism. Vol 62, no 1, January 2010.

Date of preparation: February 2012

ENB/2012/015





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DAY 1: Speakers & Clinical Oral Presenters

a.m. Thursday 20th Sept 2012 - Eupropa Hotel (Belfast)



Audience Participation



Prof Ian Bruce (University of Manchester):
'Lupus and Cardiovascular Risk'



Prof Rodney Grahame (UCH London): 'Is benign Joint hypomobility really Ehlers-Danlos Syndrome afterall?'



Niel Liggett (Craigavon Area Hospital) & Douglas Veale (SVUH)



Ismail Mohammad (Waterford Regional Hospital)



Catherine Sullivan (CUH)



Ausaf Mohammad (Galway University Hospitals)



Emese Balogh (SVUH)



teaching programme for Specialist Registrars in the Republic of Ireland. She is also the Director for Basic Specialist Training (Trinity Scheme) at the Royal College of Physicians of Ireland and has additional roles as Intern Tutor for TCD and Director of Post-graduate Training at St James's Hospital. She has established a clinical research programme in Rheumatology at St James's and is author of over 50 original publications. Her particular interests include teaching, early arthritis, connective tissue disorders and cardiovascular disease.

Dr Sandy Fraser

Consultant Rheumatologist, General Physician and Honorary Senior Lecturer Mid-Western Regional Hospitals, Dooradoyle, Limerick Dr. Alexander Fraser graduated in medicine from Trinity College Dublin in 1991. He began practicing Rheumatology in 1996 and the following year was appointed Specialist Registrar in Rheumatology at the Yorkshire Deanery. Training with Professor Emery's group in Leeds he developed a research interest in clinical, immunological and therapeutic aspects of Rheumatoid Arthritis, Psoriatic Arthritis and the Seronegative Spondyloarthropathies. He was appointed Consultant Rheumatologist and Honorary Senior Lecturer at the Leeds Teaching Hospitals NHS Trust, working at The Leeds General Infirmary and St James University Hospital, in October 2001 and working closely with Professor Paul Emery and Professor Doug Veale he has published in the area of Angiogenesis, Vascularity and Inflammation in early and established arthritis and Biomarkers of cartilage turnover. Dr Fraser took up his current appointment as Consultant Rheumatologist, General Physician and Honorary Senior Lecturer in the Mid-Western Region in August 2006.



Donough Howard

Donough Howard is a Consultant Rheumatologist at St James's Hospital and Hermitage Medical Clinic. He graduated from RCSI and completed postgraduate training both in Ireland and the US. He previously worked in Lahey Clinic Medical Centre, with academic appointments to both Harvard and Tufts Medical Schools. Dr Howard has published in the fields of vasculitis and also has subspecialty interests in the fields of scleroderma



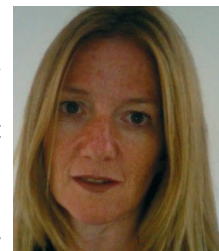
Dr Frances Stafford

Frances is a graduate of UCD, spent almost a decade in North America, training in Rheumatology first at University of Toronto, followed by a fellowship at Massachusetts General Hospital & Harvard Medical School. She was awarded a 4 year Arthritis Foundation Postdoctoral Fellowship, which I completed at the NIH, and then went on staff at the NIH. Frances is American Board Certified in Internal Medicine and in Rheumatology. She has been Consultant at Blackrock Clinic since 1995.



Dr Suzanne Donnelly

Dr Suzanne Donnelly graduated from Trinity College Dublin and trained in both Ireland and the UK, being appointed consultant rheumatologist at St George's Hospital and Medical School, University of London in 2002. Suzanne returned to Ireland in 2005 to a part time position alongside Dr Conor McCarthy as Consultant Rheumatologist in the Mater Misericordiae University Hospital. Her clinical and research interests include systemic autoimmune disease and Systemic Lupus Erythematosus.



Suzanne has held academic posts in medical education since 1996 including as Lecturer in Clinical Medicine in Trinity College Dublin; Clinical Lecturer in Rheumatology in the Nuffield Department of Medicine, University of Oxford and in St Georges' Hospital Medical School London. Suzanne joined UCD as Director of Clinical Education in 2008 and led the design and development of medical clinical education in the early years of the programme and was responsible for a series of innovative educational strategies across all disciplines. Among these was the development of a patient educator programme on behalf of UCD in association with Arthritis Ireland which raises the profile of arthritis by introducing rheumatology patients to medical students in their first weeks in college. She also led the first national undergraduate curriculum project in Ireland in any subject, published as the ISR Undergraduate Curriculum in Rheumatology in 2009, available on the ISR website. Suzanne has contributed to a number of undergraduate and specialist textbooks including the best selling Medicine at A Glance, now in its 4th edition, and The Rheumatology Handbook (2011). Suzanne has presented papers in medical education internationally, her educational research interest is in the area of student and doctor assessment and clinical handover.

Suzanne is an ISR nominee to the board of Arthritis Ireland, and until recently was a board member of the Irish Raynauds and Scleroderma Society, to which she continues as medical advisor.



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ideas about ORENCIA®



ORENCIA®
(abatacept)

ORENCIA® is indicated for the treatment of moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, in adult patients who have responded inadequately to previous therapy with one or more disease-modifying anti-rheumatic drugs (DMARDs), including methotrexate (MTX) or a Tumour Necrosis Factor (TNF) – alpha inhibitor.

ORENCIA® (abatacept) PRESCRIBING INFORMATION. See Summary of Product Characteristics before prescribing. **PRESENTATION:** 250 mg powder for concentrate for solution for IV infusion containing abatacept per vial. Each ml contains 25 mg of abatacept, after reconstitution; 125 mg pre-filled syringe for SC injection. Each pre-filled syringe contains 125 mg of abatacept in 1 ml. **INDICATION: Rheumatoid arthritis (IV infusion and SC pre-filled syringe):** Treatment of moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, in adult patients who have responded inadequately to previous therapy with one or more disease-modifying anti-rheumatic drugs (DMARDs) including methotrexate (MTX) or a Tumour Necrosis Factor (TNF) – alpha inhibitor. A reduction in the progression of joint damage and improvement of physical function have been demonstrated during combination treatment with abatacept and methotrexate. See SmPC. **Polyarticular Juvenile Idiopathic Arthritis (pJIA) (IV infusion only):** Orenzia 250 mg powder for concentrate for solution for IV infusion is indicated for treatment of moderate to severe active pJIA in paediatric patients 6 years of age and older who have had an insufficient response to other DMARDs including at least one TNF inhibitor. **DOSE AND ADMINISTRATION:** Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA. **Orenzia 250 mg powder for concentrate for solution for IV infusion. Adults and elderly:** Patients weighing < 60 kg: 500 mg (2 vials). Patients weighing ≥ 60 kg ≤ 100 kg: 750 mg (3 vials). Patients weighing > 100 kg: 1000 mg (4 vials). **Treatment of pJIA:** Paediatric patients, 6 to 17 years of age, weighing less than 75 kg: 10 mg/kg paediatric patients weighing or more: to be administered adult dosage, not exceeding a maximum dose of 1,000 mg. See SmPC for details of reconstitution and administration as a 30 minute IV infusion. After initial administration, Orenzia should be given at 2 and 4 weeks, then every 4 weeks thereafter. **Children:** Use in children below 6 years of age is not recommended. **Orenzia 125 mg solution for injection (SC pre-filled syringe) Adults and elderly:** Treatment should be initiated with a loading dose using an intravenous infusion. Following this loading dose, the first 125 mg subcutaneous injection of Orenzia should be given within a day, then 125 mg subcutaneous injections once weekly. Patients who are unable to receive an infusion may initiate weekly injections of subcutaneous Orenzia without an intravenous loading dose. Patients transitioning from Orenzia IV therapy to SC administration should administer the first subcutaneous dose instead of the next scheduled intravenous dose. **Children:** Administration in children below 18 years of age is not recommended. The continuation of treatment with abatacept should be re-assessed if patients do not respond within 6 months. **CONTRAINDICATIONS:** Hypersensitivity to the active substance or excipients. Severe and uncontrolled infections such as sepsis and opportunistic infections. **WARNINGS AND PRECAUTIONS: Allergic Reactions:** Caution in patients with a history of allergic reactions. Orenzia should be discontinued if a patient develops serious allergic or anaphylactic reaction. **Infections:** Caution should be exercised when considering the use in patients with a history of frequent infections, or underlying conditions which may prompt to infection. Treatment with Orenzia should not be initiated with patients with active infections until infections are controlled. Screening for tuberculosis and hepatitis B should be performed prior to therapy. Any patient who develops a new infection should be closely monitored and Orenzia should be discontinued if a patient develops a serious infection. Monitor patients for signs of infection when transitioning from TNF-antagonist to Orenzia. Co-administration of Orenzia with biologic immunosuppressive or immunomodulatory agents could potentiate the effects of abatacept on the immune system. Treatment with immunosuppressive therapy may be associated with progressive multifocal leukoencephalopathy (PML). Orenzia treatment should be discontinued if neurological symptoms suggestive of PML occur, and appropriate diagnostic measures initiated. **Malignancies:** The potential role of Orenzia in the development of malignancies is unknown, see SmPC. **Elderly:** Caution should be used when treating elderly patients due to a higher incidence of infections and malignancies in this patient group. **Autoimmune processes:** Theoretical risk of deterioration in autoimmune disease. **Immunisation:** Live vaccines should not be given simultaneously or within 3 months of discontinuation of Orenzia. See SmPC. **DRUG INTERACTIONS:** Concomitant therapy of Orenzia with a TNF-inhibitor is not recommended. No major safety issues were identified with the use of Orenzia in combination with sulfasalazine, hydroxychloroquine or leflunomide. **PREGNANCY AND LACTATION:** Do not use in pregnancy unless clearly necessary. Women should use contraception and not breast-feed during treatment and for up to 14 weeks after last dose treatment. **UNDESIRABLE EFFECTS:** In adult placebo-controlled trials the following adverse drug reactions were reported. **Very Common (≥ 1/10):** upper respiratory tract infection including tracheitis, nasopharyngitis. **Common (≥ 1/100 to < 1/10):** Lower respiratory tract infection (including bronchitis), urinary tract infection, herpes simplex, rhinitis, pneumonia, influenza, leukopenia, headache, dizziness, paraesthesia, conjunctivitis, hypertension, flushing, blood pressure increased, cough, abdominal pain, diarrhoea, nausea, dyspepsia, mouth ulceration, aphthous stomatitis, vomiting, liver function test abnormal (including transaminases increased), rash (including dermatitis), alopecia, pruritus, pain in extremity, fatigue, asthenia, injection site reactions. **Uncommon (≥ 1/1,000 to < 1/100):** Tooth infection, onychomycosis, herpes zoster, sepsis, musculoskeletal infections, skin abscess, pyelonephritis, pelvic inflammatory disease, basal cell carcinoma, skin papilloma, thrombocytopenia, hypersensitivity, depression, anxiety, sleep disorder, migraine, dry eye, visual acuity reduced, vertigo, palpitations, tachycardia, bradycardia, hypotension, hot flush, vasculitis, blood pressure decreased, bronchospasm, wheezing, dyspnea, gastritis, increased tendency to bruise, dry skin, urticaria, psoriasis, arthralgia, amenorrhea, menorrhagia, influenza like illness, weight increased. **Rare (≥ 1/10,000 to < 1/1,000):** Bacteraemia, gastrointestinal infection, lymphoma, lung neoplasm malignant, throat tightness. See SmPC for further details. **LEGAL CATEGORY:** POM. **MARKETING AUTHORISATION NUMBER** Orenzia 250 mg concentrate for solution for infusion - EU/1/07/389/001, 1 vial pack Orenzia 125 mg solution for injection - EU/1/07/389/008, 4 pre-filled syringes with needle guard. **MARKETING AUTHORISATION HOLDER:** Bristol-Myers Squibb Pharma EEIG, Uxbridge Business Park, Sanderson Road, Uxbridge, Middlesex UB8 1DH. **FURTHER INFORMATION FROM:** Bristol-Myers Squibb Pharmaceuticals, South County Business Park, Leopardstown, Dublin or medicalinformation@bms.com **Tel:** 1-800-749-749. **DATE OF PREPARATION:** December 2012.

AUTUMN DAY 1: Case Presenters & Speaker p.m. Thursday 20th September 2012 - Europa Hotel (Belfast)



Laura Durcan (St. James's Hospital)



Eimear Savage (Musgrave Park Hospital)



Tehzeen Wazir (Musgrave Park Hospital)



Vivienne McGoldrick (Craigavon Area Hospital) & Eamonn Molloy (SVUH)



Bernadette Lynch (AMNCH)



Prof Gaye Cunnane (St. James's Hospital): 'A History of the ISR'



Put everyday life back in their hands

The first monthly subcutaneous anti-TNF with proven efficacy in RA, PsA, and AS¹

Simponi 50 mg Solution for Injection in pre-filled pen Simponi 50 mg Solution for Injection in pre-filled syringe (golimumab) [Prescribing Information (Refer to full SPC text before prescribing Simponi (golimumab))]

Uses: Simponi (golimumab) is a human IgG1 κ antibody that neutralises the biological activity of TNF- α . Each pre-filled pen or pre-filled syringe contains 50 mg of golimumab. **Indications:** *Rheumatoid Arthritis (RA):* Simponi, in combination with methotrexate (MTX), is indicated for the treatment of moderate to severe, active rheumatoid arthritis in adults when the response to disease-modifying anti-rheumatic drug (DMARD) therapy including MTX has been inadequate; the treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with MTX. Simponi, in combination with MTX, has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function; *Psoriatic Arthritis (PsA):* Simponi, alone or in combination with MTX, is indicated for the treatment of active and progressive PsA in adults when the response to DMARD therapy has been inadequate. Simponi has been shown to reduce the rate of progression of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of the disease and to improve physical function; *Ankylosing Spondylitis (AS):* Simponi is indicated for treatment of severe, active AS in adults who have responded inadequately to conventional therapy. **Dosage and administration:** Simponi should be injected subcutaneously. Treatment should be initiated and supervised by qualified physicians experienced in the diagnosis and treatment of RA, PsA or AS. After proper training in subcutaneous injection technique, patients may self-inject, if their physician deems it appropriate. *RA:* Simponi 50 mg given once a month, on the same date each month, concomitantly with MTX. *PsA:* Simponi 50 mg given once a month, on the same date each month, alone or in combination with MTX. *AS:* Simponi 50 mg given once a month, on the same date each month. Clinical response is usually achieved within 12-14 weeks of treatment (3 or 4 doses). Continued therapy should be reconsidered in patients who show no evidence of therapeutic benefit within this time period. In patients weighing more than 100 kg who do not achieve an adequate clinical response after 3 or 4 doses, increasing the dose of golimumab to 100 mg once a month may be considered, taking into account the increased risk of certain serious adverse reactions with the 100 mg dose compared with the 50 mg dose. If a patient forgets to inject Simponi on the planned date, the forgotten dose should be injected as soon as the patient remembers. The patient should be instructed not to inject a double dose. *Elderly patients (> 65 years):* no dose adjustment required. *Paediatric patients (<18 years) and patients with renal and hepatic impairment:* Simponi is not recommended in these populations. **Contraindications:** Patients with a hypersensitivity to golimumab or any of the excipients; Patients with active tuberculosis (TB) or other severe infection such as sepsis and opportunistic infections; patients with moderate or severe heart failure (NYHA class III/IV). **Precautions and Warnings:** Infections: Patients must be monitored closely for infection before, during and for 5 months after cessation of treatment. Exercise caution when considering Simponi in patients with chronic infection or a history of recurrent infection including use of concomitant immunosuppressive therapy. Simponi should not be given to patients with clinically important active infection. Patients should be advised of the potential risk factors. Bacterial infections (including sepsis and pneumonia), mycobacterial (including TB), invasive fungal and opportunistic infections, including fatalities, have been reported. There was a greater incidence of serious infections, including opportunistic infections and TB, in patients receiving golimumab 100 mg compared with patients receiving golimumab 50 mg. Serious infections have occurred in patients on concomitant immunosuppressive therapy that, in addition to their underlying disease, could predispose them to infection. There have been reports of active TB in patients receiving Simponi. Patients should be evaluated for active or latent TB before Simponi treatment. All such tests should be recorded on the Patient Alert Card provided with the product. If active TB is diagnosed, treatment with Simponi should not be initiated. If latent TB is diagnosed, treatment with anti-TB therapy must be initiated before initiation of Simponi. Patients on Simponi should be advised to seek medical advice if signs and/or symptoms of TB appear. *Hepatitis B (HBV) reactivation:* Reactivation of HBV occurred in patients receiving Simponi who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Simponi. *Malignancies and lymphoproliferative disorders:* Caution is advised when considering Simponi treatment in patients with history of malignancy or continuing treatment in patients who develop a malignancy, additional caution should be exercised in patients with increased risk for malignancy due to heavy smoking. A risk for the development of malignancies in children and adolescents cannot be excluded.

Melanoma (all TNF-blocking agents including Simponi) and Merkel cell carcinoma (other TNF-blocking agents) have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. *Heart Failure:* Simponi should be used with caution in patients with mild heart failure (NYHA class I/II) and discontinued in the event of worsening symptoms of heart failure. *Neurological events:* Use of anti-TNF therapy, including Simponi, has been associated with cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disorders, including multiple sclerosis and peripheral demyelinating disorders. Discontinuation of Simponi should be considered if these disorders develop. In patients with a history of demyelinating disorders, the benefits and risks of Simponi treatment should be carefully considered before initiation of therapy. *Surgery:* Patients requiring surgery whilst on Simponi therapy should be closely monitored for infections. *Autoimmune processes:* If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Simponi and is positive for antibodies against double-stranded DNA, treatment must be discontinued. *Haematological reactions:* There have been post-marketing reports of pancytopenia, leucopenia, neutropenia, aplastic anaemia, and thrombocytopenia in patients receiving TNF-blockers. Cytopenias including pancytopenia have been reported infrequently in clinical trials. Patients should be advised to seek medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Discontinuation should be considered in patients with significant haematologic abnormalities. *Vaccinations:* It is recommended that live vaccines should not be given concurrently. *Allergic reactions:* If an anaphylactic reaction or other serious allergic reaction occurs, administration of Simponi should be discontinued immediately, and suitable treatment initiated. The needle cover of the pre-filled pen contains latex and may cause allergic reactions in those sensitive to latex. *Special populations:* Adverse events, serious adverse events and serious infections in patients aged ≥ 65 were comparable to those observed in younger patients. However, caution should be exercised when treating the elderly, particular attention should be paid to infections. Simponi contains sorbitol (E420). Patients with rare hereditary problems of fructose intolerance should not take Simponi. **Interactions:** Combination of Simponi and other biological therapeutics used to treat the same conditions as Simponi, including anakinra and abatacept is not recommended. **Pregnancy and Lactation:** Administration of Simponi is not recommended during pregnancy or breast-feeding. Women of childbearing potential should use adequate contraception and continue its use for at least 6 months after the last Simponi treatment. **Side-effects:** Very Common (> 1/10): upper respiratory tract infection; Common (> 1/100): bacterial infections, viral infections, bronchitis, sinusitis, superficial fungal infections, anaemia, allergic reactions, autoantibody positive, depression, insomnia, dizziness, paraesthesia, headache, hypertension, constipation, dyspepsia, gastrointestinal and abdominal pain, nausea, alanine aminotransferase increased, aspartate aminotransferase increased, alopecia, dermatitis, pruritus, rash, pyrexia, asthenia, injection site reaction, impaired healing and chest discomfort were reported. Other less common and rarely reported side effects are listed in the SPC. **Overdose:** Single doses up to 10mg/kg intravenously have been administered without toxic effect. **Package quantities:** 0.5 ml solution in a pre-filled syringe (1.0 ml Type 1 glass) with a fixed needle (stainless steel) and a needle cover (rubber containing latex) in a pre-filled pen or pre-filled syringe. Simponi is available in packs containing 1 pre-filled pen or 1 pre-filled syringe. **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number:** Pre-filled Pen EU/1/09/546/001; Pre-filled Syringe EU/1/09/546/003. **Marketing Authorisation Holder:** Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands **Date of Revision of Text:** December 2012 Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie. © Merck Sharp & Dohme Ireland (Human Health) Limited, 2012. All rights reserved. Date of Preparation: February 2013.

Ref 1: Simponi Summary of Product Characteristics Nov 2012. For full text see www.medicines.ie.



Futures Remade

The IV anti-TNF for patients that:¹

- have a rapidly progressive disease
- have a history of co-morbidities
- are unable to self inject
- need medical supervision

Remicade 100mg Powder for Concentrate for Solution for Infusion (infliximab) Prescribing Information [Refer to full SPC text before prescribing]

Remicade (infliximab) Uses: Remicade (infliximab) is a chimeric human-murine IgG1 monoclonal antibody produced in murine hybridoma cells by recombinant DNA technology. Each vial contains 100mg of infliximab. **Indications:** **Rheumatoid Arthritis (RA):** Remicade, in combination with methotrexate (MTX), is indicated for the reduction of signs and symptoms, as well as the improvement in physical function, in adult patients with active RA when the response to disease-modifying anti-rheumatic drugs (DMARDs), including MTX, has been inadequate; and in adult patients with severe, active and progressive disease not previously treated with MTX or other DMARDs. In these patient populations, a reduction in the rate of the progression of joint damage, as measured by X-ray, has been demonstrated. **Adult Crohn's Disease (CD):** Remicade is indicated for the treatment of moderately to severely active CD in adult patients who have not responded to, or are intolerant of, a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant; and fistulising active CD in adult patients who have not responded despite a full and adequate course of therapy with conventional treatment (including antibiotics, drainage and immunosuppressive therapy). **Paediatric Crohn's Disease (CD):** Remicade is indicated for the treatment of severe, active CD in children and adolescents aged 6 to 17 years, who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or who are intolerant to or have contraindications for such therapies. **Ulcerative Colitis (UC):** Remicade is indicated for the treatment of moderately to severely active UC in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6-MP or AZA, or who are intolerant to or have medical contraindications for such therapies. **Paediatric Ulcerative Colitis (UC):** Remicade is indicated for treatment of severely active UC, in children and adolescents aged 6 to 17 years, who have had an inadequate response to conventional therapy including corticosteroids and 6-MP or AZA, or who are intolerant to or have medical contraindications for such therapies. **Ankylosing Spondylitis (AS):** Remicade is indicated for the treatment of severe, active AS, in adult patients who have responded inadequately to conventional therapy. **Psoriasis (PsA):** Remicade is indicated for the treatment of active and progressive PsA, in adult patients when the response to previous DMARD drug therapy has been inadequate. Administration should be in combination with MTX or alone in patients who show intolerance to MTX or for whom MTX is contraindicated. A reduction in the rate of progression of peripheral joint damage in patients with polyarticular symmetrical subtypes of PsA has been measured by X-ray. **Psoriasis (PsO):** Remicade is indicated for the treatment of moderate to severe plaque PsO in adult patients who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, MTX or PUVA. **Dosage and administration:** Remicade should be administered intravenously, initiated and supervised by physicians experienced in the diagnosis and treatment of RA, CD, UC, AS, PsA and PsO. Remicade should be administered intravenously over a 2 hour period. All patients administered Remicade should be observed for at least 1 to 2 hours post infusion for acute infusion-related reactions by appropriately trained health-care professionals. **Shortened infusions across adult indications:** In carefully selected adult patients who have tolerated at least 3 initial 2-hour infusions of Remicade (induction phase) and are receiving maintenance therapy, consideration may be given to administering subsequent infusions over a period of not less than 1 hour. If an infusion reaction occurs in association with a shortened infusion, a slower infusion rate may be considered for future infusions if treatment is to be continued. Shortened infusions at doses >6 mg/kg have not been studied. **RA:** 3 mg/kg given as an intravenous infusion followed by additional 3 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. **Adult moderately to severely active CD:** 5 mg/kg given as an intravenous infusion followed by an additional 5 mg/kg infusion 2 weeks after the first infusion. If a patient does not respond after 2 doses, no additional treatment should be given. **Adult, fistulising, active CD:** 5 mg/kg intravenous infusion followed by additional 5 mg/kg infusions at 2 and 6 weeks after first infusion. If a patient does not respond after 3 doses, no additional treatment should be given. **UC:** 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks. Clinical response is usually achieved within 14 weeks of treatment (3 doses). **AS:** 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 6 to 8 weeks. If a patient does not respond after 2 doses, no additional treatment should be given. **PsA:** 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. **PsO:** 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks. If a patient does not respond after 2 doses, no additional treatment should be given. **Readministration:** Remicade can be readministered within 16 weeks following the last infusion. The safety and efficacy of readministration after a Remicade-free interval of more than 16 weeks has not been established in either CD or RA. The safety and efficacy of readministration in AS, other than every 6 to 8 weeks and in PsA and UC, other than every 8 weeks, has not been established. Readministration with one single Remicade dose in PsO after an interval of 20 weeks suggests reduced efficacy and a higher incidence of mild to moderate infusion reactions when compared to the initial induction regimen. Limited experience from retreatment, using a reinduction regimen suggests a higher incidence of infusion reactions, some serious, when compared to 8 weekly maintenance treatment. In case maintenance therapy is interrupted in any indication, and there is a need to restart treatment, Remicade should be reinitiated as a single dose followed by the maintenance dose recommendations. **Paediatric population:** **CD (6 to 17 years):** 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. If a patient does not respond by 10 weeks, no additional treatment should be given. **UC (6 to 17 years):** 5 mg/kg given as an intravenous infusion over a 2-hour period followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. Available data do not support further infliximab treatment in paediatric patients not responding within the first 8 weeks of treatment. **Contra-indications:** Tuberculosis or other severe infections such as sepsis, abscesses and opportunistic infections; patients with a history of hypersensitivity to infliximab, other murine proteins or any of the excipients; patients with moderate or severe heart failure (NYHA class III/IV). **Precautions and Warnings:** **Infusion reactions:** Acute infusion reactions including anaphylactic reactions may develop during (within seconds) or within a few hours following infusion. If acute infusion reactions occur, the infusion must be interrupted immediately. Emergency equipment, such as adrenaline, antihistamines, corticosteroids and an artificial airway must be available. Antibodies to infliximab may develop and have been associated with increased frequency of infusion reactions. Symptomatic treatment should be given and further Remicade infusions must not be administered. In clinical studies, delayed hypersensitivity reactions have been reported. Available data suggest an increased risk for delayed hypersensitivity with increasing Remicade-free intervals. **Infections:** Patients must be monitored closely for infections, including tuberculosis, before, during and up to 6 months after treatment with Remicade. Exercise caution with use of Remicade in patients with chronic infection or a history of recurrent infection. Patients should be advised of potential risk factors for infections. Suppression of TNF α may mask symptoms of infection such as fever. Tuberculosis, bacterial infections including sepsis and pneumonia, invasive fungal, viral and other opportunistic infections, have been observed, some of which have been fatal. Infections were reported more frequently in paediatric populations than in adult populations. There have been reports of active tuberculosis in patients receiving Remicade. Patients should be evaluated for active or latent tuberculosis before Remicade treatment. All such tests should be recorded on the Patient Alert Card provided with the product. If active tuberculosis is diagnosed, Remicade therapy must not be initiated. If latent tuberculosis is diagnosed, treatment with anti-tuberculosis therapy must be initiated before initiation of Remicade. Patients on Remicade treatment should be advised to seek medical advice if symptoms of tuberculosis appear. An invasive fungal infection such as aspergillosis, candidiasis, pneumocystosis, histoplasmosis, coccidioidomycosis or blastomycosis should be suspected in patients if a serious systemic illness is developed, a physician with expertise in the diagnosis and treatment of invasive fungal infections should be consulted at an early stage. Patients with fistulising CD and active suppurative fistulas must not initiate Remicade therapy until possible source of infection is excluded. **Hepatitis B (HBV) reactivation:** Reactivation of HBV occurred in patients receiving Remicade who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Remicade. **Hepatobiliary events:** Very rare cases of jaundice and non-infectious hepatitis, some with features of autoimmune hepatitis have been observed. Isolated cases of liver failure resulting in liver transplantation or death have occurred. **Vaccinations:** It is recommended that live vaccines not be given concurrently. Prior to initiating Remicade therapy it is recommended that paediatric patients be brought up to date with all vaccinations. **Autoimmune processes:** If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Remicade and is positive for antibodies against double-stranded DNA, treatment must be discontinued. **Neurological events:** Anti-TNF α agents have been associated with cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of peripheral and CNS demyelinating disorders, including Guillain-Barré syndrome and multiple sclerosis. In patients with a history of demyelinating disorders, the benefits and risks of anti-TNF treatment should be carefully considered before initiation of Remicade therapy. Discontinuation of Remicade should be considered if these disorders develop. **Malignancies and lymphoproliferative disorders:** A risk of the development of lymphomas and other malignancies in patients (including children and adolescents) cannot be excluded. Caution is advised in patients with history of malignancy and in patients with increased risk for malignancy due to heavy smoking. Rare post-marketing cases of hepatosplenic T-cell lymphoma have been reported which were usually fatal. All Remicade cases have occurred in patients with CD or UC treated concomitantly with AZA or 6-MP. Caution should be exercised in patients with PsO and a medical history of extensive immunosuppressant therapy or prolonged PUVA treatment. Patients with UC at increased risk for, or with a prior history of dysplasia or colon carcinoma should be screened for dysplasia before therapy and at regular intervals throughout their disease course. Melanoma and Merkel cell carcinoma have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. **Heart failure:** Remicade should be used with caution in patients with mild heart failure (NYHA class I/II) and discontinued in face of new or worsening symptoms of heart failure. **Other patients requiring surgery whilst on Remicade therapy** should be closely monitored for infections. **Haematologic reactions:** Discontinuation of Remicade therapy should be considered in patients with confirmed significant haematologic abnormalities, including pancytopenia, leucopenia, neutropenia and thrombocytopenia. **Special populations:** Particular attention should be paid when treating the elderly (>65 years) due to a greater incidence of serious infections seen in Remicade treated patients. Some of these had a fatal outcome. **Interactions:** No interaction studies have been performed. Combination of Remicade with other biological therapeutics used to treat the same conditions as Remicade, including anakinra and abatacept is not recommended. It is recommended that live vaccines not be given concurrently with Remicade. **Fertility, Pregnancy and Lactation:** Women of childbearing potential should use adequate contraception and continue its use for at least 6 months after the last Remicade treatment. Administration of Remicade is not recommended during pregnancy or breast-feeding. Administration of live vaccines to infants exposed to infliximab in utero is not recommended for 6 months following the mother's last infliximab infusion during pregnancy. Effects of infliximab on fertility and general reproductive function are unknown. **Side-effects:** **Very Common:** 1/10: Viral infection, headache, upper respiratory tract infection, sinusitis, abdominal pain, nausea, infusion related reaction, pain. **Common:** 1/10 to <1/10: Bacterial infections, neutropenia, leucopenia, anaemia, lymphadenopathy, allergic respiratory symptom, depression, insomnia, vertigo, dizziness, hypoaesthesia, paraesthesia, conjunctivitis, tachycardia, palpitation, hypotension, hypertension, ecchymosis, hot flush, flushing, lower respiratory tract infection, dyspnoea, epistaxis, gastrointestinal haemorrhage, diarrhoea, dyspepsia, gastroesophageal reflux, constipation, hepatic function abnormal, transaminases increased, new onset or worsening psoriasis including pustular psoriasis (primarily palm & sole), urticaria, rash, pruritus, hyperhidrosis, dry skin, fungal dermatitis, eczema, alopecia, arthralgia, myalgia, back pain, urinary tract infection, chest pain, fatigue, fever, injection site reaction, chills and oedema. In phase 3 clinical studies, 18% of infliximab-treated patients compared with 5% of placebo-treated patients experienced an infusion related reaction. In post-marketing spontaneous reporting, infections are the most common serious adverse event. The most frequently reported opportunistic infections with a mortality rate of >5% include pneumocystosis, candidiasis, listeriosis and aspergillosis. **Other less common and rarely reported side effects are listed in the SPC.** **Overdose:** No case of overdose has been reported. Single doses up to 20 mg/kg have been administered without toxic effects. **Package Quantities:** Type I vials, with rubber stoppers and aluminium crimps protected by plastic caps, containing a lyophilised powder (infliximab 100mg). **Legal Category:** POM Marketing Authorisation Number: EU/1/99/116/001 Marketing Authorisation Holder: Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands **Date of Revision:** December 2012 Remicade/PI-IRE/12-12/40 Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie. © Merck Sharp & Dohme Ireland (Human Health) Limited, 2012. All rights reserved. Date of Preparation: February 2013.

Reference: 1: Remicade Summary of Product Characteristics November 2012. For full text see www.medicines.ie.



Improve Strength Reduce Fractures¹

Protelos is proven to be an effective long term 1st line osteoporosis treatment option in postmenopausal women, to reduce the risk of vertebral and hip fractures, and in men at increased risk of fracture¹

**1 sachet
daily**

Protelos (strontium ranelate) abbreviated prescribing information: Please refer to the Summary of product Characteristics before prescribing. **Presentation:** Sachet containing 2g of strontium ranelate granules for oral suspension. **Indication:** Treatment of postmenopausal osteoporosis to reduce the risk of vertebral and hip fractures. Treatment of osteoporosis in adult men at increased risk of fracture. **Dosage and Administration:** The recommended daily dose is one 2g sachet once daily by oral administration at bedtime, preferably at least two hours after eating. The granules in the sachets must be taken as a suspension in a glass of water. Due to the nature of the treated disease, strontium ranelate is intended for long-term use. Patients treated with strontium ranelate should receive vitamin D and calcium supplements if dietary intake is inadequate. Elderly (>65): No dosage adjustment is required in relation to the elderly. Patients with Renal Impairment: No dosage adjustment is required in patients with mild-to-moderate renal impairment (30-70 ml/min creatinine clearance). Strontium ranelate is not recommended for patients with severe renal impairment (creatinine clearance below 30 ml/min). Patients with Hepatic Impairment: As strontium ranelate is not metabolised, no dosage adjustment is required in patients with hepatic impairment. Paediatric Population: The safety and efficacy of Protelos in children aged below 18 years have not been established. No data are available. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Current or previous venous thromboembolic events (VTE), including deep vein thrombosis and pulmonary embolism. Temporary or permanent immobilisation due to e.g. post-surgical recovery or prolonged bed rest. **Precautions:** VTE: Protelos is associated with an increased risk for VTE. The cause of this finding is unknown. Protelos should be used with caution in patients at risk of VTE. When treating patients over 80 years at risk of VTE, the need for continued treatment with PROTELOS should be re-evaluated. Skin reactions: Life-threatening cutaneous reactions (Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) and drug rash with eosinophilia and systemic symptoms (DRESS)) have been reported with the use of Protelos. Patients should be advised of the signs and symptoms and monitored closely for skin reactions. A higher incidence, although still rare, of hypersensitivity reactions including skin rash, SJS or TEN in patients of Asian origin has been reported. Interaction with laboratory test: Strontium interferes with colorimetric methods for the determination of blood and urinary calcium concentrations. Therefore, in medical practice, inductively coupled plasma atomic emission spectrometry or atomic absorption spectrometry methods should be used to ensure an accurate assessment of blood and urinary calcium concentrations. Excipient: Protelos contains a source of phenylalanine which could be harmful for people with phenylketonuria. **Interactions:** Food, milk and derivative products, and medicinal products containing calcium may reduce the bioavailability of strontium ranelate, therefore, administration of Protelos and such products should be separated by at least two hours. It is preferable to take antacids at least two hours after Protelos, however, when this dosing regimen is impractical due to the recommended administration of Protelos at bedtime, concomitant intake remains acceptable. Protelos therapy should be temporarily suspended if a patient is on a course of oral quinolone or tetracycline antibiotics as it may hinder their absorption. **Fertility, pregnancy and lactation:** There are no data from the use of strontium ranelate in pregnant women. Physicochemical data suggest excretion of strontium ranelate in human milk. Protelos should not be used during breast-feeding. No effects were observed on males and females fertility in animal studies. **Undesirable effects:** Overall incidence rates for adverse events with strontium ranelate did not differ from placebo and adverse events were usually mild and transient. Adverse reactions, defined as adverse events considered at least possibly attributable to strontium ranelate treatment in phase III studies are listed below using the following convention (frequencies versus placebo): very common (>1/10); common (>1/100, <1/10); uncommon (>1/1,000, <1/100); rare (>1/10,000, <1/1,000); very rare (<1/10,000); not known (cannot be estimated from the available data). Common: nausea (7.1% vs. 4.6%), and diarrhoea (7.0% vs. 5.0%), headache (3.3% vs. 2.7%), memory loss (2.5% vs. 2.0%), disturbance of consciousness (2.6% vs. 2.1%), dermatitis (2.3% vs. 2.0%), eczema (1.8% vs. 1.4%), venous thromboembolism (2.7% vs. 1.9%), increases in blood creatinine phosphokinase (1.4% vs. 0.8%). Rare: DRESS. Very rare: Severe cutaneous adverse reactions: SJS and TEN. **Frequency was unknown include:** paraesthesia, dizziness, vertigo, alopecia; oral mucosal irritation; bronchial hyperreactivity; hepatobiliary disorders, hepatitis, bone marrow failure, insomnia, dyspepsia, gastroesophageal reflux, constipation, flatulence, dry mouth, malaise. Undesirable effects associated with hypersensitivity skin reactions include pyrexia, lymphadenopathy and eosinophilia. **See Summary of Product Characteristics for further details. Presentation:** Box containing 28 sachets. Legal Category: POM. **Marketing Authorisation Numbers and Holder:** EU/1/04/288/001-006, Les Laboratoires Servier, 50, rue Carnot 92284 Suresnes cedex France. **Date of Preparation or Last Review:** November 2012. **Full prescribing information is available from:** Servier Laboratories, Block 2, West Pier Business Campus, Old Dunleary Road, Dun Laoghaire, Co. Dublin, Tel: (01) 6638110, Fax: (01) 6638120. **Date of Preparation of Item:** November 2012.

ISR AUTUMN 2012: Belfast



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Brian McLaughlin (N.Ire MSD), Kerry Hanniphy & Gary Hanniphy (MSD)



Celine Jordan, Maureen Kennelly & Joan Sherlock (UCB)



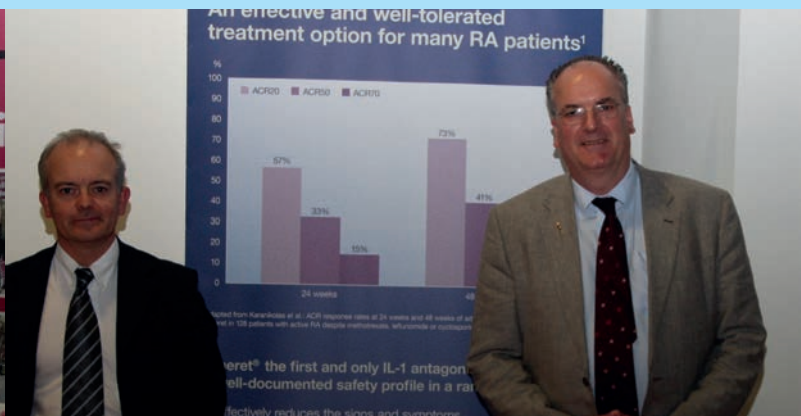
Dan Duffy, Yvonne Lindsay, Siobhan Goff & Rowland Luttrell (Abbott)



Eli-Lilly



Arthritis Care



Jamie Cahalane and Roger Rolph (SOBI)

TRUST in HUMIRA

10

YEARS OF EFFICACY DATA FOR RA IN LABEL¹

9

INDICATIONS -
THE MOST OF ANY SELF-
ADMINISTERED BIOLOGIC¹

MORE THAN

85

COUNTRIES²

15

YEARS OF CLINICAL TRIAL
EXPERIENCE, BEGINNING WITH
RHEUMATOID ARTHRITIS (RA)²

71

CLINICAL TRIALS IN THE LARGEST PUBLISHED
ANTI-TUMOR NECROSIS FACTOR (TNF)
CROSS-INDICATION SAFETY DATABASE³

Prescribing Information

Humira (adalimumab) 40mg solution for injection in pre-filled pen or pre-filled syringe and Humira 40mg/0.8ml solution for injection for paediatric use Refer to Summary of Product Characteristics for full information.

Presentation: Each 0.8ml single dose pre-filled pen, pre-filled syringe or vial contains 40mg of adalimumab. **Indications:** Rheumatoid arthritis (RA): Humira in combination with methotrexate is indicated for the treatment of moderate to severe, active RA in adult patients when the response to disease-modifying anti-rheumatic drugs (DMARDs) including methotrexate has been inadequate. Humira is also indicated for the treatment of severe, active and progressive RA in adults not previously treated with methotrexate. Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Humira has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function, when given in combination with methotrexate. Polyarticular juvenile idiopathic arthritis (JIA): Humira in combination with methotrexate is indicated for the treatment of active JIA, in children and adolescents aged 4 to 17 years who have had an inadequate response to one or more DMARDs. Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Humira has not been studied in children less than 4 years. Psoriatic arthritis (PsA): Humira is indicated for the treatment of active and progressive PsA in adults when the response to previous disease-modifying anti-rheumatic drug therapy has been inadequate. Humira has been shown to reduce the rate of progression of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of the disease and to improve physical function. Ankylosing spondylitis (AS): Humira is indicated for the treatment of adults with severe active AS who have had an inadequate response to conventional therapy. Axial spondyloarthritis (SpA) non-radiographic: Humira is indicated for the treatment of adults with severe axial spondyloarthritis without radiographic evidence of AS but with objective signs of inflammation by elevated CRP and/or MRI, who have had an inadequate response to, or are intolerant to nonsteroidal anti-inflammatory drugs. Crohn's disease (CD): Humira is indicated for treatment of moderate to severe, active CD, in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant; or who are intolerant to or have medical contraindications for such therapies. Paediatric Crohn's Disease: Humira is indicated for the treatment of severe active Crohn's disease in paediatric patients (6 to 17 years) who have had an inadequate response to conventional therapy including primary nutrition therapy, a corticosteroid, and an immunomodulator, or who are intolerant to or have contraindications for such therapies. Psoriasis (Ps): Humira is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or PUVA. Ulcerative colitis (UC): Humira is indicated for treatment of moderate to severe active ulcerative colitis in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or who are intolerant to or have medical contraindications for such therapies. **Dosage and administration:** Humira treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of conditions for which Humira is indicated. Patients treated with Humira should be given the special alert card. After proper training in injection technique, patients may self-inject with Humira if their physician determines that it is appropriate and with medical follow-up as necessary. During treatment with Humira, other concomitant therapies (e.g., corticosteroids and/or immunomodulatory agents) should be optimised. RA, PsA, AS or SpA non-radiographic: 40mg administered every other week as a single dose via subcutaneous injection. RA: In monotherapy some patients who experience a decrease in their response to Humira may benefit from an increase in dose intensity to 40mg every week. There may be a need for dose interruption, for instance before surgery or if a serious infection occurs. Available data suggest that re-introduction of Humira after discontinuation for 70 days or longer resulted in the same magnitudes of clinical response and similar safety profile as before dose interruption. For RA, JIA, PsA and AS, available data suggest that the clinical response is usually achieved within 12 weeks of treatment. Continued therapy should be carefully reconsidered in a patient not responding within this time period. JIA: Age 4 to 12 years: 24mg/m² body surface area to a maximum single dose of 40mg administered every other week via subcutaneous injection. The volume for injection is based on the patients' height and weight (see SmPC for height and weight dosing chart). A 40mg paediatric vial is available for patients who need to administer less than the full 40mg dose. Age 13 to 17 years: 40mg administered every other week via subcutaneous injection regardless of body surface area. CD: The recommended Humira induction dose regimen for adult patients with moderate to severe CD is 80mg at Week 0 followed by 40mg at Week 2. In case there is a need for a more rapid response to therapy, the regimen 160mg at Week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days), 80mg at Week 2, can be used with the awareness that the risk for adverse events is higher during induction. After induction treatment, the recommended dose is 40mg every other week via subcutaneous injection. Alternatively, if a patient has stopped Humira and signs and symptoms of disease recur, Humira may be re-administered. There is little experience from re-administration after more than 8 weeks since the previous dose. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Some patients who experience decrease in their response may benefit from an increase in dosing frequency to 40mg Humira every week. Some patients who have not responded by Week 4 may benefit from continued maintenance therapy through Week 12. Continued therapy should be carefully reconsidered in a patient not responding within this time period. Paediatric CD: patients <40kg: recommended induction dose regimen of 40mg at Week 0 followed by 20mg at Week 2 via SC injection. In case of need for a more rapid response to therapy, the regimen 80mg at Week 0 (dose can be administered as two injections in one day), 40mg at Week 2, can be used with the awareness that the risk for adverse events is higher during induction. After induction treatment, the recommended dose is 20mg every other week via SC injection. Some patients who experience insufficient response may benefit from 20mg every week; patients >40kg: double the dose regimen for the those patients <40kg. Continued therapy should be carefully considered in a subject not responding by week 12. Psoriasis: The recommended dose of Humira for adult patients is an initial dose of 80mg administered subcutaneously, followed by 40mg subcutaneously given every other week starting one week after the initial dose. Continued therapy beyond 16 weeks should be carefully reconsidered in a patient not responding within this time period. UC: The recommended Humira induction dose regimen for adult patients with moderate to severe UC is 160mg at week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days) and 80mg at week 2. After induction treatment, the recommended dose is 40mg every other week via subcutaneous injection. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Some patients who experience decrease in their response may benefit from an increase in dosing frequency to 40mg Humira every week. Available data suggest that clinical response is usually achieved within 2-8 weeks of treatment. Continued therapy is not recommended in patients not responding within this time period. **Contraindications:** Active tuberculosis or other severe infections such as sepsis, and opportunistic infections; moderate to severe heart failure (NYHA class III/IV) and hypersensitivity to adalimumab or any of the excipients. **Precautions and Warnings:** Infections: Patients taking TNF-antagonists are more susceptible to serious infections. Impaired lung function may increase the risk for developing infections. Patients must therefore be monitored closely for infections, including tuberculosis, before, during and for 4 months after treatment with Humira. Treatment with Humira should not be initiated in patients with active, chronic or localised infections until infections are controlled. In patients who have been exposed to tuberculosis and patients who have travelled in areas of high risk of tuberculosis or endemic mycoses, such as histoplasmosis, coccidioidomycosis, or blastomycosis, the risk and benefits of treatment with Humira should be considered prior to initiating therapy (see Opportunistic infections). Patients who develop a new infection while undergoing treatment with Humira should be monitored closely and undergo a complete diagnostic evaluation. Administration of Humira should be discontinued if a patient develops a new serious infection or sepsis, and appropriate antimicrobial or antifungal therapy should be initiated until the infection is controlled. Physicians should exercise caution when considering the use of Humira in patients with a history of recurring infection or with underlying conditions which may predispose to infections, including the use of concomitant immunosuppressive medications. Serious infections: Serious infections, including sepsis, due to bacterial, mycobacterial, invasive fungal, parasitic, viral, or other opportunistic infections such as listeriosis, legionellosis and pneumocystis have been reported in patients receiving Humira. Other serious infections seen in clinical trials include pneumonia, pyelonephritis, septic arthritis and septic aemia. Hospitalisation or fatal outcomes associated with infections have been reported. Tuberculosis: Tuberculosis, including reactivation and new onset of tuberculosis, has been reported in patients receiving Humira. Reports included cases of pulmonary and extra-pulmonary i.e. disseminated. Before initiation of therapy with Humira, all patients must be evaluated for both active ("latent") tuberculosis infection. Appropriate screening tests, should be performed in all patients, local recommendations may apply. If active tuberculosis is diagnosed, Humira therapy must not be initiated. If latent tuberculosis is suspected, a physician with expertise in the treatment of tuberculosis should be consulted and the benefit/risk balance of therapy with Humira should be considered. If inactive ("latent") tuberculosis is diagnosed, appropriate treatment must be started with anti-tuberculosis prophylaxis treatment before the initiation of Humira, and in accordance with local recommendations. In patients who have several or significant risk factors for tuberculosis despite a negative test for tuberculosis, anti-tuberculosis prophylaxis treatment should also be considered before the initiation of Humira and in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed. Some patients who have previously received treatment for latent or active tuberculosis have redeveloped tuberculosis while being treated with Humira. Other opportunistic infections: Opportunistic infections, including invasive fungal infections have been observed in patients receiving Humira. These infections have not consistently been recognised in patients taking TNF-antagonists and this resulted in delays in appropriate treatment,

– An unmatched legacy.

MORE THAN

670,000

PATIENTS CURRENTLY
TREATED WORLDWIDE*

MORE THAN

23,000

PATIENTS IN GLOBAL STUDIES³

HUMIRA
adalimumab

10
YEARS

sometimes resulting in fatal outcomes. For patients who develop the signs and symptoms such as fever, malaise, weight loss, sweats, cough, dyspnoea, and/or pulmonary infiltrates or other serious systemic illness with or without concomitant shock, an invasive fungal infection should be suspected and administration of Humira should be promptly discontinued. Diagnosis and administration of empiric antifungal therapy in these patients should be made in consultation with a physician with appropriate expertise. Hepatitis B Reactivation: Reactivation of hepatitis B (HBV) has occurred in patients receiving a TNF-antagonist including Humira, who are chronic carriers of this virus (i.e. surface antigen positive), with some fatal outcomes. Patients should be tested for HBV infection before initiating treatment. Patients that test positive should have a consultation with a physician. In patients who develop HBV reactivation, Humira should be stopped and effective anti-viral therapy with appropriate supportive treatment should be initiated. Carriers of HBV should be closely monitored for signs and symptoms of active HBV infection throughout therapy and for several months following termination of Humira. Neurological events: Humira has been associated, in rare cases, with new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disease including multiple sclerosis and optic neuritis, and peripheral demyelinating disease, including Guillain-Barré syndrome. Caution should be exercised when considering Humira in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders. Allergic reactions: Postmarketing serious allergic reactions including anaphylaxis have been reported very rarely. If an anaphylactic reaction or other serious allergic reaction occurs, administration of Humira should be discontinued immediately and appropriate therapy initiated. The needle cover of the syringe contains natural rubber (latex). This may cause severe allergic reactions in patients sensitive to latex. Malignancies and lymphoproliferative disorders: In clinical trials, more cases of malignancies including lymphoma and leukaemia have been observed among patients receiving a TNF-antagonist compared with control patients. These data cannot exclude a possible risk of malignancy in patients including children and adolescents treated with TNF antagonists. Furthermore, there is an increased background lymphoma risk in RA patients. Rare postmarketing cases of hepatosplenic T-cell lymphoma have been identified in patients treated with adalimumab. Some of these cases have occurred in young adult patients on concomitant treatment with azathioprine or 6-mercaptopurine used for inflammatory bowel disease. The potential risk with the combination of azathioprine or 6-mercaptopurine and Humira should be carefully considered. A risk for the development of hepatosplenic T-cell lymphoma in patients treated with Humira cannot be excluded. Caution should be exercised in considering Humira treatment of patients with a history of malignancy. All patients, and in particular patients with a medical history of extensive immunosuppressant therapy or psoriasis patients with a history of PUVA treatment should be examined for the presence of non-melanoma skin cancer prior to and during treatment with Humira. Caution should also be exercised when using TNF-antagonists in COPD patients, as well as in patients with increased risk of malignancies due to heavy smoking. With current data it is not known if adalimumab treatment influences the risk for developing dysplasia or colon cancer. All patients with UC who are at increased risk for dysplasia or colon carcinoma (e.g. patients with long-standing UC or primary sclerosing cholangitis), or who had a prior history of dysplasia or colon carcinoma should be screened for dysplasia at regular intervals before therapy and throughout their disease course. This evaluation should include colonoscopy and biopsies per local recommendations. Haematologic reactions: Pancytopenia including aplastic anaemia has rarely been reported with TNF blocking agents. Adverse events of the haematologic system, including cytopenia (e.g. thrombocytopenia, leucopenia) have been reported with Humira. Patients should be advised to seek immediate medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Vaccinations: Patients on Humira may receive concurrent vaccinations, except for live vaccines. It is recommended that JIA patients, if possible, be brought up to date with all immunisations in agreement with current immunisation guidelines prior to initiating Humira therapy. Congestive heart failure: Humira should be used with caution in patients with mild heart failure (NYHA class I/II) and discontinued in patients who develop new or worsening symptoms of congestive heart failure. Autoimmune process: Humira may result in the formation of autoimmune antibodies. If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Humira and is positive for antibodies against double-stranded DNA, further treatment with Humira should not be given. Surgery: There is limited safety experience of surgical procedures in patients treated with Humira. The long half life of Humira should be taken into consideration when a surgical procedure is planned, and the patient should be monitored for infections. Small bowel obstruction: Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture that may require surgical treatment. Available data suggest that Humira does not worsen or cause strictures. Elderly population: The frequency of serious infections among Humira treated subjects over 65 years of age was higher than those under 65 years of age. Some of those had a fatal outcome. Particular attention regarding the risk for infection should be paid when treating the elderly. **Interactions:** Combination of adalimumab with other biologic DMARDs (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended. **Pregnancy and lactation:** Administration of adalimumab is not recommended during pregnancy. Women of childbearing potential should use adequate contraception and continue its use for at least five months after the last Humira treatment. Administration of live vaccines to infants exposed to adalimumab in utero is not recommended for 5 months following the mother's last adalimumab injection during pregnancy. Women must not breast-feed for at least five months after the last Humira treatment. **Driving and machinery:** Humira may have a minor influence on the ability to drive and use machines. **Side Effects:** From clinical trials unless marked * which indicates spontaneous reporting data. Very common $\geq 1/10$: Respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral), leucopenia (including neutropenia and agranulocytosis), anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction (including injection site erythema). Common $\geq 1/100$ to $< 1/10$: Systemic infections (including sepsis, candidiasis and influenza), intestinal infections (including gastroenteritis viral), skin and soft tissue infections (including paronychia, cellulitis, impetigo, necrotising fasciitis and herpes zoster), ear infections, oral infections (including herpes simplex, oral herpes and tooth infections), reproductive tract infections (including vulvovaginal mycotic infection), urinary tract infections (including pyelonephritis), fungal infections, joint infections, benign neoplasm, skin cancer excluding melanoma (including basal cell carcinoma and squamous cell carcinoma), thrombocytopenia, leucocytosis, hypersensitivity, allergies (including seasonal allergy), hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia, hyperglycaemia, hypophosphataemia, dehydration, mood alterations (including depression), anxiety, insomnia, paraesthesia (including hypoesthesia), migraine, nerve root compression, visual impairment, conjunctivitis, blepharitis, eye swelling, vertigo, tachycardia, hypertension, flushing, haematoma, cough, asthma, dyspnoea, GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome, worsening and new onset of psoriasis (including palmoplantar pustular psoriasis), alopecia, pruritis, urticaria, bruising (including purpura), dermatitis (including eczema), onychoclasis, hyperhidrosis, muscle spasms (including blood creatine phosphokinase increased), haematuria, renal impairment, chest pain, oedema, pyrexia, coagulation and bleeding disorders (including activated partial thromboplastin time prolonged), autoantibody test positive (including double stranded DNA antibody), blood lactate dehydrogenase increased, impaired healing. Uncommon $\geq 1/1000$ to $< 1/100$: Opportunistic infections and tuberculosis (including coccidioidomycosis, histoplasmosis and mycobacterium avium complex infection), neurological infections (including viral meningitis), eye infections, bacterial infections, diverticulitis, lymphoma, solid organ neoplasm (including breast cancer, lung neoplasm and thyroid neoplasm), melanoma, idiopathic thrombocytopenic purpura, sarcoidosis, cerebrovascular accident, tremor, neuropathy, diplopia, deafness, tinnitus, myocardial infarction, arrhythmia, congestive heart failure, pulmonary embolism, chronic obstructive pulmonary disease, interstitial lung disease, pneumonitis, pleural effusion, pancreatitis, dysphagia, face oedema, cholecystitis and cholelithiasis, bilirubin increased, hepatic steatosis, night sweats, scar, rhabdomyolysis, systemic lupus erythematosus, nocturia, erectile dysfunction, inflammation, vascular arterial occlusion, aortic aneurysm, thrombophlebitis. Rare $\geq 1/10,000$ to $< 1/1,000$: Leukaemia, anaphylaxis, demyelinating disorders (e.g. optic neuritis, Guillain-Barré syndrome), pancytopenia, multiple sclerosis, cardiac arrest, pulmonary fibrosis, intestinal perforation, reactivation of hepatitis B1, autoimmune hepatitis, erythema multiforme, cutaneous vasculitis, Stevens-Johnson syndrome, angioedema, lupus-like syndrome. Very rare $< 1/10,000$: Liver failure. Not known: Hepatosplenic T-cell lymphoma, Merkel Cell Carcinoma. **Prescribers should consult the summary of product characteristics for further information on side effects. Overdose:** No dose-limiting toxicity was observed during clinical trials. The highest dose level evaluated has been multiple intravenous doses of 10 mg/kg (approximately 15 times the recommended dose). **Storage Conditions:** Store in a refrigerator at 2–8°C. Keep in the outer carton, do not freeze. **Legal Category:** POM. **Marketing Authorisation Numbers/Presentations:** Vial: EU/1/03/256/001; 1 pack contains 2 cartons each containing 1 single use vial and empty sterile injection syringe, needle and vial adapter, Pre-filled Syringe: EU/1/03/256/003. Each carton contains 2 single use pre-filled syringes in a blister. Pre-filled Pen: EU/1/03/256/008. Each carton contains 2 single use pre-filled pens in a blister. Further information is available from AbbVie Limited, Block B, Liffey Valley Office Campus, Quarryvale, Co. Dublin. Date of revision of PI: November 2012 PI/256/007. **References:** 1. HUMIRA [summary of product characteristics]. AbbVie Limited, November 2012. 2. Data on file, AbbVie Inc. 2012. 3. Burmester GR, Panacione R, Gordon KB, et al. Adalimumab: long-term safety in 23 458 patients from global clinical trials in rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, psoriatic arthritis, psoriasis and Crohn's disease [published online ahead of print May 5, 2012]. Ann Rheum Dis. doi:10.1136/annrheumdis-2011-201244.



ISR Autumn Meeting

Thursday 19th & Friday 20th

September 2013

Knightsbrook Hotel, Trim

Academic Organisers: St. James' Hospital



Front L - R: Gaye Cunnane, Frances Stafford, Miriam O'Sullivan, Sinead Harney, David Kane.
Back L - R: Sandy Fraser, Gary Wright, Michael Dineen, Donough Howard.



IRHPS Spring 2013 Update

Welcome to the Spring Conference 2013.

Firstly I must extend my thanks to the ISR, Michael & Jenny and also to the Pharma companies for their continued support for a wide range of educational opportunities through our bursaries.

We had a successful meeting in Belfast in September with speakers from within our ranks as the 2 highest scored Abstract Submissions presented their work – many thanks to Derek Deeley and Jennifer Aston. Their presentations are now available to IRHPS members on the members section of the website (www.irhps.ie). We also had an interesting presentation on Motivation Interviewing from Kathy Gomas – again available in the members section of the website.

Congratulations go to Oriel Corcoran who won IRHPS/Pfizer bursary to attend the American College of Rheumatology meeting.

Remember that this is your society and if you have any topics you would like covered in future meetings please contact us via our email edofficer@irhps.ie

Congratulations also to our newest recruits as committee members – Derek Deeley and Sarah O'Driscoll – welcome!!

Rhona Galway
IRHPS Chair



**Rhona Galway
and Miriam Molloy**
Belfast September 2012



**Left to right - Yvonne Darcy (Pfizer), Miriam Molloy,
Oriel Corcoran & Gillian Dodd (Pfizer)**

It's about confidence

Hospira is one of the major companies producing and marketing biologics globally

With over 14,000 employees in 70 countries Hospira Biologics is built on strong foundations of excellence in innovation, service and support

Global biologics producer – built on foundations of excellence

Experienced manufacturer of biologics

Hospira Biologics use their extensive biologics expertise to manufacture their marketed products both in their own facilities and through rigorously evaluated manufacturing partners

Extensive biologics manufacturing expertise

Proven efficacy and safety

We work hard to ensure our products not only meet stringent efficacy and safety requirements, but also offer the practical features you find useful

Proven efficacy and safety combined with a range of additional benefits

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Hospira is a global company with a strong heritage of over 70 years, with access to the resources and skills needed to harness the very latest technological advances in biologics development.

Our philosophy is simply to deliver more in everything we do

ISR 40th Anniversary Gala Dinner: Titanic Belfast - Thurs 20th Sept evening



Michael Dineen (CEO), Rhona Galway (IRHPS Chairperson),
Mr Edwin Poots (MLA, Minister for Health), Gary Wright & Clare Wright



Stanley Roberts, Andrew Cairns,
Mr Edwin Poots (MLA, Minister for Health), Gary Wright & Michael Finch



Gary Wright presenting the Life Time Achievement Award 2012:
Dr Walter Boyd to his daughters



Life Time Achievement Award 2012: Dr Walter Boyd -
accepted by his daughters Jackie & Julie



Back: David Kane, Prof Rodney Grahame, Jeff Lee, Mr Edwin Poots (MLA, Minister for Health), Gary Wright, Sandy Fraser,
Oliver FitzGerald, Donough Howard, Allister Taggart, Allister Taggart, Rosie Bell, Aubrey Bell.
Front: Madeleine Rooney, Sinéad Harney, Gaye Cunanne, Frances Stafford, Sandra Taggart

Help Protect Your Post-Menopausal Patients From Osteoporotic Fractures

With 5600 IU
of Vitamin D



The Only Osteoporosis Therapy With 5600 IU
of Vitamin D That Provides Demonstrated
Fracture Prevention at the Hip and Spine,^{1,2}
in one tablet



Actual size

Updated NOF³
guidelines recommend
800–1000 IU of vitamin D
per day for adults ≥50 years³

FOSAVANCE 70 mg/2800 IU Tablets (70 mg alendronate acid as alendronate sodium trihydrate and 70 micrograms (2800 IU) colecalciferol (vitamin D3))
FOSAVANCE 70 mg/5600 IU Tablets (70 mg alendronate acid as alendronate sodium trihydrate and 140 micrograms (5600 IU) colecalciferol (vitamin D3))

ABBREVIATED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing. PRESENTATION FOSAVANCE 70 mg/2800 IU Tablets Capsule-shaped, white to off-white tablets marked with an outline of a bone image on one side, and '710' on the other, containing 70 mg alendronate acid as alendronate sodium trihydrate and 70 micrograms (2800 IU) colecalciferol (vitamin D3). FOSAVANCE 70 mg/5600 IU Tablets Modified rectangle-shaped, white to off-white tablets, marked with an outline of a bone image on one side, and '720' on the other, containing 70 mg alendronate acid as alendronate sodium trihydrate and 140 micrograms (5600 IU) colecalciferol (vitamin D3). **USES** Treatment of postmenopausal osteoporosis in patients at risk of vitamin D insufficiency and for 'Fosavance' 5600 for patients not receiving Vitamin D supplementation. 'Fosavance' reduces the risk of vertebral and hip fractures. **DOSAGE AND ADMINISTRATION** The recommended dose is one-tablet **once weekly**. Patients should be instructed that if they miss a dose of FOSAVANCE they should take one tablet on the morning after they remember. They should not take two tablets on the same day but should return to taking one tablet once a week, as originally scheduled on their chosen day. Due to the nature of the disease process in osteoporosis, 'Fosavance' is intended for long-term use. The optimal duration of bisphosphonate treatment for osteoporosis has not been established. The need for continued treatment should be re-evaluated periodically based on the benefits and potential risks of FOSAVANCE on an individual patient basis, particularly after 5 or more years of use. Patients must be advised to follow the instructions below. **For adequate absorption of alendronate:** 'Fosavance' must be taken with water only (not mineral water) at least 30 minutes before the first food, beverage, or medicinal product (including antacids, calcium supplements and vitamins) of the day. Other beverages (including mineral water), food and some medicinal products are likely to reduce the absorption of alendronate. The following instructions should be followed exactly in order to minimise the risk of oesophageal irritation and related reactions: • Swallow 'Fosavance' only upon arising for the day with a full glass of water (not less than 200 ml or 7 fl.oz.). • Patients should only swallow FOSAVANCE whole. Patients should not crush or chew the tablet or allow the tablet to dissolve in their mouths because of a potential for oropharyngeal ulceration. • Do not lie down until after the first food of the day. • Do not lie down for at least 30 minutes after taking 'Fosavance'. • Do not take at bedtime or before rising the day. Patients should receive supplemental calcium (intake from diet is inadequate. Additional supplementation with vitamin D should be considered on an individual basis taking into account vitamin D intake from vitamins and dietary supplements. Equivalence of 2800 IU of vitamin D, weekly in 'Fosavance' to daily dosing of vitamin D 400 IU has not been studied. Equivalence of intake of 5600 IU of vitamin D, weekly in FOSAVANCE to daily dosing of vitamin D 800 IU has not been studied. Use in the elderly: No dosage adjustment is necessary. Use in renal impairment: No dose adjustment is necessary for patients where GFR is greater than 35 ml/min. Alendronate is not recommended for patients with renal impairment where GFR is <35 ml/min. **Use in children and adolescents:** Not recommended. **CONTRAINDICATIONS** Oesophageal abnormalities and other factors which delay oesophageal emptying, such as stricture or achalasia. Inability to stand or sit upright for at least 30 minutes. Hypersensitivity to alendronate or to any of the excipients. Hypocalcaemia. **PRECAUTIONS** Alendronate can cause local irritation of the upper gastro-intestinal mucosa and potentially worsen any underlying disease. Because there is a potential for worsening of the underlying disease, caution should be used when alendronate is given to patients with active upper gastro-intestinal problems, such as dysphagia, oesophageal disease, gastritis, duodenitis, or ulcers, or with a recent history (within the previous year) of gastro-intestinal disease such as peptic ulcer, or active gastro-intestinal bleeding, or surgery of the upper gastro-intestinal tract other than pyloroplasty. In patients with known Barrett's oesophagus, prescribers should consider the benefits and potential risks of alendronate on an individual patient basis. Oesophageal reactions (sometimes severe and requiring hospitalisation), such as oesophagitis, oesophageal ulcers and oesophageal erosions, rarely followed by oesophageal strictures, have been reported in patients receiving alendronate. Physicians should be alert to any signs or symptoms of a possible oesophageal reaction, and patients should be instructed to discontinue alendronate and seek medical attention if they develop symptoms of oesophageal irritation such as dysphagia, pain on swallowing, retrosternal pain, or new or worsening heartburn. The risk of severe oesophageal adverse reactions appear to be greater in patients who fail to take alendronate properly and/or continue to take alendronate after developing symptoms suggestive of oesophageal irritation. It is very important that the full dosing instructions are provided to, and understood by the patient. Patients should be informed that failure to follow these instructions may increase their risk of oesophageal problems. While no increased risk was observed in extensive clinical trials with alendronate, there have been rare (post-marketing) reports of gastric and duodenal ulcers, some severe and with complications. Osteonecrosis of the jaw, generally associated with tooth extraction and/or local infection (including osteomyelitis) has been reported in patients with cancer receiving treatment regimens including primarily intravenously administered bisphosphonates. Many of these patients were also receiving chemotherapy and corticosteroids. Osteonecrosis of the jaw has also been reported in patients with osteoporosis receiving oral bisphosphonates. The following risk factors should be considered when evaluating an individual's risk of developing osteonecrosis of the jaw: potency of the bisphosphonate (highest for zoledronic acid), route of administration (see above) and cumulative dose, cancer, chemotherapy, radiotherapy, corticosteroids, smoking, a history of dental disease, poor oral hygiene, periodontal disease, invasive dental procedures and poorly fitting dentures. A dental examination with appropriate preventive dentistry should be considered prior to treatment with oral bisphosphonates in patients with poor dental status. While on treatment, these patients should avoid invasive dental procedures if possible. For patients who develop osteonecrosis of the jaw while on bisphosphonate therapy, dental surgery may exacerbate the condition. For patients requiring dental procedures, there are no data available to suggest whether discontinuation of bisphosphonate treatment reduces the risk of osteonecrosis of the jaw. During bisphosphonate treatment, all patients should be encouraged to maintain good oral hygiene, receive routine dental check-ups, and report any oral symptoms such as dental mobility, pain, or swelling. Clinical judgment of the treating physician should guide the management plan of each patient based on individual benefit/risk assessment. Bone, joint and/or muscle pain has been reported in patients taking bisphosphonates. In post-marketing experience, these symptoms have rarely been severe and/or incapacitating. The time to onset of symptoms varied from one day to several months after starting treatment. Most patients had relief of symptoms after stopping treatment. A subset had recurrence of symptoms when rechallenged with the same medicinal product or another bisphosphonate. Atypical subtrochanteric and diaphyseal femoral fractures have been reported with bisphosphonate therapy, primarily in patients receiving long-term treatment for osteoporosis. These transverse or short oblique fractures can occur anywhere along the femur from just below the lesser trochanter to just above the supracondylar flare. These fractures occur after minimal or no trauma and some patients experience thigh or groin pain, often associated with imaging features of stress fractures, weeks to months before presenting with a completed femoral fracture. Fractures are often bilateral; therefore the contralateral femur should be examined in bisphosphonate-treated patients who have sustained a femoral shaft fracture. Poor healing of these fractures has also been reported. Discontinuation of bisphosphonate therapy in patients suspected to have an atypical femoral fracture should be considered pending evaluation of the patient, based on an individual benefit/risk assessment. During bisphosphonate treatment patients should be advised to report any thigh, hip or groin pain and any patient presenting with such

symptoms should be evaluated for an incomplete femur fracture. Cause of osteoporosis other than oestrogen deficiency and ageing should be considered. Hypocalcaemia must be corrected before initiating therapy with 'Fosavance'. Other disorders affecting mineral metabolism (such as vitamin D deficiency and hypoparathyroidism) should also be effectively treated before starting 'Fosavance'. The content of vitamin D in 'Fosavance' is not suitable for correction of vitamin D deficiency. In patients with these conditions, serum calcium and symptoms of hypocalcaemia should be monitored during therapy with 'Fosavance'. Due to the positive effects of alendronate in increasing bone mineral, decreases in serum calcium and phosphate may occur especially in patients taking glucocorticoids in whom calcium absorption may be decreased. **Colecalciferol:** Vitamin D₃ may increase the magnitude of hypercalcaemia and/or hypercalciuria when administered to patients with disease associated with unregulated overproduction of calcitriol (e.g. leukaemia, lymphoma, sarcoidosis). Urine and serum calcium should be monitored in these patients. Patients with malabsorption may not adequately absorb vitamin D. **Excipients:** Patients with rare hereditary problems of fructose intolerance, galactose intolerance, the Lapp lactase deficiency, glucose-galactose malabsorption or sucrose isomaltase insufficiency should not take 'Fosavance'. **Drug interactions** If taken at the same time, it is likely that food, beverages (including mineral water), calcium supplements, antacids, and some oral medicinal products will interfere with absorption of alendronate. Therefore, patients must wait at least 30 minutes after taking alendronate before taking any other oral medicinal product. Since NSAID use is associated with gastrointestinal irritation, caution should be used during concomitant use with alendronate. **Colecalciferol:** Oestra, mineral oils, orlistat, and bile acid sequestrants (e.g. cholestyramine, colestipol) may impair the absorption of vitamin D. Anticonvulsants, cimetidine and thiazides may increase the catabolism of vitamin D. Additional vitamin D supplements may be considered on an individual basis. **Use in pregnancy and lactation:** 'Fosavance' is only intended for use in postmenopausal women and therefore it should not be used during pregnancy or in breast-feeding women. There are no adequate data from the use of 'Fosavance' in pregnant women. It is not known whether alendronate is excreted into human breast milk. Colecalciferol and some of its active metabolites pass into breast milk. Fertility There are no data on fetal risk in humans. However, there is a theoretical risk of fetal harm, predominantly skeletal, if a woman becomes pregnant after completing a course of bisphosphonate therapy. **EFFECTS ON ABILITY TO DRIVE AND USE MACHINES** Certain adverse reactions that have been reported with FOSAVANCE may affect some patients' ability to drive or operate machinery. Individual responses to FOSAVANCE may vary. **SIDE EFFECTS** Frequencies are defined as: very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000), very rare (< 1/10,000)

Immune system disorders:	Rare: hypersensitivity reactions including urticaria and angioedema
Metabolism and nutrition disorders:	Rare: symptomatic hypocalcaemia, often in association with predisposing conditions
Nervous system disorders:	Common: headache, dizziness. Uncommon: dysgeusia ¹
Eye disorders:	Uncommon: eye inflammation (uveitis, scleritis, or episcleritis)
Ear and labyrinth disorders:	Common: vertigo ¹
Gastrointestinal disorders:	Common: abdominal pain, dyspepsia, constipation, diarrhoea, flatulence, oesophageal ulcer, dysphagia, abdominal distension, acid regurgitation. Uncommon: nausea, vomiting, gastritis, oesophagitis, oesophageal erosions, melena ¹ . Rare: oesophageal stricture, oropharyngeal ulceration ¹ , upper gastrointestinal PUBs (perforation, ulcers, bleeding)
Skin and subcutaneous tissue disorders:	Common: alopecia ¹ , pruritus ¹ . Uncommon: rash, erythema. Rare: rash with photosensitivity, severe skin reactions including Stevens-Johnson syndrome and toxic epidermal necrolysis ¹
Musculoskeletal and connective tissue disorders:	Very common: musculoskeletal (bone, muscle or joint) pain which is sometimes severe ¹ . Common: joint swelling ¹ . Rare: osteonecrosis of the jaw ¹ , stress fractures of the proximal femoral shaft ¹ , atypical subtrochanteric and diaphyseal femoral fractures (bisphosphonate class adverse reaction) ¹
General disorders and administration site conditions:	Common: asthenia ¹ , peripheral oedema ¹ . Uncommon: transient symptoms as in an acute-phase response (myalgia, malaise and rarely, fever), typically in association with initiation of treatment ¹

¹Frequency in Clinical Trials was similar in the drug and placebo group. ²This adverse reaction was identified through post-marketing surveillance. The frequency of rare was estimated based on relevant clinical trials. ³Identified in postmarketing experience.

OVERDOSE Alendronate Hypocalcaemia, hypophosphataemia and upper gastrointestinal adverse reactions, such as upset stomach, heartburn, oesophagitis, gastritis, or ulcer, may result from oral overdose. No specific information is available on the treatment of overdose with alendronate. In case of overdose with FOSAVANCE, milk or antacids should be given to bind alendronate. Owing to the risk of oesophageal irritation, vomiting should not be induced and the patient should remain fully upright. **Colecalciferol:** Vitamin D toxicity has not been documented during chronic therapy in generally healthy adults at a dose less than 10,000 IU/day. In a clinical study of healthy adults a 4,000 IU daily dose of vitamin D₃ for up to five months was not associated with hypercalcaemia or hypercalcaemia.

PACKAGE QUANTITIES 'Fosavance' 70 mg/2800 IU Tablets 4 tablets. 'Fosavance' 70 mg/5600 IU Tablets 4 tablets. **POM Date of review:** June 2011

Marketing Authorisation numbers: 'Fosavance' 70 mg/2800 IU Tablets EU/1/05/310/002 'Fosavance' 70 mg/5600 IU Tablets EU/1/05/310/007 **Marketing Authorisation Holder:** Merck Sharp & Dohme Limited, Hertford Road, Hoddeston, Hertfordshire EN11 9BU, UK. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie. © Merck Sharp & Dohme Ireland (Human Health) Limited, 2012. All rights reserved. Date of preparation: September 2012.



Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland



ISR 40th Anniversary Gala Dinner: Titanic Belfast - Thurs 20th Sept evening



Eoin Casey & Carmel Silke



ISR Presidents

Back: Michael Molloy, Oliver FitzGerald, Jeff Lee
Middle: Stanley Roberts, Aubrey Bell, Ronan Kavanagh, Allister Taggart
Front: Gary Wright, Gaye Cunnane, Eoin Casey



Dinner Guests

Adenuric[®]

(febuxostat)

A daily response¹
For a destructive disease²



ADENURIC 80 mg and 120 mg film-coated tablets: Abbreviated Prescribing Information Please consult the Summary of Product Characteristics (SmPC) for full prescribing information. **Presentation:** Film-coated tablets containing 80 mg or 120 mg febuxostat. Also contains lactose monohydrate. **Use:** Treatment of chronic hyperuricaemia in conditions where urate deposition has already occurred (including a history, or presence of, tophus and/or gouty arthritis) in adults. **Dosage and administration:** Oral use with or without food. Recommended dose is 80 mg once daily. If serum uric acid is > 6 mg/dL (357 μ mol/L) after 2-4 weeks, 120 mg once daily may be considered. **Elderly:** No dose adjustment required. **Renal impairment:** No dosage adjustment necessary in patients with mild or moderate renal impairment. Efficacy and safety not fully evaluated in patients with severe renal impairment. **Hepatic impairment:** Recommended dosage in patients with mild hepatic impairment is 80 mg. Limited information available in patients with moderate hepatic impairment. Efficacy and safety has not been studied in patients with severe hepatic impairment. **Children and adolescents:** Safety and efficacy in children under 18 has not been established. **Organ transplant recipients:** No experience therefore not recommended. **Contra-indications:** Hypersensitivity to the active ingredient or to any of the excipients. **Warnings and precautions:** **Cardio-vascular disorders:** **Not recommended in patients with ischaemic heart disease or congestive heart failure.** **Product allergy/hypersensitivity:** Advise patients of signs/symptoms of allergic/hypersensitivity reactions and monitor closely for symptoms. Stop treatment immediately if serious reactions occur, including Stevens-Johnson syndrome, and do not re-start febuxostat at any time. **Acute gouty attacks (gout flare):** Do not start treatment until an acute attack of gout has completely subsided. As with other urate lowering medicinal products, gout flares may occur during initiation of treatment. At treatment initiation flare prophylaxis for at least 6 months with an NSAID or colchicine is recommended. If a gout flare occurs during treatment, do not discontinue. Manage the gout flare concurrently as appropriate. Continuous treatment decreases frequency and intensity of gout flares. **Xanthine deposition:** As with other urate lowering medicinal products, in patients in whom the rate of urate formation is greatly increased (e.g. malignant disease and its treatment, Lesch-Nyhan syndrome), the absolute concentration of xanthine in urine could, in rare cases, rise sufficiently to allow deposition in the urinary tract. As there has been no experience, febuxostat is not recommended for use in these populations. **Mercaptopurine/azathioprine:** Not recommended in patients concomitantly treated with mercaptopurine/azathioprine. Where combination cannot be avoided, monitor patients closely. Dose reduction for mercaptopurine/azathioprine is recommended. **Theophylline:** Use with caution in patients concomitantly treated with theophylline. Monitor theophylline levels in patients starting febuxostat therapy. **Liver disorders:** Liver function test is recommended prior to the initiation of therapy and periodically thereafter based on clinical judgement. **Thyroid disorders:** Caution in patients with alteration of thyroid function. **Lactose:** Contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. **Interactions:** **Mercaptopurine/azathioprine:** On the basis of the mechanism of action of febuxostat on xanthine oxidase inhibition concomitant use is not recommended. No data is available regarding the safety of febuxostat during cytotoxic chemotherapy. **Theophylline:** Inhibition of XO may cause an increase in the theophylline level. Caution advised if these substances are given concomitantly, monitor theophylline levels in patients starting febuxostat therapy. **Naproxen and other inhibitors of glucuronidation:** Can be co-administered with naproxen with no dose adjustments necessary. **Inducers of glucuronidation:** Monitoring of serum uric acid is recommended 1-2 weeks after start of treatment with a potent inducer of glucuronidation. Cessation of treatment of an inducer might lead to increased plasma levels of febuxostat. **Colchicine/indomethacin/hydrochlorothiazide/warfarin:** Can be co-administered with

colchicine or indomethacin with no dose adjustments necessary. No dose adjustment necessary when administered with hydrochlorothiazide. No dose adjustment necessary for warfarin when administered with febuxostat. **Desipramine/CYP2D6 substrates:** Co administration with other CYP2D6 substrates is not expected to require any dose adjustment for those compounds. **Antacids:** May be taken without regard to antacid use. **Pregnancy and lactation:** Do not use during pregnancy or breast-feeding. Effect on fertility unknown. **Side-Effects:** **Clinical Studies and post-marketing experience:** **Common (1-10%):** Gout flares, headache, diarrhoea, nausea, liver function test abnormalities, rash, oedema. **Uncommon (0.1-1%):** Blood thyroid stimulating hormone increased, diabetes mellitus, hyperlipidemia, decrease appetite, weight increase, decreased libido, insomnia, dizziness, paraesthesia, hemiparesis, somnolence, altered taste, hypoaesthesia, hyposmia, atrial fibrillation, palpitations, ECG abnormal, hypertension, flushing, hot flush, dyspnoea, bronchitis, upper respiratory tract infection, cough, abdominal pain, abdominal distension, gastro-oesophageal reflux disease, vomiting, dry mouth, dyspepsia, constipation, frequent stools, flatulence, gastrointestinal discomfort, cholelithiasis, dermatitis, urticaria, pruritus, skin discolouration, skin lesion, petechiae, rash macular, rash maculopapular, rash papular, arthralgia, arthritis, myalgia, musculoskeletal pain, muscle weakness, muscle spasm, muscle tightness, bursitis, renal failure, nephrolithiasis, haematuria, pollakiuria, proteinuria, erectile dysfunction, fatigue, chest pain, chest discomfort, blood amylase increase, platelet count decrease, WBC decrease, lymphocyte count decrease, blood creatine increase, blood creatinine increase, haemoglobin decrease, blood urea increase, blood triglycerides increase, blood cholesterol increase, haematocrit decrease, blood lactate dehydrogenase increased, blood potassium increase. **Rare (0.1-0.01%):** Pancytopenia, thrombocytopenia, anaphylactic reaction, drug hypersensitivity, blurred vision, weight decrease, increase appetite, anorexia, nervousness, tinnitus, pancreatitis, mouth ulceration, hepatitis, jaundice, Stevens-Johnson Syndrome, angioedema, generalized rash (serious), erythema, exfoliative rash, rash follicular, rash vesicular, rash pustular, rash pruritic, rash erythematous, rash morbilliform, alopecia, hyperhidrosis, rhabdomyolysis, joint stiffness, musculoskeletal stiffness, tubulointerstitial nephritis, micturition urgency, thirst, blood glucose increase, activated partial thromboplastin time prolonged, red blood cell count decrease, blood alkaline phosphatase increase. *Treatment-emergent non-infective diarrhoea and abnormal liver function tests in combined Phase III studies more frequent in patients concomitantly treated with colchicine. **Adverse reactions coming from post-marketing experience. Rare serious hypersensitivity reactions including Stevens-Johnson Syndrome and anaphylactic reaction/shock have occurred in post-marketing experience. Hypersensitivity reactions to febuxostat can be associated with the following symptoms: skin reactions characterised by infiltrated maculopapular eruption, generalised or exfoliative rashes, also skin lesions, facial oedema, fever, haematologic abnormalities such as thrombocytopenia, and single or multiple organ involvement (liver and kidney including tubulointerstitial nephritis). Gout flares commonly observed soon after treatment start and in first months. Frequency decreases after time. Gout flare prophylaxis is recommended. Please consult the SmPC for further information. **Pack sizes:** 80 mg and 120 mg tablets: 28 film-coated tablets. **Legal category:** POM. **Marketing authorization number:** EU/1/08/447/001 & 003. **Marketing authorization holder:** Menarini International Operations Luxembourg S.A., Avenue de la Gare, L-1611 Luxembourg, Luxembourg. **Marketed by:** A. Menarini Pharmaceuticals Ireland Ltd. Further information is available on request to A. Menarini Pharmaceuticals Ireland Ltd, 2nd Floor, Castlecourt, Monkstown Farm, Monkstown, Glenageary, Co. Dublin or may be found in the SmPC. **Last updated:** January 2013. **References:** 1. Adenuric SmPC. December 2012. 2. McQueen, F.M., et al. *Nat Rev Rheumatol*, 2012. 8(3): p. 173-81.

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Date of item: January 2013
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 **A.MENARINI**
PHARMACEUTICALS IRELAND LTD
Healthcare for Life

DAY 2: Speakers & Scientific Research Oral Presenters & YIA a.m. Friday 21st September 2012



Adrian Pendleton (Musgrave Park Hospital)
& Stephanie Walker (Craigavon Area Hospital)



Prof Michael Molloy (Cork): 'Rheumatology and Sports Medicine'



David Gibson (Queen's University)



Eoghan McCarthy (Beaumont Hospital)



Professor Geraldine McCarthy (MMUH) & Roland McKane (Ulster Hospital)



Sorcha Finnegan (Queen's University)



Elisabeth Ball (Queen's University)



Mary Connolly (Dublin Academic Medical Centre & Conway Institute
of Biomolecular & Biomedical Research)

Prize Winners



Mary Connolly - Young Investigator Award Winner



Brian Whitley (MSD), Gary Wright (President) & David Gibson (1st prize: Oral)



Brian Whitley (MSD), Gary Wright (President) & Sorcha Finnegan (2nd prize: Oral)



Jay Cusack (Abbott), Gary Wright (President) & Emma Campbell (1st prize: Poster)



Jay Cusack (Abbott), Gary Wright (President) & Oliver FitzGerald accepting on behalf of Opeyemi Ademowo (2nd prize: Poster)



Gary Wright (President) & Tehzeen Wazir accepting on behalf of Eimear Savage (1st prize: Case Oral)



IN DMARD-IR AND TNF-IR RA PATIENTS,
WHEN COMBINATION WITH MTX IS NOT AN OPTION...

ROACTEMRA
STANDS OUT¹

 **RoACTEMRA[®]**
tocilizumab

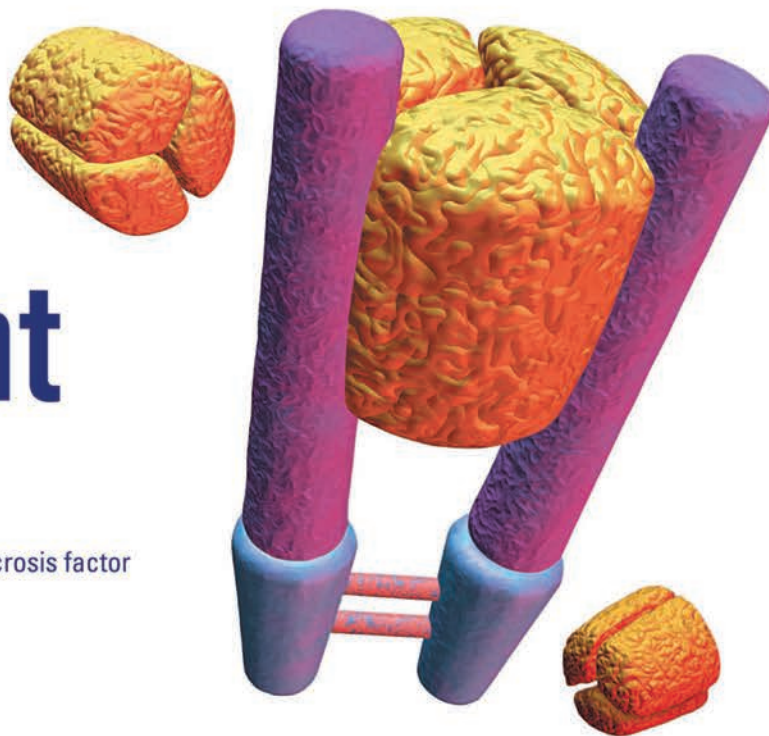
RoACTEMRA, in combination with methotrexate (MTX), is indicated for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have either responded inadequately to, or who were intolerant to, previous therapy with one or more disease-modifying anti-rheumatic drugs (DMARDs) or tumour necrosis factor (TNF) antagonists. In these patients, RoACTEMRA can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate. RoACTEMRA has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function when given in combination with methotrexate.²

ABRIDGED PRESCRIBING INFORMATION (For full prescribing information, refer to the Summary of Product Characteristics (SmPC)) RoACTEMRA[®] (Tocilizumab) 20mg/ml Concentrate for Solution for Infusion

Indications: (i) In combination with methotrexate (MTX), for the treatment of adult patients with moderate to severe active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more DMARDs or TNF antagonists. In these patients, RoACTEMRA can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate. RoACTEMRA has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function when given in combination with methotrexate. (ii) As monotherapy (in case of intolerance to MTX or where treatment with MTX is inappropriate) or in combination with MTX, for the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients ≥ 2 years of age, who have responded inadequately to previous therapy with NSAIDs and systemic corticosteroids. **Dosage and Administration:** Treatment should be initiated by healthcare professionals experienced in the diagnosis and treatment of RA and sJIA and all patients should be given the Patient Alert Card. **RA Patients:** Recommended posology is 8mg/kg diluted to a final volume of 100ml, given once every 4 weeks by iv infusion over 1 hour. For patients weighing > 100kg, doses > 800mg per infusion are not recommended. No data on doses above 1.2g. **Dose adjustments:** Dose modification, interruption or in some cases discontinuation of RoACTEMRA recommended in the event of raised liver enzymes, low absolute neutrophil count (ANC) or low platelet count (see SmPC for details). In patients not previously treated with RoACTEMRA, initiation not recommended in patients with an ANC below $2 \times 10^9/l$. Closely monitor renal function in patients with moderate to severe renal impairment as RoACTEMRA has not been studied in these patients. No data in patients with hepatic impairment. **sJIA Patients:** No data in patients < 2 years of age. **Posology:** 8mg/kg for patients ≥ 30kg or 12mg/kg for patients < 30kg once every 2 weeks by iv infusion over 1 hour. Check patient's weight at each visit – refer to SmPC. In the event of raised liver enzymes, low ANC or low platelet count, interrupt/discontinue RoACTEMRA dose or modify/stop concomitant MTX and other medications where appropriate – see SmPC for details. Reduction of RoACTEMRA dose due to laboratory abnormalities not studied in sJIA patients. Clinical improvement is generally seen within 6 weeks of starting RoACTEMRA, reconsider continued therapy if no improvement seen in this timeframe. **Contraindications:** Hypersensitivity to any component of the product; active, severe infections. **Warnings and Precautions:** Serious (sometimes fatal) infections reported in patients receiving immunosuppressive agents including RoACTEMRA. Do not initiate in patients with active infection. If serious infection develops interrupt therapy until infection controlled. Caution in patients with history of recurring/chronic infections, or other underlying conditions (e.g. diverticulitis, diabetes and interstitial lung disease) which may predispose patients to infection. Vigilance for the timely detection of serious infection recommended. Advise all patients and parents/guardians of sJIA patients to contact their healthcare professional immediately when symptoms suggestive of an infection appear. Screen for latent TB prior to starting therapy. Treat latent TB with standard anti-mycobacterial therapy before initiating RoACTEMRA. Viral reactivation (e.g. hepatitis B) reported with biologic therapies for RA. Patients screening positive for hepatitis excluded from clinical trials. Events of diverticular perforations as complications of diverticulitis reported uncommonly with RoACTEMRA in RA patients. Exercise caution in patients with a history of intestinal ulceration or diverticulitis. Evaluate patients with symptoms of complicated diverticulitis promptly. Serious hypersensitivity reactions reported – may be more severe and potentially fatal in patients who have experienced hypersensitivity reactions during previous infusions even if they have received premedication with steroids and anti-histamines. Appropriate treatment should be available for immediate use in the event of an anaphylactic reaction with RoACTEMRA. If an anaphylactic reaction or other serious hypersensitivity/serious infusion related reaction occurs, stop administration of RoACTEMRA immediately and discontinue therapy permanently. Use with caution in patients with active hepatic disease or hepatic impairment. Not recommended in patients with baseline ALT or AST > 5 x ULN; use with caution in patients with ALT or AST > 1.5 x ULN. Monitor ALT and AST levels for RA and sJIA patients according to SmPC – other liver function tests including bilirubin should be considered where indicated. If raised, follow dosage recommendations in SmPC for RA and sJIA patients. Risk of neutropenia may be increased in patients previously treated with a TNF antagonist. Continued therapy not recommended in patients who develop an ANC < $0.5 \times 10^9/l$ or platelet count < $50 \times 10^9/l$. In patients not previously treated with RoACTEMRA, initiation not recommended where ANC is below $2 \times 10^9/l$. Caution in patients with low platelet count; monitor neutrophils and platelets in RA and sJIA patients according to SmPC. If reduced, follow dosage recommendations in SmPC for RA and sJIA patients. Elevations in lipid parameters seen – refer to SmPC. Assess lipid parameters according to SmPC, if elevated, manage patients according to local guidelines for hyperlipidaemia. Potential for central demyelination with RoACTEMRA currently unknown; physicians should be vigilant for symptoms of new onset disease. Immunomodulatory medicines may increase malignancy risk in RA patients. Do not give live and live attenuated vaccines concurrently with RoACTEMRA as safety not established – refer to SmPC for further details on immunisations. RA patients should have CV risk factors managed as part of usual standard of care. Not recommended for use with other biological agents. Macrophage activation syndrome (MAS) is a serious life-threatening disorder that may develop in sJIA patients – RoACTEMRA has not been studied in patients during an active MAS episode. Advise patients experiencing dizziness not to drive or use machines until dizziness resolved. Product contains 26.55mg sodium per 100mg. **Drug Interactions:** In RA patients, levels of simvastatin (CYP3A4) were decreased by 57% one week following a single dose of tocilizumab to levels similar to or slightly higher than those observed in healthy subjects. Monitor patients taking medicines which are individually adjusted and metabolised via CYP450 3A4, 1A2 or 2C9 when starting or stopping RoACTEMRA, as doses may need to be increased to maintain therapeutic effect. The effect of tocilizumab on CYP450 enzyme activity may persist for several weeks after stopping therapy. Refer to SmPC for further details on the effects of RoACTEMRA on cytochrome CYP450. **Fertility, Pregnancy and Lactation:** No adequate data from use in pregnant women. Animal study showed an increased risk of spontaneous abortion/embryo-fetal death at high dose. RoACTEMRA should not be used during pregnancy unless clearly necessary. Women of childbearing potential should use effective contraception during and up to 3 months after treatment. No lactation data in humans. A decision on whether to continue/discontinue breastfeeding or RoACTEMRA therapy should be made taking into account the relative benefits to the child and mother. **Side Effects and Adverse Reactions:** RA: ADRs occurring in patients with RA receiving tocilizumab as monotherapy or in combination with MTX or other DMARDs: Very Common (≥ 1/10): upper respiratory tract infections and hypercholesterolaemia. Common (≥ 1/100 - < 1/10): cellulitis, pneumonia, oral herpes simplex, herpes zoster, abdominal pain, mouth ulceration, gastritis, rash, pruritus, urticaria, headache, dizziness, hepatic transaminases increased, weight increased, total bilirubin increased, hypertension, leucopenia, neutropenia, peripheral oedema, hypersensitivity reactions, conjunctivitis, cough and dyspnoea. sJIA: In general, the ADRs were similar to those seen in RA patients. Infections - Serious infections of varicella and otitis media reported. Infusion reactions - Hypersensitivity reactions requiring treatment discontinuation occurred in < 1% of patients. Other events occurring within 24 hours of infusion in 16% of patients included, but were not limited to rash, urticaria (considered serious), diarrhoea, epigastric discomfort, arthralgia and headache. IgG – decreased levels during therapy. Other – decreases in neutrophil and platelet counts, hepatic transaminase elevations, lipid parameter increases and anti-tocilizumab antibodies observed. **Serious or Potentially Serious:** active tuberculosis, invasive pulmonary infections, interstitial lung disease (including pneumonitis and pulmonary fibrosis), gastrointestinal perforations (as complications of diverticulitis), serious hypersensitivity reactions. Refer to SmPC for a complete listing of adverse events for RA and sJIA. **Legal Category:** Limited to sale and supply on prescription only. **Presentations and Marketing Authorisation Numbers:** 80mg of tocilizumab in 4ml (20mg/ml) pack of 1 (EU/1/08/492/001); 200mg of tocilizumab in 10ml (20mg/ml) pack of 1 (EU/1/08/492/003); 400mg of tocilizumab in 20ml (20mg/ml) pack of 1 (EU/1/08/492/005). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, United Kingdom. RoACTEMRA is a registered trade mark. Further information is available from Roche Products (Ireland) Limited, 3304 Lake Drive, Citywest, Naas Road, Dublin 24, Telephone: (01) 4690700, Fax: (01) 4690791. **Date of Preparation:** June 2012. p05/07/12. Copyright © 2012 by Roche Products (Ireland) Ltd. All rights reserved. **References:** 1. Nisar MK et al. The role of tocilizumab monotherapy in the management of rheumatoid arthritis: a review. Int. J. Clin. Rheumatol. (2012) 7(1): 9-19. 2. SmPC, RoACTEMRA (tocilizumab) Summary of Product Characteristics, 26 May 2012.



ENBREL is Different



A unique mechanism of action

- Enbrel is the only fully human soluble tumour necrosis factor (TNF) receptor^{1,2,3,4,5,6}
- It works differently than MAB's¹

No neutralising antibodies⁷

- Enbrel is not associated with the production of neutralising antibodies in humans

Enbrel has a short half life (<3 days)⁷

- The half-life of anti-TNF agents should be taken into account if a treatment break is required

Efficacy

- Registry data and Cochrane Review data support efficacy & safety of Enbrel^{7,8}



ABBREVIATED PRESCRIBING INFORMATION

Before prescribing Enbrel® please refer to full Summary of Product Characteristics (SmPC).
Presentation: Enbrel Pre-filled Syringe: Enbrel 25 mg and 50 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains either 25 mg or 50 mg etanercept. Enbrel Pre-filled Pen (MYCLIC®): Enbrel 50 mg solution for injection in pre-filled pen. Each pre-filled pen contains 50 mg etanercept. Enbrel Powder: Enbrel 25 mg powder and solvent for solution for injection. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel Paediatric: Enbrel 10 mg powder and solvent for solution for injection for paediatric use. Each vial contains 10 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel 25 mg/ml powder and solvent for solution for injection for paediatric use. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml bacteriostatic water for injections. **Uses:** Adults: Moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, when response to DMARDs, including methotrexate (unless contraindicated), has been inadequate. Enbrel can be given as monotherapy in the case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Severe, active and progressive RA without prior methotrexate treatment. Enbrel alone or with methotrexate has been shown to reduce the rate of progression of joint damage measured by X-ray and to improve physical function. Patients with moderate to severe plaque psoriasis (PP) who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporin, methotrexate or PUVA. Active and progressive psoriatic arthritis (PsA) when response to DMARDs has been inadequate. Enbrel has been shown to improve physical function in PsA patients, and to reduce the progression rate of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of PsA. Severe active ankylosing spondylitis (AS) when response to conventional therapy has been inadequate. Children aged 2-17 years (25 mg only): Active polyarticular juvenile idiopathic arthritis (JIA) when inadequate response to, or intolerant of methotrexate. Children aged 6-17 years: Chronic severe psoriasis when inadequately controlled by, or intolerant to, other systemic therapies or phototherapies. **Dosage:** By subcutaneous injection. Adults: RA – 25 mg twice weekly or 50 mg once weekly PP – 25 mg twice weekly or 50 mg once weekly for up to 24 weeks, or 50 mg twice weekly for up to 12 weeks followed by 25 mg twice weekly or 50 mg once weekly for a further 12 weeks if needed. Continuous therapy may be appropriate for some adult patients. Discontinue if no response after 12 weeks. For re-treatment: 25 mg twice weekly or 50 mg once weekly for up to 24 weeks. AS and PsA – 25 mg twice weekly or 50 mg once weekly. Children aged 2-17 years: JIA in children aged 2-17 years – 0.4 mg/kg (maximum per dose 25 mg) twice weekly with an interval of 3 – 4 days. Discontinuation of treatment should be considered in patients who show no response after 4 months. Children aged 6-17 years: Plaque psoriasis in children aged 6-17 years – 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. Discontinue if no response after 12 weeks. For re-treatment: 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. **Contra-indications:** Hypersensitivity to any of the ingredients, sepsis or risk of sepsis, active infections. Enbrel Paediatric (25 mg): Must not be given to premature babies or neonates as the bacteriostatic water for injections contains benzyl alcohol. **Warnings and Precautions:** Enbrel should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA, JIA, PsA, AS, PP or Paediatric PP. Patients treated with Enbrel should be given the Patient Alert Card. Use carefully in patients predisposed to, or with history of, infection due to

underlying diseases other than RA (e.g. advanced or poorly controlled diabetes) or with history of blood dyscrasias, pre-existing or predisposition to demyelinating disease or congestive heart failure. Cases of active tuberculosis have been reported, therefore all patients should be evaluated for both active and inactive TB prior to being treated with Enbrel. If active TB is diagnosed, Enbrel should not be initiated. Caution should be used when administering Enbrel to patients identified as carriers of hepatitis B virus and there have been reports of worsening hepatitis C in patients receiving Enbrel. Use with caution in patients with a history of hepatitis C. Whether treatment with Enbrel might influence the development and course of active and/or chronic infections is unknown. Concurrent administration of Enbrel and anakinra has been associated with increased risk of serious infections and neutropenia, and is therefore not recommended. In clinical studies, concurrent administration of abatacept and Enbrel resulted in increased incidences of serious adverse events, and is therefore not recommended. Use caution when considering combination therapy with sulfasalazine. Reports of various malignancies have been received in the post-marketing period, therefore with current knowledge, a possible risk for the development of lymphomas, leukaemia or other haematopoietic or solid malignancies in patients treated with a TNF-antagonist cannot be excluded. Malignancies, some fatal, have been reported among children, adolescents and young adults (up to 22 years of age) treated with TNF-antagonists (initiation of therapy ≤ 18 years of age) in the postmarketing setting. Melanoma and non-melanoma skin cancer (NMSC) have been reported in patients treated with TNF-antagonists, including Enbrel. Post-marketing cases of Merkel cell carcinoma have been reported very infrequently in patients treated with Enbrel. Periodic skin examination is recommended for all patients, particularly those with risk factors for skin cancer. Enbrel has not been studied in combination with other systemic therapies or phototherapy for the treatment of psoriasis. Monitor closely if patient develops new infection during treatment. Discontinue treatment if serious infection or allergic reaction develops or if blood dyscrasias are confirmed. Caution should be used in patients who have moderate to severe alcoholic hepatitis and Enbrel should not be used in patients for the treatment of alcoholic hepatitis. Discontinue temporarily if significantly exposed to varicella virus. Live vaccines should not be given concurrently with Enbrel. Paediatric patients should have received all vaccines recommended in current immunization guidelines prior to starting Enbrel. Treatment with Enbrel may result in the formation of autoantibodies. Enbrel is not recommended for the treatment of Wegener's granulomatosis. There have been reports of hypoglycaemia in Enbrel patients receiving medication for diabetes, necessitating a reduction in anti-diabetic medication in some of these patients. There have been reports of Inflammatory Bowel Disease (IBD) in JIA patients being treated with Enbrel. Caution should be exercised when treating the elderly and with particular attention to occurrence of infections. Enbrel Paediatric (25 mg): Contains benzyl alcohol as an excipient, which may cause toxic and/or anaphylactic reactions in infants and children up to 3 years old. **Pregnancy & Lactation:** Enbrel is not recommended in pregnant or breast-feeding women. **Undesirable Effects:** Adults: The most commonly reported adverse reactions are injection site reactions, infections, allergic reactions, development of autoantibodies, itching, and fever. See SmPC for less commonly reported side effects. TNF-antagonists, such as Enbrel, affect the immune system and their use may affect the body's defenses against infection and cancer. Serious infections affect fewer than 1 in 100 patients treated with Enbrel. Reports have included fatal and life threatening infections and sepsis. Various

malignancies have also been reported with use of Enbrel, including cancers of the breast, lung, skin and lymph glands (lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia and very rare reports of aplastic anaemia. Central and peripheral demyelinating events have been seen rarely and very rarely, respectively, with Enbrel use. There have been rare reports of lupus, lupus-related conditions, and vasculitis. Rate of new malignancies was similar to that expected for the population studied. Fatalities associated with serious infections, pancytopenia, aplastic anaemia and interstitial lung disease have also been reported. Paediatrics: Generally as for adults, except the following were more common: headaches, nausea, vomiting and abdominal pain. In addition the following were reported as severe events: varicella, appendicitis, gastroenteritis, depression/personality disorder, cutaneous ulcer, oesophagitis/gastritis, group A streptococcal septic shock, type I diabetes mellitus and soft tissue and post operative wound infection. There have been post-marketing reports of IBD in JIA patients, including cases indicating a positive re-challenge. **Legal Category:** POM. **Package Quantities:** Enbrel Pre-filled Syringe: Each carton contains 4 pre-filled syringes containing either 25 mg or 50 mg of Enbrel and 4 alcohol swabs. Enbrel Pre-filled Pen (MYCLIC): Each carton contains 4 pre-filled pens containing 50 mg of Enbrel and 4 alcohol swabs. Enbrel Powder: Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (10 mg): Each carton contains 4 vials of Enbrel 10 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (25 mg): Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of bacteriostatic water for injections, 8 empty plastic syringes, 20 needles and 24 alcohol swabs. **European Marketing Authorisation Numbers:** Enbrel Pre-filled Syringe 25 mg: EU/1/99/126/013 Enbrel Pre-filled Syringe 50 mg: EU/1/99/126/017 Enbrel Pre-filled Pen (MYCLIC) 50 mg: EU/1/99/126/020 Enbrel Powder 25 mg: EU/1/99/126/003 Enbrel Paediatric 10 mg: EU/1/99/126/022 Enbrel Paediatric 25 mg: EU/1/99/126/012. **European Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ, UK. For full prescribing information see the Summary of Product Characteristics. **Further information is available on request from:** Pfizer Healthcare Ireland, 9 Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24, telephone: +353 1 467 6500. **Medical Information:** 1 800 633 363. **API Reference Number:** EN 3_0. **Date of Prescribing Information:** January 2012

References: 1. Enbrel SPC July 2010 2. Remicade SPC 3. Humira SPC 4. Orencia SPC 5. Mabthera SPC 6. Simponi SPC 7. Singh J *et al* CMAJ: 2009;DOI:10.1503 8. Hetland ML *et al* Arthritis & Rheumatism. Vol 62, no 1, January 2010.

Date of preparation: February 2012

ENB/2012/015