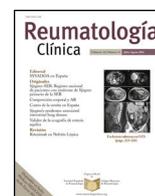




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Editorial

Experience of Biological Therapy Units in Rheumatoid Arthritis and Other Autoimmune Diseases[☆]

Experiencia de unidades de terapias biológicas en artritis reumatoide y otras enfermedades autoinmunes

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As a centre for the comprehensive treatment of rheumatoid arthritis (RA) and as professionals who work in everyday practice to achieve better clinical results in patients treated with biological therapies, we were interested in reviewing the paper recently published in the *Reumatología Clínica* journal by Álvaro-Gracia et al. on the follow-up and monitoring of the use of biological agents in different medical specialities and diseases, in a biological therapy unit (BTU) in a university hospital.

The existence of a BTU is not only associated with the application of biological medication; in our experience, the BTU improves patient adherence to follow-up and treatment, and it is associated with better education and clinical control, above all in patients with a low socio-economic level and/or those who lack a good family and/or social support network; it also leads to better control and the early identification of adverse events.

This is why we are interested in the paper by Álvaro-Gracia et al., most particularly in the results of RA. We found that the differences between survival rates of the therapies in the different diseases made complete sense, and in particular the survival rate in RA (38.4 months). This is the disease for which biological therapies are prescribed the most often, and it has been proven that the reasons for interruption were lack of efficacy, loss of effectiveness and adverse reactions.¹

The survival time of drugs in this report differs from the analysis of data by the CORRONA registry, where the average time at which therapies were changed or interrupted was 25.1 months for patients with RA. The most common reason for interruption was loss of efficacy, followed by questions of safety, the preference of the doctor, the preference of the patient and access to the treatment.²

In a 36-month follow-up of patients treated with 3 alternative anti-TNF in a cohort of 307 subjects with RA that was undertaken in our BTU, it was found that 97% completed the follow-up at 24

months and that 95% did so at 36 months; with an adverse events rate (AER) of 20% per year that differed between different medications; the lowest AER was for etanercept, at 12%, and the highest was for infliximab, at 24%.³ The paper by Álvaro-Gracia et al., shows a very similar result for the same agent (12%), while the biological agent used in rheumatology with the higher AER include anakinra (28.6%), followed by rituximab (24.6%) and infliximab (24%).¹

The similarities between the results of both follow-up studies is consistent with previous studies, showing that even when agents belong to the same pharmaceutical group, as is the case with infliximab and etanercept, they may differ in terms of response efficacy and the percentage of adverse effects, as was previously described in several follow-up studies of patients under treatment with biological therapies.^{4–9}

It should be pointed out that in analyses of this type of medication survival rates, the latter are also associated with external variables such as the type of coverage, specialist and patient preferences and limited access to biological therapies, as described in the CORRONA analysis²; our recommendation for studies of this type is therefore that data should be analysed according to disease and type of medication, and that when possible they should take into account variables connected with coverage, specialist and patient preferences, combinations of biological therapies with methotrexate and barriers against access, most especially to offer more information about the reasons for treatment discontinuation.

Financing

Pedro Santos-Moreno and Omaira Valencia declare that they received no financing for the preparation of this document.

Conflict of Interests

Pedro Santos-Moreno declares that he has received fees for congresses, advisory boards, research and other items from Abbvie, Abbott, Janssen, Pfizer, UCB, Biopas, Pharmetique, La Sante, Lafranco, Bristol, Roche, Sanofi, Lilly and Novartis.

Omaira Valencia has no conflict of interests to declare.

[☆] Please cite this article as: Santos-Moreno P, Valencia O. Experiencia de unidades de terapias biológicas en artritis reumatoide y otras enfermedades autoinmunes. *Reumatol Clín.* 2019;15:61–62.

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