

Reply to the Article “Comparing Demographics, Clinical Presentation, Treatment and Outcome Between SLE Patients Treated in One Public and One Private Health System in Santa Fe, Argentina”[☆]



Réplica al artículo «Comparación de datos demográficos, presentación clínica, tratamiento y desenlace de pacientes lúpicos tratados en un centro público y otro privado de salud en Santa Fe, Argentina»

Dear Editor,

We thank you for the comments and suggestions made. We have carefully read the comments and we add that:

1. In the “Results” section, the progress time of patients until the first consultation (public or private) was defined and we would like to clarify that demographic data, activity by SLEDAI, physical examination and lab data were obtained in the first consultation. This data is clarified again in tables 1 and 2. Likewise, we explained that the outcome data of the patients were (obviously) taken at the last consultation.
2. In the “Results” section, it is explained that 116 patients were assisted in the public healthcare system and 43 in the private

<http://dx.doi.org/10.1016/j.reumae.2014.10.001>

[☆] Please cite this article as: Schmid MM, Roverano SG, Paira SO. Réplica al artículo «Comparación de datos demográficos, presentación clínica, tratamiento y desenlace de pacientes lúpicos tratados en un centro público y otro privado de salud en Santa Fe, Argentina». Reumatol Clin. 2015;11:261.

area. We also state that the same group of experts assisted both groups; therefore, it is incorrect to infer variability in the treatments, superposition or different periods of treatment.

3. No section of the article mentions that informed consent was required. On the contrary, it is explained that it was not necessary due to the anonymous and retrospective nature of the study.
4. The colleagues are confused about the question of the ethnic group, since this topic is not in the “Results” section, but in the “Discussion” section, and they are quotes from other authors. In addition, they are confused when they affirm it is data from our study, because we are mentioning data from Reveille et al.

We suggest a better reading of this work in order to make better suggestions.

Acknowledgements

The authors thank Elena Carrera and Liliana Contini for their statistical help (Biometry Unit, Department of Mathematics, School of Biochemistry and Biological Sciences, UNL).

María Marcela Schmid, Susana Graciela Roverano,* Sergio Oscar Paira

Sección Reumatología, Hospital Provincial José María Cullen, Santa Fe, Argentina

* Corresponding author.

E-mail address: susanarove@yahoo.com.ar (S.G. Roverano).

Consensus on the Use of Methotrexate Beyond the Clinical Recommendation: Adjusted Dose and Pharmacogenetics[☆]



Consenso sobre el uso de metotrexato más allá de la recomendación clínica: dosis ajustada y farmacogenética

Mr. Editor:

We have read with great interest the original document entitled “Recommendations on the use of methotrexate in rheumatoid arthritis: dose increase and reduction and routes of administration” published by Tornero Molina et al. in *Reumatología Clínica*.¹ First of all, we want to congratulate the authors of this eminently practical consensus, since it allows us to know in depth the experts’ clinical practice in the handling of disease-modifying antirheumatic drugs (DMARD) in the treatment of rheumatoid arthritis (RA).

EULAR recommends to start treatment with DMARDs as soon as the diagnosis of RA is established.² Methotrexate (MTX) is the cornerstone of the treatment, which has 2 differentiated routes of administration. Consensus recommends the subcutaneous route of administration as a start in polymedicated patients, with overweight or obesity, under the suspicion of low adherence,

depending on patient’s preferences, with the purpose of reducing the dose to prevent gastrointestinal adverse effects and in active disease (DAS28 > 4). Moreover, the switch from the oral route to the subcutaneous route is posed as an option in cases of inefficiency, better cost-effectiveness profile and non-compliance with oral treatment. Consensus advises increases of 2.5–5 mg every 2–6 weeks depending on clinical severity, reaching a maximum dose of 25 mg.

Notwithstanding the usefulness of the document, we would like to provide 2 comments that we consider could be of special interest.

First, the average normal dose of MTX used in most studies is of 15 mg/week. Nevertheless, we consider calculating the MTX dose in accordance with the weight of the patient to be treated. The patient’s weight, among other variables, indirectly intervenes in drug’s plasma concentration, so it cannot be the same in 60 kg (132 pounds) patients as in 90 kg (198 pounds) patients. Possibly, a good approximation could be to adjust it to a dose of 0.2–0.3 mg/kg.

Another issue we find worth mentioning is the introduction of MTX pharmacogenetics in the clinical practice of RA. Several polymorphisms that can predict favourable response and toxicity to the drug have been defined, getting us closer to the concept of personalised medicine in the treatment with MTX.³ In the last decade, there have been descriptions of allelic variations in genes that participate in the folates metabolic pathway, either at transmembrane transportation level or at intracellular level, which are associated to the lack of response to MTX or MTX toxicity.⁴ Our collaboration group’s previous experiences with other drugs, such as azathioprine, have allowed us to adjust the drug dose

[☆] Please cite this article as: Moya P, Corominas H, Salazar J, Baiget M. Consenso sobre el uso de metotrexato más allá de la recomendación clínica: dosis ajustada y farmacogenética. Reumatol Clin. 2015;11:261–262.