SPECIALTY

Rheumatology

CHIEF COMPLAINT

RA with history of pericarditis

COMMENTS TO SPECIALIST

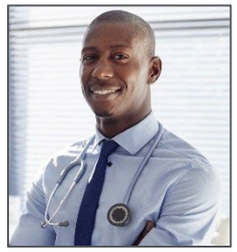
54-year-old woman with chronic pain on opiates, Effexor and benzodiazepines for anxiety. The patient has severe rheumatoid arthritis (RA) with history of pericarditis.

Patient reports worsening of RA with increasing nodules, joint swelling, and pain of hands, knees and feet. She was previously on Xeljanz but stopped nearly 1 year ago due to concerns about the side effects. She has expressed an interest today in restarting Xeljanz.

MAIN QUESTION

Please guide me on labs that I should order prior to restarting as well as initial follow-up that I should do with patient.

Arista|MD



Response from eConsult Specialist

JACOB RODGERS, MD, RHEUMATOLOGY

NPI: 1000000006

SUMMARY

Treatment options are available at the primary care level.

DETAILS

As you indicated in your comprehensive note, a baseline complete blood count (CBC), comprehensive metabolic panel (CMP), inflammatory markers: erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP). Tuberculosis (TB) screen should be done prior to starting Xeljanz. If applicable, a hepatitis screen can also be considered.

Once the Xeljanz is started, then obtain CBC, CMP, and ESR/CRP within 4-8 weeks, and then every 3 months thereafter, to screen for any neutropenia, leukopenia, bumps on liver function test (LFT), anemia, etc.

Given the patient has active disease, an extended course of moderate dosage steroids with gradual taper can be employed, with goal of tapering to "endogenous" levels (e.g. Prednisone 5 mg). An example would be starting at Prednisone 40 mg for 5 days (can be given in divided doses), then decreasing by 5 mg every 5 days.

The FDA recently cited a safety clinical trial expressing concerns that Xeljanz may increase the risk of serious heart-related problems and cancer as compared to anti-tumor necrosis factor (TNF) agents. However, since the patient has already failed multiple anti-TNFs as well as methotrexate, and has advanced and aggressive RA complicated by pericarditis, the benefits of restarting Xeljanz should be weighed against the risks of not starting at this time.

Once the patient links back with a rheumatologist, further treatment options (e.g. Rituxan, Actemra) can be discussed. In the interim, having the patient see a dermatologist each year for skin checks in addition to age-appropriate cancer screening (e.g. cervical screening) should be done. Other routine follow up to be considered would be cardiology (because of the pericarditis) and ophthalmology for screening for extra-articular disease as well as for glaucoma, given prednisone use.

One additional note, if not already discussed, the patient should be recommended for the COVID-19 vaccine. While some disease-modifying antirheumatic drugs (DMARD) may decrease the immune response for certain vaccinations, most biologics don't usually require any timing or regimen modification unless it's a live attenuated vaccine such as for meningitis or the older shingles vaccine.

The American Collage of Rheumatology released guidelines (https://www.rheumatology.org/Portals/0/Files/COVID-19-Vaccine-Clinical-Guidance-Rheumatic-Diseases-Summary.pdf), which recommends pausing Janus kinase (Jak)-inhibitors (this would include Xeljanz) for one week after each mRNA vaccine dose, but the patient could continue steroids under 20 mg daily dose. Ultimately, keep in mind that the patient is likely to achieve a better immune response once her disease is under better control.

Jacob Rodgers

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Jacob Rodgers, MD, Rheumatology

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