9.80 years. Two-thirds (66%) of patients had received one anti-TNF agent, 25% had received 2, and 9% had received 3. Prior anti-TNF therapy had been discontinued due to lack of efficacy in 58% of patients.

At Week 14, significantly ($p<0.001$) more patients who were treated with golimumab achieved ACR20 versus placebo-treated patients. These results essentially were maintained at Week 24. Golimumab also was significantly more effective than placebo in the subgroup of patients whose prior anti-TNF-alpha therapy had been discontinued due to lack of efficacy (36% golimumab 50 mg and 43% golimumab 100 mg vs 18% placebo; $p=0.006$ and $p<0.001$, respectively).

The percentage of patients who achieved ACR50 and ACR70 at Week 24 was significantly higher ($p\leq0.01$) with golimumab versus placebo (18.3% and 20.3% vs 5.2% and 11.8% and 10.5% vs 3.2%; ACR50 and ACR70, golimumab 50 mg and 100 mg vs placebo, respectively). These results are similar to those that were seen in trials that included other biologics and methotrexate [Genovese MC et al. *New Engl J Med* 2005; Cohen SB et al. *Arthritis Rheum* 2006].

Golimumab was generally well tolerated (Table 1) and demonstrated a safety profile that was similar to other anti-TNF agents. Antibodies to golimumab were detected in 3.0% of golimumab-treated patients.

"Our findings show that golimumab holds great promise in various RA patient populations, including those patients who have previously discontinued other TNF inhibitors," said Prof. Smolen.

Table 1. Summary of Safety Events Through Week 24 (% of Patients).

	Placebo	Golimumab 50mg	Golimumab 100mg	Golimumab All
Adverse events	72.3	66.4	78.3	68.1
Serious adverse events	9.7	7.2	4.6	5.9
Infections	32.9	34.9	36.2	32.4
Serious infections	3.2	3.3	0.7	1.9
Injection site reactions	3.9	5.9	10.5	8.0

Randomized Controlled Trials of Epratuzumab Reveal Clinically Meaningful Improvements in Patients with Moderate/Severe SLE Flares

Michelle Petri, MD, MPH, Johns Hopkins University, Baltimore, MD, reported the results of 2 48-week, randomized, double-blind, placebo-controlled clinical trials that evaluated the humanized anti-CD22 monoclonal antibody epratuzumab for the treatment of patients with severe BILAG A or moderate BILAG B (in ≥2 organ systems) SLE flares.

Patients were randomly assigned to receive placebo (n=37), epratuzumab 360 mg/m^2 (n=42), or epratuzumab 720 mg/m^2 (n=11) infusions for up to 4 treatment cycles. Corticosteroids were increased by ≥10 mg daily at baseline. Other SLE-specific therapies remained unchanged. Systematic tapering of corticosteroids was started at Week 4 with the aim of achieving a reduction in daily corticosteroid doses to ≤10 mg daily (Study 1) or ≤7.5 mg daily prednisone equivalents (Study 2) by Weeks 20-24. The primary study endpoint was reduction at Week 12 of all BILAG A to B and BILAG B to C, no worsening in other systems, and no addition or increase in immunosuppressives and/or anti-malarials or corticosteroids above baseline or specified taper levels. These studies were prematurely discontinued due to study drug supply interruption, and the data from the 2 trials were combined for analysis. Patients were followed for 6 months after enrollment or cessation of dosing. Patients had varying lengths of study participation and numbers of doses.

Patients were predominately women (94%), who had a mean age of 36.8 years. At baseline, >40% of patients had BILAG A, and 91% had >2 BILAG As or Bs with a mean total BILAG score of 13.2. Over 60% were receiving immunosuppressives; 43% of patients were receiving >25 mg/day corticosteroids.

Epratuzumab at both doses resulted in greater reductions in total BILAG scores versus placebo, and the probability of achieving a sustained response prior to Week 12, 24, and 48 was greater with epratuzumab treatment (Figure 1A and B). Patients who received epratuzumab were twice as likely as placebo-treated patients to achieve sustained improvement in BILAG scores (HR 2.18; $p=0.021$; Table 1). BILAG scores and global disease assessments of disease activity at Week 12 are summarized in Table 1. Cumulative corticosteroid use over 24 weeks was lower in epratuzumab-treated patients versus placebo-treated patients.

Figure 1A. Mean Change from Baseline in Total BILAG Scores.

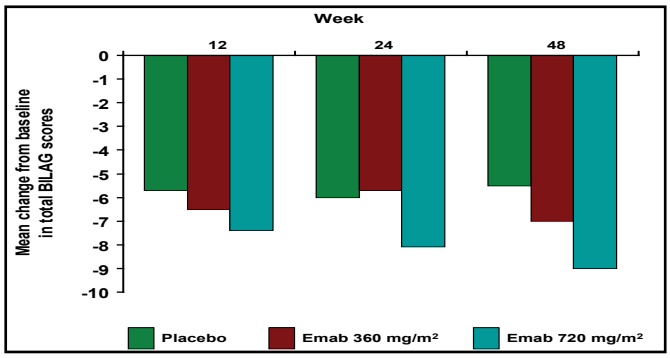

Figure 1B. Percent of Sustained BILAG.

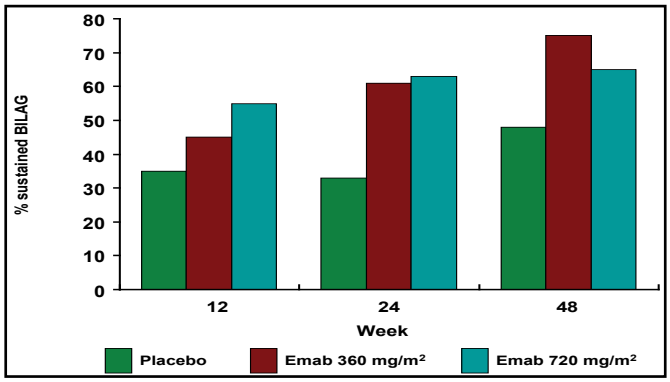

Table 1: Week 12 BILAG Scores and Global Disease Assessments (ITT Population).

	Epratuzumab 360 mg/m2 n=34	Epratuzumab 720 mg/m2 n=10	Placebo n=30
BILAG response[a]	15 (44%)	2 (20%)	9 (30%)
Per protocol pop. (total n=46)	6 (54%)	1 (25%)	3 (21%)
BILAG A/B to C	11 (32%)	0	6 (20%)
Total BILAG score[b] reduction from baseline	6.4	7.2	5.8
Time to sustained[d] A/B Flare Reduction			
Kaplan-Meier Q1 days	36	35	48
Median days (95% CI)	93 (61-301)	84 (35-NC)	NC (138-NC)
Hazard ratio vs Placebo	2.18[c]	1.21	
Improved physician global assessment[e]	76%	80%	60%
Improved patient global assessment[e]	67%	70%	53%

A=primary endpoint response definition; b=A/B/C/D/E = 9/3/1/0/0; c =HR p-value=0.021; d=at 2 consecutive visits; e=≥20% improvement on 5-category scale

The most commonly reported adverse event (AE) overall was upper respiratory infection, which occurred in 35% of patients in the placebo group, 20% of patients in the epratuzumab 360 mg group, and 27% of patients who were treated with epratuzumab 720 mg. The most common AEs (≥10% incidence with epratuzumab) included headache, arthralgia, nausea, pyrexia, abdominal pain, oral candidiasis, peripheral edema, chest pain, cough, and blurred vision. The incidence of SAEs, infusion-related AEs, and infections was similar between placebo and epratuzumab treatment groups.

Treatment with both doses of epratuzumab resulted in clinically meaningful efficacy, as evidenced by improvements in BILAG, physician and patient global assessment, and clinically meaningful corticosteroid sparing in patients with moderate and severe SLE flares. "These initial clinical results for epratuzumab are very encouraging," said Dr. Petri. "Developing new compounds for SLE patients is critical because currently available treatments, such as immunosuppressants and corticosteroids, often have serious and debilitating side effects. We look forward to seeing results from other clinical trials involving epratuzumab."

Joint Lavage in Knee Osteoarthritis

Intra-articular injection (IAI) with corticosteroids is a procedure that is commonly used in the management of osteoarthritis (OA). Parmigiani et al., Universidade Federal de São Paulo, São Paulo, Brazil, reported results from a randomized, double-blind, controlled study that compared medium-term effectiveness and tolerance between IAI with triamcinolone hexacetonide plus joint lavage (JL/TH Group) versus IAI with triamcinolone hexacetonide alone (TH Group) in patients with OA of the knee.

Patients with primary knee OA, with pain in at least one of the knees and grades II and III on the Kellgren-Lawrence index (KL II and III), were randomly assigned to treatment with joint lavage with 0.9% saline solution (1000 ml) followed by a 60-mg injection of triamcinolone hexacetonide (3 ml) (the JL/TH group) or to simulated joint lavage followed by a 60-mg injection of TH (3 ml) (the TH group). Patients were evaluated at baseline and at Weeks 1, 4, 8, and 12 by an observer, blinded to the treatment regimen. The following tools were used: visual analog scale (VAS) for pain at rest and during movement; goniometry; Womac index; Lequesne questionnaire;