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PARADOXAL PSORIASIS IN USE OF CERTOLIZUMABE: CASE REPORT

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BACKGROUND

The treatment of rheumatoid arthritis (RA) is performed using disease-modifying drugs (MMCDs), conventional synthetic, biological and/or small target-specific molecules and aims to achieve low activity or sustained remission of the disease. Paradoxical adverse events (EAPs) were reported during the use of biological MMCDs, defined as the occurrence of a pathological condition (psoriasis, Crohn's disease or hidradenitis suppurativa). The development of psoriasis resulting from use of anti-tumor necrosis factor (anti-TNF) was described in 0.6 to 5.3% of cases and palmoplantar pustulosis is the most associated clinical form. The anti-TNF agents most associated with the occurrence of psoriasis are infliximab, adalimumab and etanercept. Cases with certolizumab are rare. The average latency time between the onset of anti-TNF and the appearance of skin lesions is 10 months, ranging from days to years. The objective of this report is to describe a case of paradoxical plaque psoriasis in a patient using certolizumab, after the medication induction phase.

CASE REPORT

Woman, 60 years, first consultation on May 2019. Rheumatoid arthritis for 18 years, therapy with leflunomide 20 mg/day and prednisone (5 mg irregularly, intermittently). No history of drugs allergy, CDAI scored 14 (arthritis in 2 joints and 4 painful). Exams ordered and prescribed prednisone 5 mg/day and maintained Leflunomide. Return June 2019, rheumatoid factor: 1:256 and PCR 9.4 mg/L and blood count, renal and thyroid function, blood glucose and liver enzymes were normal; negative viral serologies. X-ray with bilateral osteoarthritis on the knees and carpal bones, worse on the right. Certolizumab pegol was prescribed; started medication in October 2019, returning for evaluation on 11.7.19, reported hair loss and extensive erythematous-scaling skin lesions in plaques on his feet and legs (Fig. 1A and 1B), which started at the end of the first month of certolizumab. Was opted to suspend medication on suspected of paradoxical psoriasis when using certolizumab, confirmed by a dermatologist, medication was discontinued, treated with topical corticosteroids, progressing with significant improvement, but persisted with some injuries after six months of suspension (Fig. 2). The therapy started with tocilizumab and Leflunomide being replaced with methotrexate, aiming at joint and skin improvement.

Figure 1. Erythematous-scaling skin lesions in plaques on feet and legs after use of Certolizumab.

Figure 2. Significant reduction of injuries after suspension of treatment with Certolizumab.

CONCLUSION

Although rare, described in about 1% of cases and typically associated with palmoplantar pustulosis, this report shows the occurrence of extensive and plaque psoriasis after induction and the importance of rapid definition and proper management of the case, in order to minimize damage to health and provide clinical and quality of life improvement for patients.