Management in patients older than 75 years old

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Age older than 75 years is not per se a contraindication to abatacept therapy. As with TNFα antagonists, the decision to start or to continue abatacept therapy should be based primarily on the risk/benefit ratio, as potential adverse effects of abatacept may be more marked than in younger patients. The risk/benefit ratio of abatacept therapy should be compared to that of alternative treatments such as low-dose prednisone therapy. Scrupulous attention is therefore required at treatment initiation. More specifically, contraindications and precautions for use must be followed rigorously (refer to the fact sheet entitled "Pre-treatment assessment") and early detection of any infections followed by appropriate treatment must be ensured (refer to the fact sheet entitled "Infections").

Pharmacokinetics

Similar to gender, age has no impact on the elimination kinetics of abatacept after adjustment for body weight (20). Therefore, there is no need to adjust the abatacept dosage according to patient age.

Therapeutic trials

To date, no comprehensive studies have evaluated the efficacy and safety of abatacept in elderly patients in clinical trials or registries.

The Summary of Product Characteristics indicates that 323 patients aged 65 years or over (including 53 patients aged 75 years or over) were given abatacept during clinical trials (20). No major differences were found in terms of clinical response or adverse event rates compared to younger patients during these trials. However, the numbers of patients were too small to rule out an increase in adverse event rates, which might become apparent as clinical experience with abatacept increases. In addition, the risks of severe infection and malignancy relative to placebo were higher in patients older than 65 years than in younger patients. No information is given on whether the over 65 age group had significant differences regarding these risks in the pooled abatacept and placebo groups. Data are still lacking on patients seen in routine clinical practice, whose profile in the over-75 age group may differ even more markedly from that in clinical trial populations, compared to younger patients. In a study on the risk of hospital admission for infection, only 3% of the 4134 abatacept-treated patients with RA, were older than 75 years old, whereas in registries, this proportion ranged from 9% (cohort of 523 patients with early RA) to 11% (cohort of 1409 RA patients in Canada) and 14% (cohort of 1438 RA patients in the US and cohort of 500 early-RA patients in Sweden), corresponding to a 3- to 5-fold increase (29). These data suggest that recruitment of patients over 75 years old in clinical trials was biased, with preferential selection of patients at lower risk. However, this bias is probably not greater than in studies with other biologic agents, including TNFα antagonists.

Therefore, one needs to be cautious in elderly patients. More specifically, before starting abatacept therapy, every effort should be made to rule out cancer and latent infection, as development during treatment may expand and be mistakenly assigned to abatacept exposure.

In a study conducted between 1999 and 2007 in 212 RA patients, the retention rate of biologic agents (of any type, including abatacept) was lower in patients older than 65 years than in younger patients (84). The discontinuation rate of the first biologic agent was 47% and the reason for discontinuation was adverse event in 48% of cases and lack of efficacy in 43% of cases. Among the 48 adverse events, malignancies (23%) were more common than infections (19%) or cardiac disorder (19%) (84).

Another study comparing the retention rates of different biologic agents in 428 veterans (mean age, 59±12 years) between 1999 and 2007 found that etanercept had a higher retention rate than the other drugs, including abatacept. However, this study is biased by the inclusion of patients with a variety of underlying rheumatic diseases for biologic therapy (e.g., spondylarthritis) (85).