Department of Rheumatology
Dumfries and Galloway Royal Infirmary
Consultant Dr M J McMahon
Dr A Drever, Associate Specialist, Dr L Maggiori Associate Specialist
Bankend Road, Dumfries, DG1 4AP, Tel. 01387 246246

METHOTREXATE DMARD TREATMENT – updated 2017

INFORMATION FOR GENERAL PRACTITIONERS

The aim of treatment is to suppress disease activity and preserve joint function in the Inflammatory Arthropathies and other Rheumatic Disorders.

DOSAGE- reduced by 50% In CKD 3 (eGFR 30-59), contraindicated in CKD 4/5 (eGFR <29)

7.5 mg – 30 mg ONCE WEEKLY. Starting dose will usually be 15mg weekly, and usually increase in monthly increments of 5-10mg until disease stabilized. Usual effective dose 10-25mg weekly. If maximum oral dose ineffective or not tolerated ,an equivalent Subcutaneous route can be used instead.
Folic Acid 5 mg should be prescribed once weekly, taken the day after the Methotrexate dose. This reduces adverse effects.
Pneumococcal and Annual Flu vaccine is recommended. Passive immunization using VZIG recommended if exposed to chickenpox

MONITORING PROCEDURE

Pre-Treatment – Hepatitis and HIV serology, FBC, U+E, CRP, LFT inc Albumin, CXR (unless done in last 6 months), PFTs in selected patients.
Then FBC, U+E, CRP, LFT inc Albumin fortnightly until dose stable for 6 weeks then monthly until stable for 3 months then 3 monthly (monthly if combined with Leflunomide).
Entering the results into a monitoring booklet will ensure trends are not missed.
Patients who do not attend for monitoring should be warned of the risk that serious adverse effects may go unnoticed. In the event of persistent failure to attend for monitoring please inform the Rheumatology department.

WBC <3.5) withhold and discuss with Rheumatology
Neutrophils < 1.6) "
Platelets < 140)
AST or ALT >100 "
Albumin <30mg/l-if unexplained)
Creatinine increase >30% in 12 months
Eosinophils >0.5 if unexplained
MCV > 105 –withhold and check B12,Folate and TFT, treat, and discuss if neccessary

Rash or oral ulceration "
New or increasing dyspnoea or cough –withhold and discuss **urgently**

Significant deterioration in renal function -see BNF and withhold until discussed
Abnormal bruising or sore throat - withhold until FBC available

HOSPITAL CONTACT

***Secretary**	01387 241776 Iseabail Graham/Danica Hyslop
***Helpline**	01387 241095 Petra Cannon/Ingrid Crane/Jane Murray- Nurse Specialists
Dr M J McMahon	Direct Line 01387 241776
Dr Anne Drever	Direct Line 01387 241023
Dr Lucy Maggiori	via switchboard 01387 246246 ext 32012

Duration of Treatment and Time to Response

Treatment is continued indefinitely providing it remains effective and there are no significant side effects. Methotrexate takes about 2-3 months to become effective. During this period there are likely to be continued symptoms or signs of disease activity. it is reasonable to use IM Depo Steroid (Kenalog 40 mg or Depo Medrone 80 mg) up to monthly, depending on the requirements of the individual patient. The dose required is small (eg monthly Kenalog 40 mg = 1.6 mg Prednisolone daily). If IM steroids are still required three months after starting treatment the Methotrexate should be increased by 5 mg.

Flares

Unfortunately disease modifying drugs will not prevent all flares. These can be managed with IM Depo Steroid as outlined above. If flares become more frequent, or the disease fails to settle between flares, the dosage should be increased, or an alternative discussed with the Rheumatologist.

Contraindications

Alcoholism, severe renal, hepatic or haematological impairment. Immunodeficiency, bone marrow failure with unexplained anaemia , cytopenia, pregnancy, breast feeding, live vaccines, co-prescription of folate antagonists eg Co-trimoxazole.

Warnings

Caution in renal impairment, peptic ulcer, ulcerative colitis, ulcerative stomatitis, diarrhoea, and debility, localized or systemic infection inc Hepatitis B, C or TB. Avoid conception for 3-6months after treatment stops. Patients should be cautioned to contact GP immediately if they develop a cough or dyspnoea. Treatment should be interrupted if there is marked GI upset usually severe stomatitis. Caution to remain “well within” national recommendations for alcohol intake.
Serum pro-collagen III test not useful in inflammatory arthritis so not recommended.
Caution, and generally not recommended in established ILD.
Withdraw during illness/dehydration –folinic acid rescue may be required if severe.

Interactions

Methotrexate excretion may be affected but actual toxicity is exceedingly rare when co-prescribed with salicylates, sulphonamides, diuretics, hypoglycaemics, diphenylhydantoins, tetracyclines, Chloramphenicol, P-aminobenzoic acid and NSAIDs.

Side effects

Common effects are in bold type
Mucocutaneous - urticaria, erythematous, itch, alopecia, severe or increasing oral ulceration
Haematological- neutropenia, thrombocytopenia and rarely aplastic anaemia
Gastrointestinal -**GI UPSET,** enteritis

Other - acute tubular necrosis, interstitial pneumonitis, liver fibrosis, depression, irritability