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DMARD MONITORING GUIDELINES – Reviewed 23.01.15

RNHRD GP TELEPHONE ADVICE LINE (from 11.00am to 1.00 pm daily): 07747 630875

The current BSR DMARD and Denosumab Monitoring Guidelines are now available via the following link: http://www.rnhrd.nhs.uk/our-services/for-clinicians

Sulfasalazine

A. Indications:
(Licensed) RA, ulcerative colitis and Crohn's disease.

(Unlicensed) Sero-negative spondyloarthropathy including psoriatic arthritis and psoriasis.

B. Sulfasalazine dosage: Grade of evidence: C
Typical dose: 500 mg/day increasing by 500mg weekly to 2.0–3.0 g/day. Occasionally doses above 3.0 g/day are prescribed [1].

C. Route of administration: Oral

D. Time to response: Minimum of 3 months

E. Caution: Grade of evidence: C and B

(1) Glucose-6-phosphate dehydrogenase deficiency: May cause haemolysis [1–3].
(2) Renal impairment (moderate): May cause significant crystalluria and must ensure high fluid intake. In case of severe renal failure: Avoid.
(3) Slow–acetylators of the drug: May cause drug-induced lupus-like syndrome [2, 3]. It is not necessary to assess acetylator phenotype.
(4) May impair folate absorption [1].
(5) Pregnancy and breast feeding [1, 2].
(6) Sulfasalazine can be prescribed to men of childbearing potential although there may be transient reversible oligospermia [4, 5].

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(7) If sulfasalazine is to be prescribed during pregnancy, an analysis of risks and benefits to the mother should be undertaken, against the possible small risk related to the
unborn child and doses should not exceed 2 g/day [4, 5].
(8) Folic acid: a supplement should be prescribed to those trying to conceive and during pregnancy [6, 7].
(9) Small amounts of the drug may be excreted in breast milk although these are not thought to be a risk to a healthy full-term infant [8].

F. Contraindications: Grade of evidence: C and B
Hypersensitivity to sulphonamides/co-trimoxazole [1, 2] or aspirin [2].

G. Notable drug interactions (refer to BNF and SPC)
(1) Azathioprine may contribute to bone marrow toxicity.
(2) Cardiac glycosides—possibly reduces absorption of digoxin[1, 2].

H. Monitoring schedule: Grade of evidence C

	BSR and BAD
(a) Pre-treatment assessment	**FBC, U&E, creatinine, LFTs**
(b) Monitoring	**FBC and LFTs (including AST/ALT) monthly for the first 3 months and 3-monthly thereafter. If, following the first year, dose and blood results have been stable, frequency of blood tests can be reduced to every 6 months for the second year of treatment. Thereafter, monitoring of blood for toxicity may be discarded. Patient should be asked about the presence of rash or oral ulceration at each visit.**
(c) Following dose changes	**Repeat FBC, LFTs one month after dose increases.**

Rheumatology

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I. Actions to be taken: Grade of evidence C

WBC < 3.5 x 10^9/l	**Withhold until discussed with specialist team.**
Neutrophils < 2.0 x 10^9/l	**Withhold until discussed with specialist team.**
Platelets < 150 x 10^9/l	**Withhold until discussed with specialist team.**
AST, ALT > twice upper limit of reference range	**Withhold until discussed with specialist team.**
MCV > 105 fl	**Check B12, folate and TSH. If abnormal treat any underlying abnormality. If normal, discuss with the specialist team.**
Nausea/dizziness/headache	**If possible continue. May have to reduce dose or stop if symptoms severe. Discuss with specialist team.**
Abnormal bruising or severe sore throat	**Check FBC immediately and withhold until results available. Discuss with the specialist team if necessary.**
Unexplained acute widespread rash	**Withhold and seek urgent specialist (preferably dermatological) advice.**
Oral ulceration	**Withhold until discussed with specialist team.**

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References

Sulfasalazine

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