Dear Editor,

Colchicine is the mainstay treatment of familial Mediterranean fever (FMF) [1]. However, there is growing knowledge about the beneficial effect of biologic treatments in FMF. Especially, anti interleukin-1 (IL-1) medications are the alternative treatment options in case of colchicine resistance [2]. Currently, IL-1 blockade is not considered as first line treatment. The European League against Rheumatism recommendations for the management of FMF suggested administering anti IL-1 blockade during colchicine intolerance or insufficiency [3]. Nevertheless, in FMF patients with AA amyloidosis, colchicine treatment is often ineffective while the creatinine level is higher than 1.5 mg/dL or in the presence of nephrotic range proteinuria with impaired renal function [4,5]. Furthermore, in FMF patients with AA amyloidosis, several reports demonstrated the effectiveness of IL-1 blockade during renal insufficiency or renal transplant recipients [1,6]. In these manuscripts, data of 19 FMF patients with AA amyloidosis during on anakinra were reported. Herein, anakinra reduced the levels of proteinuria in all four patients with nephrotic range proteinuria. Moreover, amyloidosis did not recur in eight of the patients who underwent renal transplantation [6]. Likewise, in Akar et al.’s study, 47 of the FMF patients with AA amyloidosis had proteinuria > 500 mg/day. Herein, with anti IL-1 therapy, urinary protein excretion completely resolved in 10 (21%) of them. Also, proteinuria levels decreased in 36 (77%) of the patients [7]. Moreover, Ugurlu et al. reported that 24 of their 29 FMF patients with AA amyloidosis responded at least to one of the IL-1 blockers without any significant side effect. The authors also emphasized that the effect of the IL-1 blockers may be more pronounced in patients with creatinine < 1.5 mg/dL [8]. In all these reports, patients were under colchicine treatment before and during IL-1 blockade. In another study, canakimumab treatment was found safe and effective in three renal transplant recipient FMF patients [9]. In FMF patients presenting with AA amyloidosis, nephrotic range proteinuria or renal function impairment or in late diagnosed FMF patients with AA amyloidosis, starting solely colchicine as a first line treatment may be ineffective and the patients may irreversibly lose their chance to benefit from IL-1 blockers. Consequently, the clinicians should consider administering colchicine and IL-1 blockade therapy concomitantly as first line treatment in treatment naive FMF patients with AA amyloidosis, nephrotic range proteinuria or renal function impairment.

Funding
None.

Declaration of Competing Interest
None.

Acknowledgement
None.

References


Mehmet Engin Tezcan
University of Health Sciences, Kartal Dr. Lutfi Kirdar Training and Research Hospital, Department of Rheumatology, Turkey
E-mail address: kartalromatoloji@gmail.com.