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IN BRIEF

THERAPY

Glucosamine: no evidence of structural benefits

A short-term, randomized, double-blind placebo-controlled clinical trial has found no evidence that glucosamine chloride leads to structural improvements in patients with arthritis. Patients with mild-to-moderate chronic pain in one or both knees typical of knee osteoarthritis ($n = 201$) were assigned to receive a drink containing 1,500 mg glucosamine hydrochloride or placebo daily for 24 weeks. Cartilage damage was then assessed by 3T MRI. Patients in the placebo group showed more improvement in terms of bone marrow lesions than those treated with glucosamine hydrochloride (adjusted OR 0.537; 95% CI 0.291–0.990) and cartilage damage was not decreased in the treated group in comparison with the placebo group (adjusted OR 0.938; 95% CI 0.528–1.666).

Original article Kwoh, C. K. *et al.* The Joints on Glucosamine (JOG) Study: the effect of oral glucosamine on joint structure, a randomized trial. *Arthritis Rheum.* doi:10.1002/art.38314

VASCULITIS SYNDROMES

Single dose of rituximab for ANCA-associated vasculitis

Patients with antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis treated with rituximab currently receive four infusions of 375 mg/m^2 (the standard lymphoma schedule). Given that B-cell depletion seems to occur soon after the first dose, would a single dose be effective? A single-centre study of 19 patients (17 with generalized disease and 2 with severe disease [creatinine level >500 μm]) found that satisfactory B-cell depletion occurred following a single dose of rituximab in 89% of patients, after a median of 13 days. The median time to complete remission was 38 days, and the 3-month probability of complete remission was 80%. The median times to B-cell repopulation and to disease relapse/re-dose were 9.2 and 27 months, respectively. The authors conclude that this single-dose protocol is a reasonable and cost-effective approach.

Original article Turner-Stokes, T. *et al.* Induction treatment of ANCA-associated vasculitis with a single dose of rituximab. *Rheumatology (Oxford)* doi:10.1093/rheumatology/ket489

SPONDYLOARTHROPATHIES

Apremilast effective for the treatment of PsA

A 24-week, randomized, placebo-controlled phase III trial (PALACE 1) has found that apremilast (an oral phosphodiesterase 4 inhibitor) is an effective treatment for patients with active psoriatic arthritis (PsA) who have failed to respond to previous DMARD and/or biologic therapies. Patients ($n = 504$) were randomized 1:1:1 to receive 20 mg or 30 mg apremilast or placebo twice daily for 24 weeks; at week 16 all patients who had not achieved ≥20% reduction in swollen and tender joint scores (ACR20 response) were re-randomized equally to the two apremilast doses, if they were originally on placebo, or remained on their original apremilast dose. More patients receiving 20 mg (31%) or 30 mg (40%) apremilast achieved the primary outcome of an ACR 20 response at week 16 than those receiving placebo (19%; $P < 0.001$). Apremilast was safe and well tolerated.

Original article Kavanaugh, A. *et al.* Treatment of psoriatic arthritis in a phase 3 randomised, placebo-controlled trial with apremilast, an oral phosphodiesterase 4 inhibitor. *Ann. Rheum. Dis.* doi:10.1136/annrheumdis-2013-205056