Worsening of obstructive sleep apnoeas in a patient with rheumatoid arthritis treated with anti-tumor necrosis factor

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Summary

We report on a case of an adult patient treated for rheumatoid arthritis with infliximab, a chimerical monoclonal antibody to TNFα. Apart from this, the patient also showed clinical signs of obstructive sleep apnea syndrome that was confirmed by polysomnographic study. After infliximab treatment, additional sleep studies revealed an increase in the number of apneic events and SaO₂ dips suggesting that TNFα plays an important role in the pathophysiology of sleep apnea. Thus, clinical recognition of sleep disordered breathing should be taken into account when rheumatoid arthritis patients are to be treated with infliximab.

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Introduction

Tumour necrosis factor-α (TNFα) is a cytokine that plays an important role in the pathogenesis of rheumatoid arthritis (RA), and blocking strategies.1 In patients with long standing RA and high disease activity despite conventional treatment, infliximab, a chimerical monoclonal antibody to TNFα, has been shown to be clinically effective.2 TNFα is also involved in sleep regulation3 as well as in the pathogenesis of obstructive sleep apnea (OSA).4–6 Therefore, the use of TNFα antibodies may help define the role of cytokines in OSA.

We report on a case of an adult patient with RA and who was treated with infliximab. The patient also had a condition of OSA and the result of the infliximab treatment was an increased number of apneic events and SaO₂ dips.

Case report

A 62-year-old woman was referred to the Rheumatology Division for treatment with infliximab. She had a 19-year-history of RA, according to the standard criteria.7 Cervical spine radiographs showed no evidence of significant atlantoaxial subluxation. The patient reported frequent nocturnal awakenings with a sensation of choking, snoring, unrefreshing sleep, daytime sleepiness and fatigue for 2 years. Her Epworth sleepiness...
score was abnormal. Physical examination showed
obesity (BMI = 31 kg/m²), severe deforming arthri-
tis of multiple joints with no active synovitis, and
absence of dental malocclusion.

Two polysomnographic studies were carried out
and the diagnosis of OSA was confirmed (Table 1).
Afterwards, infliximab (3 mg/kg of body weight)
was applied normally as a treatment for the RA.
Additional sleep studies were performed revealing
a clear worsening of the condition after the
application of infliximab. There was an increase in
obstructive apneas and hypopneas, as well as
oxygen desaturation index (SaO₂ dips), and a
worsening of the sleep oxymetric pattern; on the
other hand, the number arousal decreased (Fig. 1,
Table 1). In response to this, overnight continuous
positive airway pressure (CPAP) was started and
infliximab treatment was maintained which re-
sulted in the elimination of the respiratory events.

Discussion

In RA patients, sleep apnea can be caused by
narrowing of upper airway, either by changes in
the temporomandibular joints and the position of
cervical vertebrae. In our case, however, clinical
and radiological examination did not show these
disturbances. Therefore, it is our opinion that this
patient presented both RA and sleep apnea coin-
cidentally, that is, the diseases were not asso-
ciated. The infliximab treatment for RA may have
worsened an already existing OSA, as evidenced by
the increased number of apneic events and SaO₂
dips after infliximab treatment. Polysomnographic
studies indicated no changes in body position or
sleep stages before and after infliximab treatment.
The reasons why infliximab worsens the
apneas and SaO₂ dips in our OSA patient while
improving arousals remains obscure but a hypoth-
thesis which involves the role of TNFα to explain this
seemingly contradictory finding can be advanced.

Table 1  Sleep parameters before (Days 1 and 2) and during treatment with infliximab (Day 3).

<table>
<thead>
<tr>
<th></th>
<th>Before treatment</th>
<th></th>
<th>After treatment</th>
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<tbody>
<tr>
<td></td>
<td>Day 1</td>
<td>Day 2</td>
<td>Day 3</td>
</tr>
<tr>
<td>Total sleep time (min)</td>
<td>396</td>
<td>419</td>
<td>346</td>
</tr>
<tr>
<td>Sleep efficiency (%)</td>
<td>67</td>
<td>84</td>
<td>80</td>
</tr>
<tr>
<td>Sleep latency (min)</td>
<td>24</td>
<td>30</td>
<td>27</td>
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<tr>
<td>Stages I + II (%)</td>
<td>80</td>
<td>78</td>
<td>88</td>
</tr>
<tr>
<td>Stages III + IV (%)</td>
<td>16</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Stage REM (%)</td>
<td>4</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Arousal/h</td>
<td>14</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Mean SaO₂ (%)</td>
<td>88</td>
<td>91</td>
<td>86</td>
</tr>
<tr>
<td>Minimum SaO₂ (%)</td>
<td>70</td>
<td>81</td>
<td>52</td>
</tr>
<tr>
<td>ODI4</td>
<td>59</td>
<td>46</td>
<td>198</td>
</tr>
<tr>
<td>Mean heart rate (bpm)</td>
<td>72</td>
<td>69</td>
<td>64</td>
</tr>
<tr>
<td>Obstructive apnea count</td>
<td>54</td>
<td>137</td>
<td>212</td>
</tr>
<tr>
<td>Hypopnea count</td>
<td>226</td>
<td>196</td>
<td>175</td>
</tr>
<tr>
<td>AHI</td>
<td>47</td>
<td>49</td>
<td>74</td>
</tr>
</tbody>
</table>

ODI4: (oxygen desaturation index, indicates events with falls of SaO₂ ≥ 4% per night); Mean SaO₂ (%): Mean SaO₂ during desaturation during the recording; Minimum SaO₂ (%): Minimum SaO₂ during the recording; AHI: Apnea hypopnea index.

Figure 1  Two trends of SaO₂ before (a) and after infliximab treatment (b). After infliximab treatment the oxymetric pattern shows greater desaturations.
The worsening of OSA can be associated to the effect of TNFα on leptin. Finck et al.9 have shown that TNFα induces leptin production. Also, leptin circulating levels have been shown to be positively correlated with apnea–hipopnea index and TNFα and leptin levels decrease after CPAP treatment.10 Therefore, it is possible that blocking TNFα with infliximab reduces leptin and that this leptin deficiency plays a role in the major desaturations experienced by OSA patients.11,12 On the other hand, in OSA patients some authors have shown that TNFα is positively correlated with the degree of hypoxia and the degree of nocturnal sleep disturbance and may mediate the daytime sleepiness associated with this disorder, independent of obesity.5,6 Moreover, in patients with RA and elevated circulating levels of TNFα, sleep fragmentation and frequent arousals with marked disruption of sleep continuity can occur.14 Thus, TNFα seems to be involved in sleep fragmentation and arousability. It is known that TNFα may signal the central nervous system via vagal afferents15 and vagus nerve stimulation may influence respiration via central projections to the reticular formation of the medulla or medial pons.16 By interfering with this mechanism, the anti-TNFα treatment may decrease the arousal response to the obstructive episode. Unfortunately, measurements of leptin and TNF were not made for our patient and, thus, this hypothesis cannot yet be confirmed.

References