New RA Guidelines Stress Early Intervention

BY DENISE NAPOLI
FROM THE AMERICAN COLLEGE OF RHEUMATOLOGY AND THE EUROPEAN LEAGUE AGAINST RHEUMATISM

The promised overhaul of treatment guidelines for rheumatoid arthritis has finally arrived, and with it, a “new paradigm” that focuses on early identification and management of the disabling disease.

The guidelines, which were developed by a joint committee from the American College of Rheumatology and the European League Against Rheumatism, are the latest update since the current guidelines were created in 1987.

Published jointly in the EULAR journal Annals of the Rheumatic Diseases (2010;69:1580-8) and the ACR’s Arthritis & Rheumatism (2010;62:2569-81), the new guidelines were created in three phases over 2 years. In the first phase, the goal was to “to identify the contributions of clinical and laboratory variables that in practice were the most predictive of the decision to initiate (disease-modifying antirheumatic drug) therapy in... patients with early undifferentiated synovitis,” wrote the authors, led by Dr. Daniel Aletaha of the Medical University of Vienna.

To do this, a working group from both societies looked at data from 3,115 patients and correlated whether the results of undifferentiated peripheral inflammatory arthritis were the most predictive of the decision to initiate treatment. The recommendation applies only if arthritis is currently considered to be RA.

Finally, phase III aimed to utilize the results of phases I and II “to develop a scoring system that would be applicable to newly presenting patients with undifferentiated inflammatory arthritis, to permit identification of those with a high probability of developing persistent and/or erosive RA.”

This final scale assigns points in the following manner:

- One swollen “large joint” (defined as shoulders, elbows, hips, knees, and ankles) gets 0 points; involvement of 2-10 large joints gets 1 point.
- Involvement of 1-3 “small” joints (defined as metacarpophalangeal joints, proximal interphalangeal joints, second to fifth metatarsophalangeal joints, thumb interphalangeal joints, and wrists) gets 2 points, regardless of location involvement; involvement of 4-10 small joints gets 3 points.
- Involvement of more than 10 joints, including at least 1 small joint, gets 5 points.

Both a negative rheumatoid factor (RF) test and a negative anti-citrullinated protein antibody (ACPA) test gets 0 points, whereas having a “low-positive” RF or ACPA (defined as lower than three times the upper limit of normal) gets 2 points. A “high-positive” of either test gets 3 points.

- A normal CRP and normal ESR get 0 points, whereas at least one abnormal test gets 1 point.
- Symptom duration of fewer than 6 weeks gets 0 points; duration of 6 weeks or longer gets 1 point.

Scores of 6 or more out of 10 are classified as “definite RA.”

Commenting on the new criteria in an interview, Dr. Eric L. Matteson, who is with the Mayo Clinic in Rochester, Minn., and was not involved with the new guidelines, said, “A major useful feature is that the new guidelines do not require multiple joints to be inflamed before a diagnosis can be made of early inflammatory rheumatoid arthritis.”

Indeed, a patient may score 6 points without multiple joint inflammation, according to the new guidelines. When asked what was missing from the new guidelines, he pointed to a lack of awareness of extra-articular components of RA, which also can occur early in the course of the disease.

Disclosures: Several of the guideline authors disclosed financial and other relationships with multiple pharmaceutical companies; Dr. Matteson stated that he had no financial disclosures relative to his comments.

MULTINATIONAL GROUP OFFERS RECOMMENDATIONS FOR UPIA

BY HEIDI Splete
FROM THE ANNALS OF RHEUMATIC DISEASES

Ten recommendations for how best to investigate and follow patients with undifferentiated peripheral inflammatory arthritis were developed by an expert panel of nearly 700 rheumatologists from 17 countries.

Many patients who present to rheumatologists have recent-onset arthritis that aren’t rheumatoid arthritis, said the authors. The American College of Rheumatology and the European League Against Rheumatism, committee from the American College of Rheumatology and the European League Against Rheumatism, created in 1987.

The study was supported by Abbott Laboratories.

GUIDELINES LACK DEFINITION

This is a very difficult area, and the authors are to be commended for the tremendous amount of work they did to try to make undifferentiated peripheral inflammatory arthritis a little clearer. They did a careful literature search and a grading system so they could be transparent about what data they had.

The question is how much the guidelines will be used. There are some problems because of the lack of data in some areas. This undoubtedly led to several recommendations that were based on expert opinion rather than evidence.

Ultimately, what makes the guidelines difficult to use is that we do not end up with a definition. This document tells us how to try to define what is going on with a patient, but it doesn’t say, “So this is what UPIA is.” Instead, it says a lot about what it is not. The guidelines lean strongly toward a diagnosis of RA, but it would help to have a table of tests the researchers recommended and why they recommended them.

A key point the recommendations make is to do a good history and physical, plus appropriate laboratory investigations. It is good to have that in writing.

These recommendations are a good effort, and more helpful in what not to do than what to do.

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Daniel E. Furst, M.D., is Carl M. Pearson Professor of Rheumatology at the University of California, Los Angeles. He reports having no conflicts relevant to this discussion.