Guest Editorial

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Managing Rheumatoid Arthritis in the VA: Effective Collaborative Care

The current VA patient population is predominantly older, male, and low income—although there are increasing numbers of female and younger veterans. This population also has a high prevalence of obesity and tobacco, alcohol, and drug use. Vietnam War–era veterans, who make up a large proportion of VA patients, are now in the age range of late 50s to late 60s. Many of these veterans have a history of exposure to Agent Orange. They also have high rates of hepatitis C virus (HCV) infection and the attendant comorbidities of type 2 diabetes, prostate and other cancers, atherosclerosis, and chronic obstructive pulmonary disease.

With these factors in mind, it is clear that VA patients are at high risk for developing rheumatoid arthritis (RA). RA is an autoimmune condition with an incidence that peaks around the age of 60 years.[1] Smoking and low socioeconomic status are considered risk factors for RA,[2] obesity may exacerbate the condition, and viral infection is a possible cause.

Studies have pointed to improved outcomes in patients with RA who are treated early, and current disease management involves early, aggressive therapy.[3] Therefore—as detailed by Keith and O'Brian in this month's CME activity ("The Role of Primary Care Providers in Managing Rheumatoid Arthritis, Part I—Early Diagnosis and Referral," on page 42)—RA needs to be diagnosed as early as possible to prevent further joint damage, decreased quality of life, and increased mortality. In addition, patients with RA need to be referred from primary care to a rheumatologist for a thorough evaluation and appropriate treatment. Close and thoughtful communication is key to the interaction between the primary care provider (PCP) and rheumatologist, and it can mean all the difference to the patient in the long run.

WHAT THE PCP SHOULD LOOK OUT FOR

As noted in this issue's CME activity, referral to rheumatology needs to be preceded by a careful and complete musculoskeletal assessment by the PCP, with special attention paid to the patient's hands and wrists. The American College of Rheumatology criteria for RA notes the remarkable symmetry of the disease, which affects the hands and wrists bilaterally.[4] Synovitis, as evidenced by the presence of joint edema, erythema, or excessive warmth or tenderness, needs to be documented, as does the presence of any subcutaneous nodules. Joint range of motion and muscle strength needs to be determined.

A patient who reports muscle and joint aches and pain and does not have a complete musculoskeletal assessment by a PCP needs full documentation of the presence or absence of synovitis in affected joints prior to referral to a rheumatologist. Unfortunately, failure to document the presence of synovitis upon physical examination is the most common error seen in referrals to rheumatology. Given the waxing and waning nature of synovitis in RA (and, subsequently, the changing results on physical examination), this documentation is the most important action that the PCP can offer.

Early referral to rheumatology should be considered for patients with existing immune suppressing etiologies of RA, such as psoriasis, type 2 diabetes, or hypothyroidism. A positive family history of inflammatory arthropathy or connective tissue disease also increases susceptibility to the development of RA, and thus should be elicited when documenting a patient's medical history.[5]

THE ROLE OF THE RHEUMATOLOGIST

Rheumatologists best serve the function of administering and monitoring immune suppression, but they also can confirm diagnosis of RA—on physical examination and by ordering appropriate serologic testing and imaging. It is worth noting that no serologic testing is diagnostic for RA; false positives and false negatives abound for such tests as rheumatoid factor. Most blood tests have little specificity without evidence of synovitis on physical examination. The most specific serologic test is the recently described test for anti-cyclic citrullinated peptide antibodies.

As with blood tests, x-rays often are insufficient to document the patient's skeletal structure status, as they are not diagnostic unless erosions are present (a marker of more aggressive and advanced disease). Computed tomography scan and magnetic resonance imaging are used infrequently in RA diagnosis or treatment. Apart from the typical uses of these modalities in primary care (including documentation of vertebral lesions and acute

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ligamentous and meniscal derangements), these forms of imaging are confined largely to research studies of new pharmacologic treatments of RA. Although the role of ultrasound (particularly in large joints of the body) is still undergoing refinement, it is of most value in guiding invasive procedures. Plain x-ray films, to demonstrate either juxta-articular erosions or periarticular osteopenia, remain the preferred imaging modality in RA.

TEAMING UP FOR TREATMENT

Initiating treatment should be done in consultation with a rheumatologist, and potential adverse effects of therapy should be monitored according to the most stringent guidelines of the American College of Rheumatology.[6] Informed consent is of growing importance prior to initiating treatment, as many RA therapies are considered chemotherapy.

Methotrexate is a standard RA treatment; when properly monitored with appropriate laboratory workup, it is inexpensive and has the best established safety record of any immunosuppressive drug used to treat RA.[7] Comanaged care with the PCP and rheumatologist creates a potential pitfall with regard to documentation of laboratory test results. Nevertheless, bimonthly documentation in the patient's medical record is strongly encouraged. Failure to adequately titrate the methotrexate dose is the most common error seen in managing ongoing inflammation. Patients who have hepatitis B virus (HBV) or HCV infection should not be given methotrexate because of its high potential for hepatotoxicity. Screening for HBV and HCV antibodies is imperative in the initial evaluation of patients with RA.

Hydroxychloroquine is a mild immunosuppressive agent that can be used as monotherapy for RA or, because it takes a long time to build up in the body, as an adjunct medication with methotrexate. When using hydroxychloroquine, eye examinations for color vision and acuity must be completed every six months, with visualization by indirect ophthalmoscopy for any evidence of potential retinopathy.

Biologic response modifiers typically are reserved for patients who have not responded favorably to methotrexate monotherapy. Although patients with RA who have HBV or HCV infection can be considered for biologic monotherapy, these agents generally are given in addition to methotrexate and thus should be initiated in consultation with a rheumatologist. Methotrexate increases the effectiveness of the biologics by suppressing autoantibody formation. The major risk of biologic response modifiers is infection—reactivation tuberculosis, in particular. The documentation of tuberculin skin test status is imperative prior to initiation of biologics.

Finally, a word about prednisone. Its powerful immunosuppressive properties can provide almost immediate relief of RA symptoms. Its judicious and short-term use is appropriate. The difficulty with prednisone is that it can mask all symptoms of RA completely and effectively suppress all laboratory results for inflammatory markers. When prescribing prednisone to a patient with suspected RA, it is recommended that the PCP advise the patient to discontinue the prednisone for at least seven days prior to a rheumatologic workup. This seven-day period allows for a more accurate assessment by the rheumatologist. The long-term use of prednisone should be minimized whenever possible, as it may place patients at elevated risk for developing osteoporosis, as well as other comorbidities in RA (such as diabetes and hypertension).[8]

ONGOING COLLABORATION

It is important to monitor patients for potential adverse effects, particularly infections due to immunosuppression. Early use of antibiotics in patients with RA is strongly encouraged if signs or symptoms of infection are present. In most cases, this can be done without withholding the patient's immunosuppressive regimen.

Given that VA patients with RA are at high risk for many adverse effects, routine laboratory monitoring for hepatoxicity and bone marrow suppression is strongly recommended. Additionally, patients with RA are at greater risk for coronary artery disease,[9] as are VA patients in general due to a high prevalence of diabetes, hyperlipidemia, tobacco use, and male sex. Finally, there is increased risk of malignancy in patients with RA—particularly lung cancer, lymphoma, and prostate cancer.[10] The alert practi-

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Author disclosures

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