RA Comorbidities Hike Price Tag of Care

BY DENISE NAPOLI

Rheumatoid arthritis patients with comorbid depression and/or cardiovascular disease accumulated thousands more dollars in annual health care costs than did their peers with RA alone.

This finding is based on a study of over 10,000 people with rheumatoid arthritis conducted by Amie T. Joyce of Pharmetrics Inc., Watertown, Mass., and her associates.

In an interview, Edward H. Yelin, Ph.D., an expert on the economic impacts of chronic diseases who was asked by this publication to comment on this research, said "We are seeing increasingly that inflammation [is present in] many chronic diseases and, thus, it is impossible to separate out specific illness costs perfectly."

Rheumatologists can help bring down utilization costs for these patients "by treating the whole person, rather than just the single most pressing condition," said Dr. Yelin, who was not involved in the study. He is professor in residence of medicine and health policy in the division of rheumatology at the University of California, San Francisco.

Dr. Joyce's study looked at 10,298 RA patients culled from PharMetrics Inc.'s patient-centric database from 2001 to 2005. The database contains medical and pharmaceutical claims from 92 health plans across the United States. Of the sample, 8,916 patients (87%) had RA alone, 608 (6%) had RA with CVD, 716 (7%) had RA with depression, and 58 (0.6%) patients had all three conditions.

The annual cost for patients with RA alone was $14,257 vs. $21,410 for patients with RA plus depression, $24,444 for patients with RA plus CVD, and $35,246 for all three conditions.

Patients with RA plus depression had higher annual RA-specific costs than did patients with RA alone ($9,940 vs. $9,322; $P = .014$), and the RA-specific costs increased even more in patients with all three conditions, to $12,318 ($P = .012$). That effect was not seen in the RA plus CVD group (J. Rheumatol. 2009 Feb. 15 [doi:10.3899/jrheum.080670]).

Hospitalization contributed to the increased costs. Just 8% of patients with RA alone had a hospital stay in the 12 months prior to their index date (the date of the patient's first claim with an RA diagnosis). In the RA plus CVD cohort, this jumped to 35%. In the RA plus depression cohort, it was 19%, and among the patients who had all three diagnoses, 60% were hospitalized during that 12-month period. (For all rates, P was less than .001.)

The average number of prescriptions filled also increased with increasing comorbidities. RA-only patients filled an average of 46.8 prescriptions in the 12 months following RA diagnosis, compared with 69.2 in the RA plus CVD group, 71.3 in the RA plus depression group, and 114.3 in the RA plus depression plus CVD group.

The authors disclosed funding from Wyeth Research. Three of the authors are also Wyeth Research employees. ■

Physician Extenders Needed to Help Fill Gap in Arthritis Care

BY MICHAEL VLESSIDES

KANANASKIS, ALTA. — Rheumatologists' best hope for dealing with the coming deluge of joint disease is to use physician extenders to triage patients and oversee their physical therapy.

A report by the American College of Rheumatology has anticipated a significant shortage of rheumatologists that will begin after 2010 and continue for at least 20 years. In 2006, when the report was published, fellows of the ACR averaged 56 years of age. Rheumatology is one of many specialties with projected shortfalls of physicians that may reach 200,000 by 2025, according to the ACR (Arthritis Rheum. 2007;56:722-9).

"The challenge is in determining who is going to do what. Fortunately, we now have some evidence to show that doing things differently can help facilitate the delivery of these interventions to more people in a more timely manner," Linda Li, Ph.D., said at the annual meeting of the Canadian Rheumatology Association.

Dr. Li and her associates developed an integrated framework for rheumatoid arthritis treatment to shorten the delays between various levels of care, based on a review of the literature (Arthritis Rheum. 2008;59:1171-83).

The framework begins at the community level, where health care services should provide information to patients during the interval between symptom onset and the first visit to a primary care physician. "Some interventions involve using community therapists, pharmacists, and nurses to facilitate the transition from community to primary care," noted Dr. Li, the Harold Robinson/Arthritis Society Chair in Arthritic Diseases at the University of British Columbia, Vancouver.

One study looked at the use of community pharmacists to disseminate information about the relationship between knee pain and osteoarthritis (Arthritis Rheum. 2007;57:1238-44). A simple screening questionnaire found that 190 (98%) of 194 patients who indicated knee pain met ACR clinical criteria for knee osteoarthritis.

At the primary care level, where specially trained nurses triaged rheumatology referrals using standardized guidelines, the rate of appropriate referrals increased from 50% to 90% within 2 years (Rheumatology [Oxford] 2003;42:763-8).

Another study found that specially trained physical therapists reduced referrals to orthopedists by 17% and to rheumatologists by 8%, compared with the conventional model of direct referral from general practitioners to hospital departments (Am. J. Phys. Med. Rehabil. 2005;84:702-11).

Secondary care focuses on self-management and follow-up assessments, yet another area where nonphysicians can play a role in effective clinical care, Dr. Li said. This frees up rheumatologists to see the sickest people, she added.

Dr. Linda Li is supported by the Harold Robinson/Arthritis Society Chair in Arthritic Diseases, a Canadian Institutes of Health Research (CIHR) New Investigator Award, and an American College of Rheumatology Research & Education Foundation Health Professional New Investigator Award. ■

Early MRI Targets Rheumatoid Arthritis Care

BY NANCY WALSH

FORT LAUDERDALE, FLA. — The use of magnetic resonance imaging has provided a keyhole view into the early pathological events of rheumatoid arthritis, long before structural damage becomes evident on conventional radiography, according to recent research.

MRI has yet to be as fully embraced by rheumatologists as it has been in other specialties, according to Dr. Norman B. Gaylis. "I believe that we are going to catch up, however, and our approach to management of rheumatoid arthritis will be more like that used for other systemic diseases such as lymphoma," Dr. Gaylis said at a meeting sponsored by RHEUMATOLOGY NEWS and Skin Disease Education Foundation.

Bone marrow edema on MRI predicts both joint damage and disability better than clinical features.

DR. GAYLIS

Conventional radiography cannot visualize bone marrow edema in rheumatoid arthritis (RA). "Bone marrow edema may be the best biomarker that we haven't been using in the management of rheumatoid arthritis," said Dr. Gaylis, who is in private practice in Aventura, Fla.

Bone marrow edema in RA was first recognized in a cohort of patients from New Zealand who had MRI scans of the wrist at the time of diagnosis (Ann. Rheum. Dis. 1998;57:350-6).

The lymphocyte and osteoclast infiltration in the subchondral bone seen in bone marrow edema suggests that this might be the site for important pathological events driving the rheumatologic joint damage in RA.

Bone marrow edema also is more predictive of later MRI-detected erosions than is any other clinical feature, including disease activity score, C-reactive protein, or anticyclic citrullinated peptide antibody, and it predicts functional disability at 6 years more closely than does other MRI features such as synovitis and tendinitis (Ann. Rheum. Dis. 2004;63:555-61).

Dr. Gaylis stated that he had no conflicts of interest. SDEF and this news organization are owned by Elsevier.

To view a video interview of Dr. Gaylis, go to http://www.youtube.com/watch?v=IObehXizRQg. ■

Drug Patches Should be Off During MRI Scans

BY ELIZABETH MECHCATIE

To eliminate any risk of skin burns, transdermal medication patches should be removed before patients undergo magnetic resonance imaging scans, the Food and Drug Administration advises.

The FDA's public health advisory was prompted by fewer than half a dozen reports of burns associated with medication patches that contain trace amounts of aluminum or other metals, which can heat up just enough during an MRI scan to cause a burn.

The reported cases have been in nicotine patches, Dr. Sandra Kweder, deputy director of the FDA's Office of New Drugs, said during an FDA telebriefing.

About 60 medicated patches are on the market, and include both over-the-counter and prescription products. Uses include smoking cessation, contraception, hormone therapy, and pain treatment. More than 25% of patches contain metal, Dr. Kweder said. Even transparent patches may contain metals.

Clinicians should instruct the patient about when to remove the patch before the procedure and about replacing it after the procedure, the advisory said.

The FDA is currently reviewing the labeling and composition of all transdermal medication patches, and is working with manufacturers to improve labeling, which could include some type of warning on the patch. ■

A link to the advisory is available at: www.fda.gov/medwatch/safety/2009/safety09.htm#Transdermal.