Exams Need to Be Standardized

Assessment *from page 1*

7% indicated they always did a formal 28 TJC, and 28% did so for more than half of exams. About one-third of respondents never perform formal 18 swollen joint counts, one-third do so less than 50% of the time, and another third do so more than 50% of the time.

Rheumatologists not do routinely include physician or patient pain assessments in their evaluations. About 80% never or rarely ask patients to complete a pain visual analog scale, and only about 20% often or always do so. Similar findings were reported for physician assessments of pain, said Dr. Pincus of New York University.

A request for patient self-assessment is rarely included in the routine rheumatology exam. More than half of respondents said they never include a patient global estimate of status, whereas 15% each reported they do so infrequently (less than 50% of the time), frequently, or always. In contrast, the use of a patient self-assessment questionnaire was rare: In all, 73% said they never asked patients to complete the MDHAQ (Multidimensional Health Assessment Questionnaire–Physical Function), whereas 20% frequently or always did so. The HAQ (Health Assessment Questionnaire–Physical Function) was utilized more often, with about one third of respondents indicating they frequently or always included this assessment, whereas 40% never used it.

With regard to laboratory measures, 75% reported that they always measure C-reactive protein and 64% often or always measure erythrocyte sedimentation rate. Indices such as the CDAI (Clinical Disease Activity Index) or RAPID3 (Routine Assessment of Patient Index Data 3) are rarely included, whereas the DAS28 was frequently or always calculated by 30% of respondents.

Rheumatologists do not routinely include physician or patient pain assessments in their clinical evaluations.

DR. PINCUS

When he surveyed all members of the American College of Rheumatology prior to the 2010 ACR meeting, he found that – unlike clinicians who treat many other chronic diseases – clinicians who treat patients with RA rely most on patient history and physical exam.

When asked about how often they performed a formal tender and swollen joint count, the 118 responses were fairly equally divided across the spectrum from "never" to "always." The evaluation of rheumatoid factor was more consistent, with 84% frequently or always running this test. The group was also consistent in excluding patient self-report questionnaires, with 63% rarely or never including this in the clinical visit.

Dr. Pincus developed a 10-point checklist to follow during an exam. (See related story.)

Dr. Pincus said he had no relevant financial disclosures to report. ■

Ten-Point Evidence-Based Guide To the Rheumatology Visit

BY AMY ROTHMAN SCHONFELD

EXPERT ANALYSIS FROM A COURSE SPONSORED BY NEW YORK UNIVERSITY

NEW YORK – Despite clinical advances, most rheumatology patient encounters are conducted much as they were 40 years ago, according to Dr. Theodore Pincus, who spoke at both the New York University Hospital for Joint Diseases meeting on Evidence-Based RA Therapy and the Fifth Annual Clinical Research Methodology Course.

And the patient loses out as a result.

Laboratory tests that are usually performed are not necessarily diagnostic, as 30%-40% of patients with rheumatoid arthritis have normal values of many measures (erythrocyte-sedimentation rate, C-reactive protein, and presence of rheumatoid factor and/or anti–cyclic citrullinated peptide antibodies). In addition, radiography and formal joint counts have significant clinical limitations, said Dr Pincus.

There is underuse of patient self-assessment tools such as the HAQ (Health Assessment Questionnaire) or MDHAQ (Multidimensional Health Assessment Questionnaire), both of which predict work disability, costs, and death from RA more precisely than do radiographs or laboratory tests, he said.

"I believe the MDHAQ-RAPID3 [Routine Assessment of Patient Index Data 3] should be incorporated into your infrastructure of care," said Dr. Pincus, a clinical professor of medicine at New York University.

He described a 10-point checklist for all visits with patients who have rheumatic disease that is based on evidence and that relies more upon patient self-assessment and physician global assessment than it does on findings from joint counts, laboratory tests, or radiography.

Dr. Pincus proposed that physicians follow the 10-measure checklist during every clinical encounter to document patient status and quantify patient progress. (See box.) The checklist includes six self-report measures from the MDHAQ self-report questionnaire, including evaluation of function, pain, fatigue, and other symptoms; a patient global estimate of status; and the RAPID3 score. The four physician global measures include assessment of inflammation, damage, and changes that are noninflammatory, as well as a physician global estimate of status.

The MDHAQ is a version of the HAQ, which was the only patient self-assessment tool actually developed in the clinic, said Dr. Pincus. The MDHAQ has been modified to reflect escalating standards of rheumatology care, so currently patients are asked if they can walk 2 miles or participate in recreational activities or sports. Queries about sleep, anxiety, and depression have also been added. In addition, the MDHAQ provides a review of systems and recent medical history information.

According to Dr. Pincus, the HAQ and MDHAQ are better predictors than are joint count, laboratory tests, or radiographs of functional status, work disability, joint replacement surgery, or cost.

Dr. Pincus reported having no relevant financial disclosures. ■

Visit Checklist

In the 10-point checklist, the patient MDHAQ self-report questionnaire measures include the following:

- ▶ Function.
- ▶ Pain.
- ▶ Patient global estimate of status.
- ▶ RAPID3.
- ▶ Fatigue.

The physician global measures include the following:

- ▶ Physician global estimate of status.
- ▶ Inflammation.
- ▶ Damage.
- ▶ Noninflammatory/nondamage.

Source: Dr. Pincus

Given Time, the First Biologic Is Likely to Work

BY AMY ROTHMAN SCHONFELD

EXPERT ANALYSIS FROM A COURSE SPONSORED BY NEW YORK UNIVERSITY

NEW YORK – Prescribing errors, such as premature withdrawal of a biologic agent once remission is achieved and hasty switching of agents, can undermine optimum results with biologics in the management of rheumatoid arthritis, according to Dr. Yusuf Yazici.

For instance, results from the BEST (Behandel Strategieen) trial (Ann. Rheum. Dis. 2009;68[suppl. 3]:544) showed that if patients who achieved remission with biologic therapy stopped that therapy, within 2 years 54% (62/115) stayed in drug-free remission, said Dr. Yazici, a rheumatologist who is director of the Seligman Center for Advanced Therapeutics and Behcet's Syndrome Evaluation, Treatment and Research Center at the New York University Hospital for Joint Diseases. The remaining patients saw their disease flare, but while about three-quarters of those (39/53 or 34% of the original group) were brought back into remission within 6 months, about one-quarter (14/53 or 12% of the original group of 115) did not achieve remission again. "That number is too large," said Dr. Yazici.

"Just as we would not consider stopping treatment for diabetes or hypertension, this chronic disease treatment approach should also be considered in patients with RA," said Dr. Yazici. He advised against tapering or stopping the combination of medications that was required to achieve remission unless there is a safety concern.

Another problem that Dr. Yazici has noticed is failure to allow enough time for one tumor necrosis factor–inhibiting (TNFi) biologic to take effect before switching to another biologic. Common reasons for switching cited are inefficacy or adverse events.

In a retrospective analysis of an insurance claims database of 9,075 patients with RA who started a TNFi agent during the period 2000-2005, Dr. Yazici saw more frequent changes among different TNFi agents and shorter duration of treatment before change, as time progressed. The use of a first-prescribed biologic medication dropped by about 45% after the first year and 70% after the second year; by 3 years, only a small percentage remained on the same therapy. In this study, infliximab had the highest duration of continuation, about 50% at 2 years. After adalimumab was introduced into the market, a dramatic drop in time to switch was observed, from a mean of 454 days to 237 days among TNFi agents (J. Rheumatol. 2009;36:907-13). "The more biologics we have, the faster we switch, it seems," commented Dr. Yazici.

Dr. Yazici also cited data from the DANBIO registry, a nationwide Danish registry of patients with RA, in which 2,326 patients were observed after initiation of biologic therapy.

After 4 years, 56% were still taking etanercept, 52% were still on adalimumab, and 41% remained on infliximab. Drug withdrawal was primarily attributed to adverse effects and secondarily to lack of efficacy (Arthritis Rheum. 2010;62:22-32).

Published data on etanercept, adalimumab, infliximab, and abatacept suggest no real differences in efficacy in most patients who use them, said Dr. Yazici. Data from registries tend to show no preference for one over another. He suggested that physicians allow at least a 3- to 6-month trial period before switching biologic agents.

Dr. Yazici serves as a consultant to Bristol-Myers Squibb, Celgene, Genentech, Roche, and UCB. ■