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 treatment 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 or not the patients were ultimately prescribed methotrexate to an "agreed-upon list of standardized clinical and laboratory variables collected at baseline."

The odds of eventual methotrexate initiation were calculated for each variable. For example, swelling of the metacarpophalangeal joint had an odds ratio of 1.5, as did swelling of the proximal interphalangeal joint and the wrist. Tenderness of the hand (either the MCP, PIP, or wrist) was assigned an odds ratio of 2.0.

Moderate elevation of C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) was assigned an OR of 1.0; high elevation of either assay got an OR of 2.0.

In phase II, a panel of 12 rheumatologists related the above clinical and laboratory factors to the "probability of developing 'persistent inflammatory and/or erosive arthritis that 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 large-joint 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) testgets 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 doesn't meet clinical criteria, but they are concerned about their odds of developing a more serious disease, wrote Dr. Pedro Machado of the University of Coimbra (Portugal) Hospital and colleagues on behalf of the panel (Ann. Rheum. Dis. 2010 Aug. 19 [doi:10.1136/ard.2010.130625]).

To develop the recommendations, the panelists participating in the 3E (Evidence, Expertise, Exchange) Initiative created 10 clinical questions related to undifferentiated peripheral inflammatory arthritis (UPIA) and reviewed the evidence-based literature that addressed each one.

They agreed on 10 recommendations, and each participant indicated whether the recommendations would change their current clinical practices:

► **Consider all alternatives.** UPIA is a diagnosis of exclusion. All causes of arthritis – including trauma, malignancy, and metabolic problems, as well as autoimmune causes – should be ruled out. This recommendation applies only if arthritis persists, and not if it is self-limiting.

► **Note red flags during the history and physical.** Previous studies have shown that older age, female sex, and greater morning stiffness are predictors of an ultimate rheumatoid arthritis diagnosis.

► **Perform erythrocyte sedimentation rate and C-reactive protein assessments.** Do these at baseline, and repeat when clinically relevant.

► **Test for rheumatoid factor and/or anticytoplasmic antibodies (ACPA) in patients with UPIA.** But remember that negative results do not exclude eventual progression to RA.

► **Perform baseline x-rays of affected joints.** Be sure to review x-rays of affected hands, wrists, and feet when evaluating a patient for UPIA, as erosions in these areas can predict future RA. Repeat within a year of the first evaluation.

► **MRI can be used, cautiously, to diagnose UPIA in the hands and wrists.** Some evidence shows that MRI can be useful for predicting RA in UPIA patients, but the data are too limited to recommend the routine use of MRI or ultrasound imaging in these patients.

► **Consider HLA-B27 genetic test in certain clinical settings.** Although no genetic test is available that can be routinely recommended for UPIA, the HLA-B27 test might be helpful in patients with suspected spondyloarthritis.

► **Synovial biopsy can help in the differential diagnosis in patients with monoarthritis.** However, there is not enough evidence to recommend this as a routine procedure in UPIA patients.

► **Document predictors of persistent inflammatory arthritis.** Predictors include duration of 6 weeks or longer, over 30 minutes of morning stiffness, involvement of more than three joints, and evidence of radiographic erosion.

► **Monitor disease activity as well as possible.** In five studies that evaluated four different questionnaires, none stood out as fully validated for use in UPIA, but it is important to make an effort to record disease activity using a tool such as the WHO Disability Assessment Scale or the London Handicap Scale.

When the panelists were asked which recommendations were most likely to change the way they approach patients with suspected UPIA, 25% mentioned the recommendation on documenting predictors of persistent inflammatory arthritis. About 18% of the panelists said that the recommendation on MRI and ultrasound would change their practice.

The development of new criteria for RA from ACR/EULAR will likely make it harder to diagnose UPIA, because some of these patients meet the new criteria for RA, the researchers noted. ■

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VIEW ON THE NEWS

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 unavoidably 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 recommend and why they recommend 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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