RA Patients Lack Care Following Heart Attack

BY SARA FREEMAN

FROM THE ANNUAL EUROPEAN CONGRESS OF RHEUMATOLOGY

LONDON – Patients with rheumatoid arthritis who have had a heart attack for the first time do not appear to be getting medications recommended to prevent a further cardiovascular event, according to the findings of a large Danish study.

Aspirin, statins, and beta-blockers – cardioprotective medications that are given as the standard of care to most patients immediately following a myocardial infarction – were all less frequently prescribed to patients with rheumatoid arthritis (RA) than to members of the general patient population.

Indeed, 1 month after an MI, the odds ratios for the prescription of these drugs were 0.75 (95% confidence interval, 0.63-0.90) for aspirin, 0.68 (95% CI, 0.57-0.82) for a statin, and 0.76 (95% CI, 0.63-0.91) for beta-blockers. These results did not change greatly at follow-ups of 3 months, 6 months, or 1 year.

The increased risk of cardiovascular disease in RA is well known and could result from a number of causes, including the presence of classical risk factors such as dyslipidemia and hypertension, possible adverse effects of RA treatment, and an accelerated atherosclerotic process driven by the high levels of inflammation characteristic of the rheumatic disease.

"What's not been considered, [however,] and perhaps the simplest explanation, is whether or not there is undertreatment of [RA] patients," Dr. Jesper Lindhardsen, of the cardiology department at Gentofte University Hospital, Copenhagen, said at a press briefing during the congress.

To determine whether patients with RA were being given standard cardioprotective medications after a first MI, he and his colleagues analyzed data from several Danish patient registries, including those giving prescription records, details of comorbidities, and income.

The study population consisted of 66,389 patients who had had a first heart attack between 2002 and 2009. Of these, 875 (1.3%) had RA. The median age was 72.6 years for RA patients and 69.4 years for patients without RA.

VITALS

Major Finding: Odds ratios for the prescription of aspirin, a statin, and beta-blockers 30 days after a first MI were 0.75, 0.68, and 0.76, respectively.

Data Source: Danish registry study of 66,389 patients – 875 (1.3%) with RA – who had a first MI between 2002 and 2009.

Disclosures: Dr. Lindhardsen and Dr. Schett had no conflicts of interest to declare.

At baseline, the use of cardioprotective medications by patients with and without RA were relatively similar or the same, at 27% and 25.1%, respectively, for aspirin; 19.1% and 19.1% for a statin; 23.9% and 22.5% for a beta-blocker; and 3.3% and 2.2% for clopidogrel.

Although aspirin, statin, and beta-blocker use was later found to be lower in the RA patients than in the non-RA patients throughout the early post-MI period, there was no significant difference in the prescription of clopidogrel at 1, 3, or 6 months or at 1 year.

Commenting on the findings in an interview, Dr. Lindhardsen conceded that it's not known what medications patients were taking before they had their heart attack, which could influence the findings.

Dr. Georg Schett, who is chief of rheumatology at the University of Erlangen-Nuremberg, Germany, but was not involved in the study, said the findings illustrate that the high cardiovascular risk in patients with RA is still not being taken seriously enough.

Indeed, Dr. Lindhardsen and his colleagues recently published data showing that RA is associated with the same risk of MI as diabetes (Ann. Rheum. Dis. 2011;70:929-34). ■

Administration Costs Four Times As Much in U.S. as Canada

BY JANE ANDERSON

FROM HEALTH AFFAIRS

Physician practices in the United States spend four times as much money as do those in Ontario, Canada, to cope with paperwork and communications involving health insurers and payers, according to a study.

The investigators found that medical practices in the United States spend nearly $83,000 per year per physician to deal with health plans. In contrast, physician practices in Ontario spend about $22,200 to interact with Canada's single-payer health care system. The report adjusted the figures slightly to account for exchange rates and specialty mix.

"If U.S. physicians had similar administrative costs to Ontario physicians, the total savings would be approximately $27.6 billion per year," wrote Dr. Dante Morra, assistant professor of medicine at the University of Toronto, and his colleagues (Health Aff. 2011 [doi:10.1377/hlthaff.2010.0893]).

Most of the problems U.S. physicians face relate to the fact that they're trying to cope with multiple payers, while Canadian physicians must deal with only one, said Dr. Morra and colleagues, who added that U.S. insurers could help by taking steps to improve the efficiency of transactions, such as implementing electronic transactions.

The differences in staff time spent on insurance issues started with the physicians themselves. U.S. physicians spent an average of 3.4 hours per week interacting with multiple insurers, while Canadian physicians spent an average of 2.2 hours per week dealing with that country's single payer. The main difference in time is the 1 hour per week that U.S. physicians spent obtaining prior authorizations, which accounted for most of the difference in the results, the study said.

In addition, practice staff members in the United States spent far more time on insurance issues than did their Canadian peers, according to the study, which called the differences "striking." U.S. nursing staff, including medical assistants, spent 20.6 hours per physician in the practice per week interacting with payers, nearly 10 times the 2.5 hours per week spent by Ontario nursing staff.

VITALS

Major Finding: Medical practices in the United States spend nearly $83,000 per year per physician to deal with health insurance plans; practices in Ontario spend about $22,200 per physician per year to interact with Canada's single-payer health care system.

Data Source: Surveys of physician practices in Ontario and in the United States, as well as 37 interviews with physicians, health plan executives, and practice administrators.

Disclosures: The authors reported no financial conflicts of interest for the study, which was funded by the Robert Wood Johnson Foundation and the Commonwealth Fund.

The study found that the U.S. nursing staff members spent more time in every possible category, including prior authorizations, which cost them 13.1 hours per physician in the practice per week. In Canada, nursing staff members spent no time on prior authorizations.

Clerical staff members worked 53.1 hours per physician per week in the United States, mainly on billing issues and obtaining prior authorizations, the study said. Meanwhile, clerical staff members in Canada worked only 15.9 hours per week, and only on claims and billing issues.

Standardizing transactions and conducting them electronically holds the potential for reducing some of these administrative costs in the United States, the study concluded. ■

Focus on Cardiovascular Risk in RA Patients

BY SHARON WORCESTER

The jury is still out on just how cardiovascular risk should be screened for and managed in rheumatoid arthritis patients, but it is clear that the risk is increased and must be addressed.

In one study, silent myocardial infarction was shown to occur more often in RA patients than controls, and sudden death was also more likely in the RA patients (Arthritis Rheum. 2005;52:402-11). In another study, survival among patients with acute cardiac syndrome was substantially reduced in patients with RA versus those without (Ann. Rheum. Dis. 2006; 65:348-53).

The European League Against Rheumatism has proposed that conventional cardiovascular risk models be multiplied by 1.5 when assessing risk in RA patients (Ann. Rheum. Dis. 2010;69:325-31). This approach is not well validated, and Dr. Joan Bathon, director of the division of rheumatology at Columbia University, New York, said she is not sure it is being widely used at this point.

The proposal illustrates the importance of focusing on cardiovascular risk in RA patients, and it suggests that considering RA as a risk factor equivalent to diabetes mellitus – at least for decision making regarding low-density lipoprotein goals – is a reasonable strategy, Dr. Bathon said at the annual congress of clinical rheumatology.

She also said a potential screening strategy involves yearly cardiovascular risk assessments. The benefits of using imaging and biomarkers for screening are unclear, and no guidelines are currently in place, but some data suggest that the use of carotid ultrasound scans to look for plaques and to assess intima-media thickness, and the calculation of a coronary artery calcium score calculated on computed tomography findings may be useful in patients over age 40 years.

As for potential management strategies, aspirin therapy might be beneficial, but it should be considered in the context of other medications the patient is taking. Statins are also a potential management tool, but questions remain about whether all RA patients should be treated regardless of LDL level, she said.

Definite treatment strategies for RA patients include weight management for overweight patients, which will help reduce inflammation, and exercise for all RA patients, because good quality muscle building will help restore insulin sensitivity and reduce fat deposits that are the most inflammatory. Tight blood pressure control and tight RA control are also imperative, she said.

Dr. Bathon had no relevant disclosures. ■