Management of Rheumatoid Arthritis 2012: A Canadian State of the Art

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*The Journal of Rheumatology* is a monthly international serial edited by Earl D. Silverman featuring research articles on clinical subjects from scientists working in rheumatology and related fields.
Editorial

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Our thesis is that there is no specific therapy for rheumatoid arthritis. With early diagnosis, simple conservative measures plus salicylates can be so effective that there is little need to utilize more potent pharmacologic therapy with the attendant increase in danger.

These words were one man’s opinion of the state of the art of the treatment of rheumatoid arthritis (RA) in 1966. Whether one agreed completely with that opinion or not in 1966, it needs to be acknowledged that the opinion was well argued and informed by a thorough, albeit not systematic, review of the literature of the time. The author found the published evidence on salicylates and personal experiences with bed rest convincing, decried the lack of well-done randomized clinical trials evaluating gold, noted that any long-term benefits of gold were not sustained, and concluded that the lack of sustained effect coupled with the well-known toxicities of gold could not justify its use. This opinion (level II/III evidence) led to a course of action (strength of recommendation C, D).

In the past 3 years, patients have been adequately managed with bed rest, salicylates, and physiotherapy at the Massachusetts Memorial Hospitals and Boston City Hospital. Indeed, gold salt therapy has not been used by any of a large group of Arthritis Clinic Staff Physicians in these clinics, and no patient has been started on this form of treatment.

Revisiting the issue of care of RA in 1974, the editors opined that no developments had occurred to alter the conclusions of 1966.

Since 1974, the development of numerous effective drugs to treat RA has evolved into our current action, the strategy of treating to a target. Targeted care is designed to minimize the time a patient spends on inadequate care. Well-conducted clinical trials examining such strategies repeatedly have demonstrated benefits in controlling measures of disease activity and halting radiographic progression. Targeted care requires a commitment by the treating rheumatologist to measure disease status at frequent intervals, about every 1 to 3 months, and to alter therapy if the target has not been met. In following such a strategy, patients with RA are expected to be exposed to one or more traditional nonbiologic disease-modifying antirheumatic drugs (DMARD), with or without a concomitant biologic DMARD.

In a tour de force, the Canadian Rheumatology Association (CRA) has developed evidence-based recommendations for the pharmacologic management of RA with traditional and biologic DMARD, published in 3 parts.

The strength of the recommendations is firmly rooted in the methods used to generate the recommendations. First, the recommendations are written in response to a needs assessment by treating Canadian health professionals. Treating professionals, not the authors, identified the issues for guideline development. While the perspective is clearly Canadian, the guidelines can be generalized to many other countries. Second, the guidelines are based on a comprehensive search of the international literature. The authors did not re-review the original studies but analyzed international clinical practice guidelines (CPG) and consensus statements (CS) with recommendations for traditional and biologic DMARD licensed for use in Canada for adult patients with RA. An ADAPTE framework was applied to modify international guidelines for use in the Canadian healthcare context. Third, guideline quality was assessed using the validated Appraisal of Guidelines Research and Evaluation (AGREE) instrument. Fourth, a working group of 16 Canadian stakeholders including patient consumers were involved in each step of guideline development. No representatives of pharmaceutical companies were involved in the process.

The articles read easily. Each recommendation is suc-
many important additional questions that need to be answered. Which biologic is best overall can be answered only by direct comparison. Which biologic is best for my specific patient is a question that we hope may be answered in the future. The CRA guidelines tell us when to start drugs. We anticipate future publications that will inform us when we can stop drugs. With regard to safety, it is clear that conventional randomized controlled trials (RCT) have been inadequate in addressing many physicians’ concerns. RCT are of limited duration and have excluded patients with complicated disease, thereby deliberately avoiding answering the questions that make clinical practice difficult. Many of the data used to inform the CRA recommendations on safety are derived in a retrospective manner, with all the attendant limitations. To enhance our confidence on very longterm safety, studies prospectively evaluating specified safety issues are obviously needed.

The promise of utilizing a treat-to-target philosophy is more than a reduction in the number of active joints and improvement in the Health Assessment Questionnaire. Data are accumulating on enhanced work productivity, decreased need for joint replacement surgery, and improved cardiovascular outcomes. For most patients with RA, these very longterm benefits cannot be achieved by simple measures, but require the services of a physician with sophisticated expertise in the use of multiple drugs, frequently under complicated circumstances.

The superb CRA recommendations will facilitate the treatment of patients with RA because they have brought clarity and have recommended actions to deal with some of the dilemmas that have perplexed treating physicians.

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REFERENCES


