Consensus Statement on the Management of Comorbidity in Patients with Rheumatoid Arthritis and Psoriasis

To the Editor:

We have read with great interest the recommendations for the management of comorbidities in rheumatoid arthritis (RA), psoriasis (PsO), and psoriatic arthritis (PsA) made by the Canadian Dermatology-Rheumatology Comorbidity Initiative[1]. The work is very interesting and comprehensive, and we congratulate the authors for combining more general recommendations for the management of the comorbidity of these 3 diseases. Indeed, it is sometimes difficult to distinguish between comorbidities, risk factors, medication adverse events, and extraarticular manifestations. But it holds clear that the presence of several different diseases aggravates the monitoring of these patients.

We have recently published a consensus statement for the management of comorbidity and extraarticular manifestations in RA[2] and a practical derivation algorithm of patients with comorbidity associated with PsO in Spain[3]. In the mentioned manuscript, the Canadian experts selected 8 main topics regarding comorbidities in RA, PsA, and PsO[1]. The Spanish panel selected the 10 most relevant comorbidities and risk factors based on a ranking depending on incidence, mortality, and preventability. Interestingly, 8 out of the top 10 comorbidities agreed completely with the 8 selected by the Canadian Initiative[1,2].

As in the Spanish recommendations (Table 1), most of the 19 recommendations from the Canadian Initiative received a grade C/D from the Oxford Centre for Evidence-based Medicine, with a level of agreement > 80% in all of them[1,2]. The overall assessment of the recommendations, according to the Centre for Evidence-based Medicine, is low (C/D, with A the highest and D the lowest) because they are based on expert opinion, although their influence is strong, which can be inferred by their wide applicability to clinical practice. Further, we would like to make some comments on this document.

First, despite substantial gaps in the current knowledge and management of cardiovascular (CV) risk in patients with chronic inflammatory rheumatic diseases (CIRD; recommendation 1), a recent work demonstrates that the prevalence of CV disease remains high even in subjects with CIRD periodically evaluated at rheumatology clinics[4]. This applies to almost half of the patients receiving biological therapy, even though most of them have low disease activity[4].

Table 1. Recommendations of the Madrilenian Society of Rheumatology for the management of comorbidities in rheumatoid arthritis. From Roubille C, et al. Rheumatol Int 2015;35:445-58.

No.	The Panel Recommends...	%A	LOE	GOR
1	...investigating comorbidities and risk factors with high incidence or mortality, especially those that may be potentially preventable, or that may interfere with the assessment of RA or its treatment*.	92	5	D
2	...early diagnosis and treatment of comorbidity in patients with RA, as well as standardized followup.	90	4	D
3	...optimizing the use of the clinical history, physical examination, and electronic information as major sources to identify and confirm comorbidities in RA.	89	5	D
4	...to carefully register all medications the patient is taking, related or not to RA.	93	5	D
5	...a very tight control of RA especially when extraarticular manifestations are present, according to what is recommended in key clinical guidelines.	89	3	C
6	...applying, whenever needed and as soon as possible, preventive measures of osteoporosis and fractures in patients with RA with increased risk of fracture.	93	2	B
7	...being especially cautious at assessing chronic pain, fatigue, and depression, e.g., ruling out the coexistence of fibromyalgia, at the time of evaluating and deciding a treatment for RA.	89	5	D
8	...involving the rheumatologist in all phases of planning and decision making of surgical procedures — orthopedic or others — in patients with RA.	89	5	D
9	...defining the level of responsibility in the management of nonrheumatic comorbidity adjusted to the setting and available resources, and following national or international guidelines for their management.	90	5	D
10	...routinely promoting health in patients with RA.	89	3	C
11	...to insist on maintaining an oral hygiene and to follow preventive strategies in case of tooth extraction or dental surgery in patients with RA.	87	5	D
12	...promoting sexual health and education in patients with RA and their partners, especially concerning issues related to the disease.	79	5	D
13	...observing evidence-based guidelines for risk management of antirheumatic drugs, especially DMARD — synthetic or biologic — glucocorticoids, and NSAID.	96	5	D
14	...to inform — and to advise when necessary — regarding the effect of RA and treatments on pregnancy and fertility.	98	5	D
15	...a periodic individualized assessment of polymedicated patients with RA, weighting the benefits and risks of each medication at each point.	91	5	D
16	...including the specific management of patients with RA with multimorbidity/polypharmacy in rheumatology training programs, clinical sessions, and research.	89	5	D
17	...the rheumatologist to be the principal coordinator of integrative care in patients with RA and multimorbidity, independently of the participation and responsibility of other health professionals or specialists.	88	5	D
18	...establishing good communication, collaboration, and coordination between rheumatology units and other healthcare professionals or providers in the same or other health levels.	95	4	D
19	...the participation or need of specialized nursing in rheumatology units.	91	5	D
20	...documenting systematically health outcomes in patients with RA.	87	5	D
21	...engaging and involving rheumatologists into the development of chronic care models.	92	5	D

* Top 10 most important comorbidities are cardiovascular disease, pulmonary disease, cancer, serious infections, smoking, diabetes, amyloidosis, depression and anxiety, obesity, and osteoporosis. %A: agreement degree; LOE: level of evidence; GOR: grade of recommendation; RA: rheumatoid arthritis; DMARD: disease-modifying antirheumatic drugs; NSAID: nonsteroidal antiinflammatory drugs.

Second, given the increased risk of infections in patients starting systemic therapy (recommendation 12), we believe it is important to remember the use of vaccinations as internationally accepted[5]. In relation to the patients with increased risk of skin cancer (recommendation 13), we support the recommendation, especially in patients with PsO/PsA who have received antitumor necrosis factor drugs, cyclosporine A, and psoralen ultraviolet A. Another interesting point that is unclear in these recommendations (recommendation 15) is the relation with bone loss and fractures, especially in patients with RA[6]. In fact, the presence of RA is currently considered an independent risk factor for incident fractures in the risk evaluation by the FRAX tool (www.shef.ac.uk/FRAX/tool.jsp?lang=sp).

Further, it is essential to highlight the frequent coexistence of depression and/or anxiety in these patients, because their presence worsens the outcome and modifies assessment scores and the response to therapies. In fact, depression was the most prevalent comorbidity in RA in the COMORA (Comorbidities in Rheumatoid Arthritis) study[7]. Strikingly, depression is the comorbidity more often disregarded in clinical practice by both rheumatologists and dermatologists. The Canadian Initiative includes 3 recommendations (recommendations 17–19) on the importance of this comorbidity. In our derivation algorithm of patients with PsO, we recommend, periodically, performing a simple scale such as the Goldberg's scale, for early detection of mood disorders and an adequate referral to the psychologist or psychiatrist as soon as they are suspected[3]. Significantly, the Canadian document also reflects the effect of the recommendations on clinical practice. We observe that, while the presence of depression is rarely considered by rheumatologists and dermatologists, these 3 final recommendations have a greater effect (≥ 50%) on daily clinical practice[1].

Both consensus documents agree on the importance of focusing on comorbidity in early diagnosis because it improves outcome globally and individually by each comorbidity. Moreover, it is difficult to treat patients when other rheumatic diseases are associated, especially osteoarthritis or fibromyalgia.

We draw special attention to 2 particular comorbidities that are not discussed at all in the Canadian document: oral health and sexual disorders. The importance of periodontal disease has gained tremendous interest in the last decade, especially in patients with RA, for its involvement in both pathogenicity and as a predictor of poor prognosis[8]. Also, accumulating evidence shows high prevalence of sexual disorders and erectile dysfunction in persons with PsO, PsA, and RA[9,10]. We think that recommendations on the management of comorbidities in CIRD should also include aspects of health promotion, especially in these key areas.

Finally, we believe that an integrated approach to these diseases must be multidisciplinary, as the authors of the initiative propose, where the rheumatologist or dermatologist or both should be involved as coordinators and managers of the comorbidity with other specialties, and where specialized nurses in rheumatology and dermatology must also be involved in its management.

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