Editorial

The role of specialists in managing established rheumatoid arthritis

Rheumatologists, nurses, therapists and general practitioners (GPs) all contribute to managing patients with RA. ‘Shared care’ is consequently a prerequisite for good care [1]. Some aspects of RA follow-up in the UK are traditionally devoted to primary care. An example is prescribing and safety monitoring of DMARDs in patients receiving long-term stable therapy. GPs can provide blood tests through ‘near patient testing’ [2] with national guidelines providing a framework to manage risk [3]. A crucial question is how often specialist rheumatologists should see patients with established stable RA.

Current RA management assumes that DMARD and biologic therapy will result in good disease control or remission, with the multiplicity of definitions of remission [4, 5] acting as a minor distraction. During RA flares it seems self-evident that urgent specialist advice is needed. For patients receiving stable DMARD treatment UK standards of care recommend annual specialist review [6] with broadly similar guidance to that of North America [7–13]. These annual reviews, which are multidisciplinary, provide an opportunity to assess the adequacy of RA disease control, identify new comorbidities, review cardiovascular risk factors and enhance patient education. A growing body of clinical trial data is helping identify the best strategies for managing stable RA over and above annual reviews.

One trial, from a single UK centre, evaluated the impact of patient-initiated follow-up appointments [14]. It lasted 2 yrs with an extension until 6 yrs [15]. The trial enrolled 209 RA patients (median disease durations 7–10 yrs) who were individually randomized to direct access and control groups. Direct access patient-initiated reviews had no clinical or psychological disadvantages and patients initiating 38% fewer hospital reviews, and found direct access more acceptable.

A second trial, from 24 Dutch centres, evaluated the impact of standardized monitoring using the disease activity score-28 (DAS28) [16]. It lasted 6 months, extending previous research by the same group [17, 18]. The trial enrolled 384 RA patients (mean disease durations 6–7 yrs) who were randomized by centre. Monitoring DAS28 resulted in more patients having low DAS28 (mean disease durations 6–7 yrs) who were randomized by centre. It lasted 6 months, extending previous research and found direct access more acceptable.

A third trial, from five UK centres, evaluated 4-monthly hospital follow-up aimed at optimizing DMARDs and steroids in patients with established RA on stable DMARD treatment [19]. It enrolled 466 patients (median duration 11 yrs). Its ‘clinical effectiveness’ design meant all consenting eligible patients were entered whether or not they would take more DMARDs. Three-year hospital follow-up and community care by specialist nurses with annual hospital review resulted in similar deteriorations in HAQ scores. Community-based care was slightly more cost-effective [20]. There was heterogeneity between centres; social deprivation varied and was associated with worse function and greater improvements with treatment [21].

A critique [22] of the British rheumatoid outcome study group (BROSG) trial noted that patients receiving community care changed DMARDs more frequently than expected and patients receiving hospital care were often unwilling to use DMARDs intensively, suggesting individual patients’ responses are more important than the context in which care is provided. There is debate about the best assessments in late RA. Systematic reviews show HAQ [23] and disease activity assessments [24] are insensitive to DMARDs and biologics in late RA. HAQ scores mainly reflect joint damage in late RA [25, 26], DAS28, which was developed to assess early RA [27, 28] may be less relevant in late RA than composite measures like ‘overall status in rheumatoid arthritis’ (OSRA) [29]. Interestingly, in the BROSG trial, OSRA suggested a significant benefit from intensive treatment [30] (Table 1).

One conclusion from these trials is that remission may be an unrealistic goal in late RA. Those patients receiving intensive DMARD therapy in the BROSG trial achieved mean swollen joint counts under 3 and mean ESRS under 25 mm/h at the end of 3 yrs’ follow-up; these levels are comparable with long-term results with biologics [31–35] that also rarely achieve remission [36, 37]. Good symptom control may be a more realistic target in late RA.

Another conclusion is that patients with late RA stabilized on DMARDs, who have well-controlled symptoms, annual specialist review combined with urgent specialist access is sufficient when the need arises. Local factors like deprivation may modulate the need for specialist input. Although patients and clinicians recognize the importance of timely access to specialists [38], it seems reasonable to aim for structured long-term primary-care-based supervision involving specialist rheumatology nurses together with annual specialist review.

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References

3 Chakravarty K, McDonald H, Pullar T et al. BSR & BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British