This editorial refers to ‘First-line DMARD choice in early rheumatoid arthritis—do prognostic factors play a role?’, by Satish M. Rachapalli et al., doi:10.1093/rheumatology/kep389, on page 1267.

Of the many factors that influence the initial perceptions which a patient gathers of his/her disease, many arise in the physician’s waiting room. Thirty years ago severely disabled patients with RA, often wheelchair bound, were more the norm than the exception, whereas in the 21st century individuals with early diagnosis of the disease, synovitis is better controlled and the damage contained.

Whether this shift is due to a single factor or multiple factors is unclear. A hypothesis, initially derided, postulated that RA may disappear sometime in this century. Now an increasing number of reports have documented milder disease at onset with markedly lower inflammatory indices and lower RF titres [1, 2]. Greater awareness in primary care that, combined with the earlier and sustained use of DMARDs, has also probably been contributory. Thus, in this new era of rheumatoid disease, on what grounds should rheumatologists base their choice of DMARD?

In this issue of *Rheumatology*, Rachapalli et al. [3] report about the use of initial DMARD from a network of 16 UK rheumatology centres, the Early Rheumatoid Arthritis Network (ERAN) cohort. In this cross-sectional study, the investigators analysed demographical and disease activity parameters at onset to identify which factors influenced the choice of initial DMARD. Eighty-eight per cent of patients with newly diagnosed RA were treated with a DMARD; similar numbers were started on MTX (46%) and SSZ (42%) as monotherapy. Factors that influenced choice were the number of swollen joints and presence or absence of RF, whereas erosions and disability at presentation as evaluated by HAQ did not.

In this cohort, rheumatologists chose MTX in preference to SSZ in patients with more severe disease as defined by those who were seropositive and had a high swollen joint count. In keeping with this observation is a recent survey of British rheumatologists, many of whom have also expressed a preference for MTX as their DMARD of initial choice [4]. This study was not designed to determine outcomes.

Of the many issues that Rachapalli et al.’s [3] observation raise, the principle one is how the results of DMARD studies have changed the clinical practice of rheumatologists. In a comprehensive, systematic review of DMARDs, firm evidence showed the equivalence of SSZ, MTX and LEF, despite the absence of a study comparing MTX and SSZ directly [5]. Almost all the studies were short term in a life-long disease. Thus, what is it that influences choice of one agent over the other when two agents are of equal benefit? MTX is cheaper and has a greater flexibility in dosage.

In addition, a meta-analysis reported that patients were more likely to remain on MTX than SSZ [6]. Thus, in clinical practice, MTX seems to be better tolerated than SSZ in the short to medium term. However, many patients in our clinical practice are concerned about hair loss and restrictions with alcohol use. As we use the drug earlier in the disease course at much higher dosages than previously and often in combination with other drugs, the long-term safety, particularly on hepatic function and risk of malignancy, especially lymphomas, needs to be considered. Such long-term safety issues may in the future significantly tip the balance; in the interim what should physicians do? Should rheumatologists continue to assume responsibility or should patients be encouraged to make their own informed choices?

Suggestions have been made that the models of health-care transferred to chronic diseases from acute illnesses are neither efficient nor effective [7]. Many of us who manage patients with chronic diseases, because of the systems we work in, are forced to deliver health-care in a process whereby the patient is a customer and therefore potentially at risk from being excluded from the health-care process. An alternative approach argued by Hart and promoted by Halstead and Lorig views health as the product and the patient a partner in the health-care process [7, 8]. Encouraging patients as partners places greater responsibilities on both parties and, if successful, may result in fewer symptoms, improved physical ability and the reduced need for hospitalization. One important component of this partnership is the communication of risk.

As evidence accumulates, how best to communicate risk by simply getting the facts correct and conveying them effectively, are said not to be enough [9]. Discussing evidence with patients requires many additional professional competencies, many of which will have been acquired through experience and from role models, but few of us have learnt formally [10]; as a result, many of us apparently spend less than 1 min of a 20-min consultation on discussing treatment and planning
Epstein, Alper and Quill have suggested a five-step process, shown in Table 1, for discussing evidence with patients, supplemented with communication of the risk in numerical rather than descriptive terms [12, 13]. We reviewed published resources available in the UK of DMARDs and found that none seems to meet the standards advocated. The new face of RA is that of a milder disease but one in which we have greater opportunities of not just achieving control of synovitis, but potentially remission of disease. In light of this, the risk–benefit ratio has also shifted. Perhaps less emphasis should be placed on the choice of DMARD and more on how best to achieve optimum patient concordance to meet the expectations of both clinician and patients.

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References

Table 1 The steps in discussing evidence with patients [13]

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<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Understand the patients and their experience and expectations.</td>
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<tr>
<td>2</td>
<td>Build partnerships.</td>
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<tr>
<td>3</td>
<td>Provide evidence.</td>
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<tr>
<td>4</td>
<td>Present recommendations.</td>
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<td>5</td>
<td>Check for understanding and agreement.</td>
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