Is it time to optimize anchor therapy for rheumatoid arthritis?

Treating the disease and the patient

The European League Against Rheumatism (EULAR) recommends that treatment of RA be considered in three phases [1]. Phase I should start immediately after diagnosis of RA, with patients recommended to receive synthetic DMARDs such as MTX, with or without the addition of glucocorticoids. Response to this anchor therapy should be monitored regularly (every 1–3 months), with the aim of achieving remission or low disease activity as rapidly as possible. Patients who do not achieve the target within 3–6 months enter phase II of treatment, with modification of the anchor therapy by switching synthetic DMARD or adding a second synthetic DMARD to existing therapy, with or without glucocorticoid.

If prognostically unfavourable factors (e.g. high disease activity, early joint damage) are present in patients entering phase II, an alternative approach recommended by EULAR is to add a biologic DMARD, such as an inhibitor of TNF [1]. This approach is also recommended for patients who fail to achieve remission or low disease activity with synthetic DMARD combinations. Failure or lack of efficacy and/or toxicity at phase II results in progression to phase III of therapy, with a change in biologic treatment recommended.

At all phases, the aim of therapy is to ensure tight control of inflammation so that the disease is quickly and adequately suppressed, preventing or minimizing structural damage to the joints [1]. It is also important to reduce symptoms and minimize impairment in patient quality of life [2]. Achieving these aims as early as possible in the disease course has been shown to have a beneficial impact on long-term outcomes [3]. This implies that the success of phase I of therapy has a long-term impact on patients. There is also an economic imperative to achieve successful outcomes with these therapies, as they may reduce the number of patients in need of costly biologic therapies [4].

But do we know how best to use available anchor therapies? With recent awareness that the choice of synthetic DMARD and the dosage regimen of MTX may affect outcomes, and development of parenteral MTX [5–8], the time is right to consider how the use of synthetic DMARDs may be optimized. Likewise, increased understanding of the disease-modifying potential of low-dose glucocorticoids and awareness that the appropriate timing of glucocorticoid administration (or use of modified-release preparations) may result in better suppression of morning stiffness [9–11], it is also apt to consider how the use of glucocorticoids may be optimized [12]. The treatment strategy, including combination therapies, also appears to play an important role in determining outcomes from initial therapies [13–15].

Acknowledgements

This supplement has been commissioned and funded by Mundipharma International Limited. It contains papers based on presentations given at a meeting held on 24 May 2011 and a satellite symposium held on 26 May 2011 at the EULAR annual congress, both arranged and sponsored by Mundipharma International Limited. I would like to thank all the faculty members and participants for their contributions, and also Mundipharma International Limited, who arranged and sponsored the meetings, provided travel expenses and honoraria to speakers, and funded the development and production of this supplement.

Supplement: This paper forms part of the supplement ‘Optimizing use of anchor therapies for rheumatoid arthritis: treating the disease and the patient’. This supplement was commissioned and funded by Mundipharma International Limited.

Disclosure statement. J.W.J.B. has been a consultant and speaker for Nitec, Mundipharma and Horizon.

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Accepted 13 March 2012

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