F Y I

Point-of-Sale Drug Abuse Information

Facts about prescription abuse will now be provided at the point of sale to buyers of the most highly abused drugs. The fact sheets will be provided by the Substance Abuse and Mental Health Services Administration to 6,300 pharmacies. The sheets will offer tips for safe storage and disposal of the drugs. Please visit www.samhsa.gov/rxsafety.

CMS Posts Medicare Training

The Centers for Medicare and Medicaid Services offers an updated Web-based training course to explain Medicare's coverage and billing for women's preventive health services. The course features billing guidelines for mammographies, pelvic exams, and bone density measurements. For more information, contact the CMS by visiting http://cms.meridianksi.com.

NIH Offers Online Info for Seniors

A free curriculum, "Helping Older Adults Search for Health Information Online: A Toolkit for Trainers," is available from the National Institute on Aging. The kit contains easy-to-read information from NIHSeniorHealth in different formats, including large type and open-captioned videos. For more information, visit http://nihseniorhealth.gov/toolkit.

Osteoarthritis Guide Now in Spanish

The Agency for Healthcare Research and Quality has issued a Spanish guide about osteoarthritis. "Escogiendo Medicamentos Para el Dolor por Osteoartritis" summarizes the efficacy, cost, and side effects of NSAIDs, COX-2 inhibitors, and other drugs. To view the pdf, visit http://effectivehealthcare.ahrq.gov/reports/topic.cfm?topic=4&sid=31&rType=1&lang=1.

E-Prescribing Standards Proposed

BY ALICIA AULT
Associate Editor, Practice Trends

The Health and Human Services department has proposed federal e-prescribing standards to be used for Medicare participating physicians, pharmacists, and software vendors.

The proposal was issued November 16; comments are being accepted through mid-January.

E-prescribing is not required for participation in the Medicare Part D drug benefit. But under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—the law that established the benefit—drug plans, physicians, and pharmacists who use electronic prescribing are required to meet the HHS standards.

Some organizations have pushed for required e-prescribing for Medicare participation. The Pharmaceutical Care Management Association (PCMA), which represents pharmacy benefit managers, is spearheading the effort.

The organization launched a print and broadcast ad campaign in November that called for adoption of e-prescribing by 2010—the same deadline set by the Institute of Medicine in a report on reducing adverse drug reactions that was issued in July 2006.

The American Health Information Community has also urged the HHS to require e-prescribing for Medicare.

The American Medical Association and other groups oppose a mandate.

"From a practical side, a mandate would be premature," said Stacey Swartz, Pharm.D., senior director of pharmacy affairs at the National Community Pharmacists Association, in an interview.

"We can see the benefits of it, but we can't ignore that there are costs involved," she added.

The final e-prescribing standards should be issued by April 1, 2008. ■

Advertisement

Are certain patients at greater risk for rapidly progressing RA?

Joint damage is responsible for much of the disability associated with rheumatoid arthritis (RA).[1] Early diagnosis and effective treatment may play a critical role in preventing functional decline and loss of quality of life—especially in patients with poor prognosis.[2]

The course of radiologic damage in RA is not completely understood. The amount of damage seen on radiographs of RA patients can vary widely. It remains unclear whether erosions and joint space narrowing are equally important in determining degree of radiologic damage. In addition, there is little detailed information on the rate of progression of radiologic abnormalities from disease onset. Some studies suggest a nonlinear, first-order kinetics model with most of the damage progression occurring in the initial years; other studies suggest a linear, stable rate of progression throughout the course of the disease.[3]

Despite these questions, there is little doubt about the correlation between radiologic damage and disability in RA.[1] Data from 10 prospective, longitudinal studies indicate significant correlations that become more obvious as disease duration increases.[1] It has been suggested that physical disability in early RA is largely determined by disease activity, while in late RA, joint damage plays a more important role.[4] In addition, patients at risk for long-term disability are those with seropositive erosive disease and high initial average Health Assessment Questionnaire scores.[1]

There is a clear case for identifying and treating RA patients early. Finckh, et al, conducted a meta-analysis of 12 studies to examine the correlation between late therapeutic initiation and joint damage. An average delay in treatment start of 9 months altered disease progression over the long term. However, early initiation of therapy reduced radiologic damage, resulting in a dramatically altered disease progression curve. (See Figure 1.)[5]

Despite the evidence that rapidly progressing RA benefits from early and aggressive treatment, early diagnosis has proven difficult in many patients. In many cases, American College of Rheumatology criteria may not be met in patients who nevertheless will deteriorate rapidly.[6]

There are measurable variables at initial visit that can identify patients at high risk for rapid radiologic progression. (See Table 1.) Of particular interest is arthritis of the large joints, especially the knee.[7] In a Linn-Rasker, et al, regression analysis of 1009 patients, arthritis of the knee at initial presentation was revealed to be a strong predictor of a more destructive course of disease.[7] Also compelling is a study by Taylor, et al, that demonstrated a clear relationship between sonographic measurements of synovial thickening and vascularity at baseline to magnitude of radiologic joint damage at Week 54.[8]

These markers may present a means to identify rapidly progressing RA patients early in the course of the disease, rather than risking unsuccessful treatment with less aggressive therapies. Early and more aggressive treatment for appropriately identified patients has the potential to reduce further radiologic joint damage and functional decline.[2]

Figure 1. Early therapeutic initiation alters RA progression over time[5]

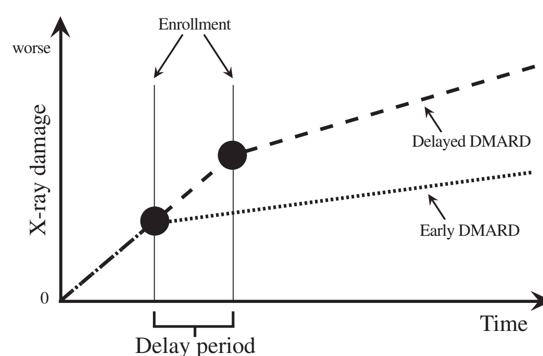

Table 1. Measurable variables at initial visit to identify high-risk patients[4,6-9]

- Swollen joint count
- Erythrocyte sedimentation rate
- Serum IgM rheumatoid factor
- Arthritis of the large joints, particularly the knee
- Anti-cyclic citrullinated peptide antibodies
- Synovial thickening and vascularity at baseline

References: 1. Scott DL, et al. *Clin Exp Rheumatol*. 2003;21(suppl 31):S20-S27. **2.** Quinn MA, et al. *Arthritis Rheum*. 2005;52:27-35. **3.** Hulsmans HMJ, et al. *Arthritis Rheum*. 2000;43:1927-1940. **4.** Jansen LMA, et al. *Ann Rheum Dis*. 2001;60:924-927. **5.** Finckh A, et al. *Arthritis Rheum (Arthritis Care Res)*. 2006;55:864-872. **6.** Riedemann JP, et al. *Clin Exp Rheumatol*. 2005;23(suppl 39):S69-S76. **7.** Linn-Rasker SP, et al. *Ann Rheum Dis*. 2007;66:646-650. **8.** Taylor PC, et al. *Arthritis Rheum*. 2004;50:1107-1116. **9.** Nishimura K, et al. *Ann Intern Med*. 2007;146:797-808.

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INDEX OF ADVERTISERS

Advertiser	Page
Abbott Laboratories	
Humira	25-28
Actelion Pharmaceuticals US, Inc.	
Tracleer	8a-8b
Bayer HealthCare LLC	
ALEVE	19
Centocor, Inc.	
Remicade	16a-16d, 17-18
Corporate	30
Endo Pharmaceuticals	
Opana	11-14
Ferring Pharmaceuticals Inc.	
Euflexxa	20a-20b
Genentech, Inc.	
Rituxan	3-5
Gilead Sciences, Inc.	
Corporate	7
Roche Laboratories Inc.	
Corporate	32
UCB, Inc.	
Corporate	23-24