New RA Criteria Should Not Replace Judgment

RA classification is geared to studies with defined populations; diagnosis is for clinical management.

BY MITCHEL L. ZOLER

FROM THE ANNUAL EUROPEAN CONGRESS OF RHEUMATOLOGY

ROME — Although the updated classification criteria for rheumatoid arthritis released by the American College of Rheumatology and the European League Against Rheumatism last October marked the start of a new era of identifying patients earlier in the course of their disease, the new criteria do not trump the diagnostic experience and medical judgment of a rheumatologist.

"A clinical diagnosis [of rheumatoid arthritis (RA)] has to be established by the physician. It includes many more aspects than can be included in formal criteria, [which] might be a guide to establish a clinical diagnosis," Dr. Daniel Aletaha said.

"Rheumatologists are still in charge for making a diagnosis. We are not replaced by the new criteria," said Dr. Aletaha, a rheumatologist at the Medical University of Vienna and a key member of the joint ACR/EULAR task force that developed the criteria. "The new criteria are not diagnostic, but in clinical practice, they may inform a physician's diagnosis."

His talk in the meeting's opening session formally introduced the new criteria to the EULAR audience, since they have not yet been published. The only other public presentation of the criteria took place last October at the annual meeting of the ACR in Philadelphia.

An important difference between RA classification and diagnosis is that classification is primarily for studies, and generally involves a well-defined and relatively small patient population, while diagnosis is for clinical management and deals with a patient population that is larger and less well defined.

In reviewing the new classification criteria, Dr. Aletaha emphasized several elements of how they should be applied.

First, he dealt with what to do about patients whose score from the criteria falls below 6 (of a possible 10), the threshold for identifying patients with definite RA. He suggested that such patients be followed and might eventually reach a score of 6 or more with time, or their history can be reviewed to identify a time in the past when their score reached at least 6.

It's appropriate for physicians to tally classification criteria points for any patient with at least one joint with definite clinical synovitis, such as a swollen joint, and when the synovitis is not explicable by another disease.

And although the new criteria do not rely on radiologic evidence of joint damage, a patient with radiologically apparent joint damage can be classified as having RA even if their score falls short of 6.

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"Radiographs serve as an option for classifying patients with a history but with no documentation of symptoms compatible with RA." But, he added "the term 'erosions typical for RA' needs yet to be exactly defined."

Joint involvement means any swollen or tender joint, excluding the distal interphalangeal joints of the hands and feet, the first metatarsophalangeal joint, or the first carpometacarpal joint, the joints that are commonly affected in osteoarthritis. Small joints that fulfill the criteria are the metacarpophalangeal, the proximal interphalangeal, the second-fifth metatarsophalangeal, the thumb interphalangeal, and the wrist.

The maximum score of 55 for joint involvement requires at least 10 affected joints, including at least 1 small joint. Other joints that can count toward the total of 10 include the temporomandibular, the sternoclavicular, and the acromioclavicular, or others that are typically involved in RA. Joints considered large when scoring the criteria include the shoulders, elbows, hips, knees, and neck.

For the serology scoring category, which includes both rheumatoid factor and anticitrullinated protein antibody, a negative finding is a level at or below the upper limit of normal for both these factors. A low positive level is above the upper limit of normal but not more than three times the upper limit for one or both. A high positive is a level more than three times the upper limit of normal for at least one.

Finally, he noted that scoring symptom duration can depend entirely on a patient's self-report of the maximum duration of signs and symptoms of any joint that is clinically involved at the time of assessment. ■

Disclosures: *Dr. Aletaha reported having no relevant disclosures.*

Joint Erosions Persist Despite Response to Methotrexate

BY MITCHEL L. ZOLER

FROM THE ANNUAL EUROPEAN CONGRESS ON RHEUMATOLOGY

ROME — Rheumatoid arthritis patients with a sustained clinical response to methotrexate therapy can still have radiographic progression of the disease in the joints of their hands and feet, even when in remission, based on follow-up of 114 patients.

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Major Finding: Early rheumatoid arthritis patients who had an initial clinical response to methotrexate and had a 72% remission rate after 2 years on treatment continued to develop radiographic progression of joint damage, with an average rise of four points in their van der Heijde-modified Sharp score over 2 years.

Data Source: A total of 114 patients who initially had clinical responses to methotrexate monotherapy and had full radiographic follow-up after 1 and 2 years on treatment enrolled in the SWEFOT trial.

Disclosures: Mr. Rezaei said that he had no disclosures. Dr. van Vollenhoven said that he has been a consultant to Abbott, Bristol-Myers Squibb, Pfizer/Wyeth, Roche, Shering Plough, and UCB, and that he has received grant support from Abbott, Pfizer/Wyeth, Roche, and Schering-Plough. The SWEFOT study was funded in part by Schering-Plough. Dr. Gossec had no disclosures.

"If you choose to use methotrexate [monotherapy] you need to monitor patients both clinically and radiologically. Even when patients are doing well clinically, you can't stop there. You need to also look at their x-rays," said Dr. Ronald F. van Vollenhoven, senior physician at the Karolinska Institute in Stockholm and senior researcher for the new report.

"A possible driver of radiographic progression is synovitis, so aim for a low level or absence of synovitis" with rheumatoid arthritis (RA) treatment, commented Dr. Laure Gossec, a rheumatologist at Cochin Hospital, Paris.

"A good clinical response to methotrexate does not preclude radiographic progression," Hamed Rezaei said at the annual European Congress of Rheumatology.

The new analysis reported by Mr. Rezaei focused on 147 of 487 early RA patients enrolled in the Swedish Pharmacotherapy (SWEFOT) trial who had significant clinical responses to methotrexate monotherapy when treatment began at the start of the study, with their disease activity score (DAS)28 falling to 3.2 or less. The main portion of the SWEFOT trial focused on the 340 patients who did not respond adequately to methotrexate monotherapy and then underwent randomization to additional treatment (Lancet 2009;374:459-66).

The report from Mr. Rezaei reviewed the x-ray scans obtained from 114 of the 147 initial methotrexate responders at 1 year and 2 years after initiation of their treatment. During these 2 years of ongoing treatment with methotrexate, at dosages of at least 20 mg/week, 61% of the initial responders were in full remission after 1 year and 72% reached full remission after 2 years of treatment. Also at 2 years, 88% of patients had low disease activity. Despite this good level of clinical response, radiologic assessments showed a different situation. The average van der Heijde-modified Sharp score at baseline was 3.8, which rose to 6.0 after 1 year and 7.9 after 2 years. The percent of the 114 patients followed radiologically who had a 10-point or greater increase in their van der Heijde-modified Sharp score after 2 years on treatment was 15%, with an additional 15% having an increase of 5-9 points. A 10-point or greater rise in the score is clinically significant, the Karolinska researchers said.

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DR. VAN VOLLENHOVEN

The average joint erosion score and joint narrowing score for all 114 patients also showed increases from baseline to year 1 and year 2.

The percent of patients showing no joint damage at all on their x-rays was 48% at baseline, 27% after 1 year, and 20% after 2 years, said Mr. Rezaei, a doctoral student and researcher in the rheumatology unit at the Karolinska Institute.

Additional analysis showed that patients who were positive for rheumatoid factor had a higher average van der Heijde-modified Sharp score after 2 years compared with patients negative for rheumatoid factor, but the link was not statistically significant. Patients who were positive for anti-citrullinated protein antibody (ACPA) had no significant difference in their average score compared with ACPA-negative patients, and gender also did not have a significant link to radiologic progression.

Based on these findings, "we need to have more frequent x-ray examinations over the first 2 years of treatment in patients who clinically respond to methotrexate," Mr. Rezaei said. He declined to suggest what additional treatment should be added to slow or prevent further joint damage in patients on methotrexate monotherapy. ■