

RA Incidence Rises With Age, Peaking During 70s

BY MITCHEL L. ZOLER

FROM THE ANNUAL EUROPEAN CONGRESS OF RHEUMATOLOGY

LONDON – The incidence of rheumatoid arthritis rises with age in both men and women and shows the biggest jump during the sixth decade of life, when the incidence among adults in their 50s nearly doubles compared with those in their 40s, based on findings from an analysis of about 10,000 Swedish patients diagnosed for the first time during 2006-2008.

The nationwide data also showed that peak RA incidence occurs among men and

women in their 70s, with a new-onset rate of at least 73 cases per 100,000 population annually, Jonas Eriksson said.

The nationwide Swedish data that allowed analysis of about 10,000 cases far exceeded the scope of previous incidence estimates, enabling Mr. Eriksson and his associates in the clinical epidemiology unit at the Karolinska Institute, Stockholm, to estimate incidence rates by age and sex. They said they used data collected by the Swedish Rheumatology Quality Register, the National Patient Register, and the Prescribed Drug Register.

To assess incident RA cases, the investi-

VITALS

Major Finding: The incidence rate of newly diagnosed rheumatoid arthritis rises with age, peaking among people in their 70s with an incidence of 73 new cases per 100,000 population annually.

Data Source: Review of Swedish national patient registers for 2006-2008, which identified about 10,000 newly diagnosed cases of RA.

Disclosures: Mr. Eriksson said he had no disclosures.

rates were 22 cases/100,000 in men and 48 cases/100,000 in women. Mr. Eriksson also reported incidence rates among men and women broken down by age. (See table.) The peak new-onset rates occurred in people aged 70-79 years, with rates of 60 cases/100,000 per year among men and 86 cas-

es/100,000 per year in women.

To further broaden the analysis, the researchers calculated incidence rates using two less stringent definitions. They applied a “medium” definition that eliminated the exclusion portion of their initial, strict definition. This identified 9,133 new-onset cases during the 3 years studied, with an overall incidence rate of 41 cases/100,000 per year and rates of 25 cases/100,000 per year in men and 55 cases/100,000 per year in women.

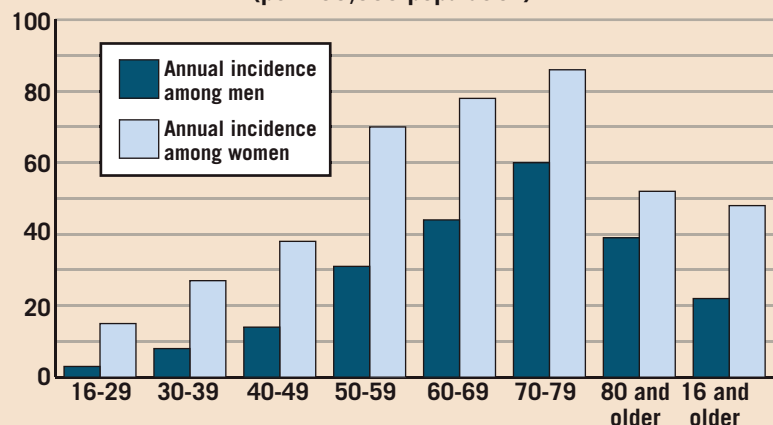
A third, “liberal” definition of RA limited the identifying criteria to the first two elements from the original list of five: a first-ever inpatient visit, a specialist outpatient visit, or inclusion in the Swedish Rheumatology Quality Register during 2006-2008; and at least one visit to a rheumatology or internal medicine department. This identified 11,715 new-onset cases in 2006-2008, an overall rate of 52/100,000 per year, with rates of 33/100,000 per year in men and 71/100,000 per year in women, he said. ■

gators used three different definitions of new-onset disease. The most restrictive definition involved patients who met all of five separate defining criteria:

- ▶ A first-ever inpatient visit, a specialist outpatient visit, or inclusion in the Swedish Rheumatology Quality Register with a RA diagnosis during 2006-2008;
- ▶ At least one visit to a rheumatology or internal medicine department;
- ▶ At least two visits with a diagnosis of RA during 2006-2008;
- ▶ A second visit with a RA diagnosis within 1 year after a first visit; and
- ▶ Exclusion of patients treated with a disease-modifying antirheumatic drug more than 6 months before the first visit with a RA diagnosis, pain in joints, or an unspecified diagnosis.

Applying these criteria to the databases for 2006-2008 identified 7,953 patients with a presumed first-time diagnosis of RA, which resulted in a calculated incidence rate of 35 cases/100,000 population per year. Broken down by gender, the

Rheumatoid Arthritis Incidence by Age and Sex (per 100,000 population)



Note: Based on 7,953 patients who were newly diagnosed during 2006-2008 using a strict definition of RA and data from three Swedish national registers.

Source: Mr. Eriksson

ELSEVIER GLOBAL MEDICAL NEWS

Recognize Need for Pain Management in Older Patients

BY SHARON WORCESTER

The burden of pain among older patients is great, and its consequences can be “serious and significant,” according to a presentation by Dr. Perry G. Fine.

The prevalence of pain ranges from 25% to 50% in the older population, and it increases with age, he said.

Indeed, among older nursing home residents, the prevalence is estimated at 45%-80%. In one study, 20% of individuals aged 65 and older admitted to having a day-long bout of pain in the past month, and about 60% said they had experienced pain for a year or more, said Dr. Fine, professor of anesthesiology at the University of Utah, Salt Lake City.

The sources of pain in these patients are many and varied, and the consequences can include mood disorders, sleep disturbances, decreased socialization, increased health care utilization and costs, limitations in activities of daily living, comorbidities, and polypharmacy, all of which can lead to

diminished function and quality of life.

Further complicating the problem is the fact that studies have repeatedly shown that pain in older adults is frequently undertreated, Dr. Fine said.

This may be the result of one or more of the numerous, identified barriers to the management of pain in older patients.

These include language and cultural barriers, fear of judgment, fear of addiction, cognitive impairment, sensory impairment, and adverse effects such as fear of falling, constipation, sedation, and drug-drug interactions.

Barriers for clinicians can include the lack of objective measures of pain and pain response, concerns regarding addiction and/or drug seeking, fear of causing harm from medication-related adverse effects, lack of time in the office setting, and lack of pain management training, according to findings from two studies on the topic (Clin. J. Pain 2007;23[suppl. 1]:S1-43; J. Adv. Nurs. 2009;65:2-10).

Following a list of 10 “universal precautions” in pain man-

agement can help with overcoming some of these barriers, Dr. Fine said (Pain Med. 2005;6:107-12). These include the following:

- ▶ Making a diagnosis with appropriate differential diagnoses.
- ▶ Performing psychological assessment, including evaluation for risk of addictive disorders.
- ▶ Obtaining informed consent.
- ▶ Developing treatment agreements.
- ▶ Performing pain and function assessments.
- ▶ Using pain medication – and particularly opioids – on a trial basis.
- ▶ Reassessing pain, function, and behavior.
- ▶ Regularly reassessing the “Four As” (analgesia, activities of daily living, adverse events, and aberrant drug-taking behaviors).
- ▶ Periodically reviewing diagnosis and comorbidities.
- ▶ Documenting thoroughly.

Also, keep in mind that aging results in a number of physiological changes that will influence both pharmacokinetics and

pharmacodynamics, including changes in body composition; decreases in gastrointestinal motility, hepatic metabolism, renal clearance, and protein binding; and increased central nervous system sensitivity to

Pain is prevalent in 25% to 50% of the older population, and is estimated to occur in as much as 80% of older nursing home residents.

noxious stimuli and medication effects, Dr. Fine said (Neurobiol. Aging 2010; 31:494-503; Clin. J. Pain 2004;20:220-6).

While speaking at the Congress of Clinical Rheumatology, Dr. Fine listed the following general principles to follow when it comes to pharmacotherapy in light of these changes and the needs of older adults:

- ▶ Titrate according to individual circumstances.
- ▶ Anticipate and monitor for adverse effects, prevent them

when possible, and treat them when necessary.

▶ Practice synergy by combining lower doses of drugs that mediate analgesia via different mechanisms.

▶ Know and understand the distinctions among tolerance, dependence, addiction, and pseudoaddiction.

In those with cognitive impairment, in whom pain assessment can be particularly challenging, clinicians should consider alternatives to standard numeric rating scales for pain assessment.

Patients who have difficulty reporting pain based on these types of scales may do better with the Iowa Pain Thermometer, which allows a patient to rate pain using increments on a picture of a thermometer (Pain Med. 2007;8:585-600), or with the Brief Pain Inventory. Reports from caregivers may also be useful, Dr. Fine said.

Dr. Fine reported having no conflicts of interest that were relevant to his presentation. ■