ASK THE EXPERT

Decision Tree for First DMARD in Early RA

Numerous studies have demonstrated the efficacy of early treatment with disease-modifying antirheumatic drugs for minimizing the inflammation and structural damage associated with rheumatoid arthritis, yet practical treatment guidelines for the use of these agents in very early disease have been nonexistent.

To remedy this, the Working Group for Therapeutic Strategies for Rheumatoid Arthritis, on behalf of the French Society of Rheumatology, recently developed a clinical practice decision tree to guide the choice of the first disease-modifying antirheumatic drug (DMARD) for use in early (less than 6 months duration) rheumatoid arthritis.

BY XAVIER LE LOËT, M.D.

To design the stepwise tool, Dr. Xavier Le Loët, of Rouen (France) University Hospital, along with colleagues from rheumatology divisions of 12 other French university hospitals, conducted a critical review of published data on DMARD efficacy with respect to arthritis activity and structural damage, produced a thorough inventory of factors that might contribute to optimal DMARD choice, selected the most relevant of these factors to drive choice in routine practice scenarios, and incorporated them in an easy-to-use clinical tool (Ann. Rheum. Dis. 2006;65:45-50).

In most cases, methotrexate and leflunomide are usually the first-line treatment of choice, according to the decision tree. In rheumatoid factor–positive patients with no structural damage and low to moderate disease activity, sulfasalazine is an appropriate option. In cases of low to moderate severity, low-activity disease in which there is neither structural damage nor rheumatoid factor, hydroxychloroquine can be considered. Finally, etanercept is an option for the combination of high disease activity, structural damage, and rheumatoid factor.

In this month's column, Dr. Le Loët discusses the need for the decision guide and its potential clinical implications.

Rheumatology News: What are the challenges involved in choosing the appropriate DMARD for a given patient early in the disease process?

Dr. Le Loët: Early administration of a DMARD generally results in rapid control of disease activity and reduces or delays for a long time the structural damage. Choosing the appropriate drug makes this control possible, but the best choice depends on the activity and structural severity of the disease. In clinical practice, it is not always easy to identify the prognostic factors of structural damage.

RN: How can the decision tool help the practicing rheumatologist plan treatment?

Dr. Le Loët: This is the first time that recommendations for DMARD use in very early rheumatoid arthritis have been presented as an easy to apply decision tree. It requires only three simple items commonly used in clinical practice: Disease Activity Score (DAS) 28, rheumatoid factor, and the presence or absence of erosion. The clinician can then adapt the recommended choice in the decision tree, based on these considerations, to take into account patient age, comorbidities, associated treatments, tolerance of DMARDs, and patient opinion. It is important to note that the decision tree concentrates exclusively on patients with confirmed, untreated rheumatoid arthritis.

RN: In developing the decision tree, what criteria were the most important in comparing the various agents?

Dr. Le Loët: The most important criteria were efficacy against rheumatoid activity and structural involvement in early rheumatoid arthritis. In clinical practice, however, we must also take into account the tolerability of these drugs.

RN: The decision tree is designed to help in the choice of the first DMARD in early rheumatoid arthritis. Is there a resource to guide subsequent treatment decisions if the first-line therapy is ineffective or intolerable?

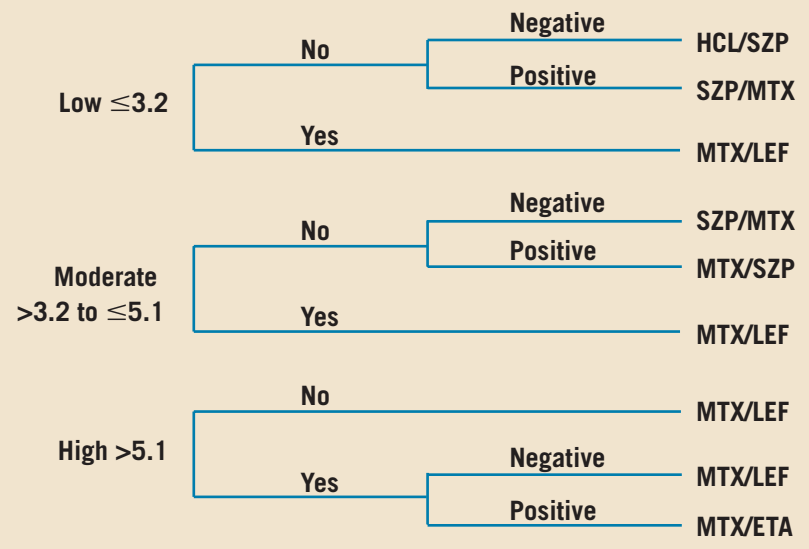
Dr. Le Loët: We have a study in progress.

RN: To your knowledge, is there evidence that the decision tree is a useful clinical tool for practicing rheumatologists?

Dr. Le Loët: The decision tree has already started being used in France, but the publication is so recent that it's too soon to measure the real-life impact. ■

DR. LE LOËT *is a member of the department of rheumatology at Rouen University Hospital, Rouen, France, and the French Society of Rheumatology's Working Group for Therapeutic Strategies for Rheumatoid Arthritis.*

Decision Tree for First DMARD in Early RA*



*Early RA is defined as a disease duration less than 6 months.
Notes: DAS 28, 28-joint disease activity score; DMARD, disease modifying antirheumatic disease; ETA, etanercept; HCL, hydroxychloroquine; LEF, leflunomide; MTX, methotrexate; RF, rheumatoid factor; SZP, sulfasalazine.
Source: Dr. Le Loët and colleagues, Annals of the Rheumatic Diseases

NSAIDs Plus Aspirin Sharply Increase GI Complication Risks

BY BRUCE JANCIN
Denver Bureau

HONOLULU — Even over-the-counter doses of nonselective NSAIDs significantly increase the risk of serious GI complications, Joseph Biskupiak, Ph.D., said at the annual meeting of the American College of Gastroenterology.

Moreover, his study of a large, national outpatient primary care database of electronic medical records showed that this risk is further intensified by concomitant use of low-dose aspirin, added Dr. Biskupiak of the University of Utah College of Pharmacy, Salt Lake City.

"I think there are a couple of take-home messages here for the patient and physician populations. It's that [over-the-counter] NSAIDs are not benign. As physicians, you need to assess patient usage of these medications and inform them of the associated risks. And patients taking these medications need to discuss their use with their physician," he said.

Dr. Biskupiak reviewed the 3.2-million-patient GE Medical Systems Centricity database and identified 11,957 individuals taking OTC naproxen at 220 mg/day and 38,507 taking OTC ibuprofen at 200 mg/day who were free of medical conditions or therapies that would predispose to GI bleeding. He compared the incidence of GI perforations, ulcers, or bleeding (PUB) during the first 3 months after taking the NSAID—even a single dose—with the rates during the 6- and 12-month periods prior to taking either NSAID.

NSAIDs are not benign. Patients taking them need to be informed of the associated risks.

DR. BISKUPIAK

In the 6 months prior to taking ibuprofen, 55 patients experienced a PUB, as did 100 in the year prior to taking the drug. During the 3 months after starting on ibuprofen, patients were 2.5 times more likely to experience a PUB than in the previous 6 months, and 38% more likely to experience a PUB than in the year prior to taking the NSAID.

Similarly, patients who took naproxen were 2.74 times more likely to develop PUBs than in the 6 months before taking the drug, and 54% more likely than in the year beforehand, he continued.

Concurrent low-dose aspirin was used by 2,328 patients who took naproxen; their risk of developing a PUB was twice that of patients on naproxen alone. The 4,843 patients on low-dose aspirin and ibuprofen were 3.36 times more likely to develop a PUB within 3 months of starting the NSAID than patients taking ibuprofen alone.

Session cochair Dr. David Y. Graham questioned the clinical relevance of Dr. Biskupiak's findings.

"The actual PUB complication rates with [over-the-counter] NSAIDs were maybe 1 in 200 patients per year. In the control group, it would be a little less than that. That's an extraordinarily low number. The question is, is it clinically important?" asked Dr. Graham, professor of medicine at Baylor College of Medicine, Houston.

Dr. Biskupiak's answer was emphatically yes. "Considering that we're talking about an estimated 60 million Americans using OTC pain medications daily—many of whom are unaware that NSAIDs can cause major GI problems—even though 1 in 200 is a very small number, it turns out to be a significant total number of people," noted Dr. Biskupiak. "And remember: More than 100,000 hospitalizations annually . . . are attributed to GI complications of NSAID usage."

His study was funded by Pfizer Inc. ■