New RA Guidelines Stress Early Intervention

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The promised overhaul of treatment guidelines for rheumatoid arthritis has finally arrived, and with it, a "new paradigm" that focuses on early identification and treatment of the disabling disease.

The guidelines, which were developed by a joint committee from the American College of Rheumatology and the European League Against Rheumatism, are the latest update since the current guidelines were created in 1987.

Published jointly in the EULAR journal Annals of the Rheumatic Diseases (2010;69:1580-8) and the ACR's Arthritis & Rheumatism (2010;62:2569-81), the new guidelines were created in three phases over 2 years.

In the first phase, the goal was to "to identify the contributions of clinical and laboratory variables that in practice were the most predictive of the decision to initiate [disease-modifying antirheumatic drug] therapy in a population of patients with early undifferentiated synovitis," wrote the authors, led by Dr. Daniel Aletaha of the Medical University of Vienna.

To do this, a working group from both societies looked at data from 3,115 patients, and correlated whether or not the patients were ultimately prescribed methotrexate to an "agreed-upon list of standardized clinical and laboratory variables collected at baseline."

The odds of eventual methotrexate initiation were calculated for each variable. For example, swelling of the metacarpophalangeal joint had an odds ratio of

VITALS

Major Finding: A new criteria set for rheumatoid arthritis identifies early disease based on a score of 6 or higher out of 10.

Data Source: An international committee of rheumatologists from both the European League Against Rheumatism and the American College of Rheumatology.

Disclosures: Several of the authors of the guidelines disclosed financial relationships with multiple drug makers.

1.5, as did swelling of the proximal interphalangeal joint and the wrist. Tenderness of the hand (either the MCP, PIP, or wrist) was assigned an odds ratio of 2.0.

A moderate elevation of C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) was assigned an OR of 1.0; a high elevation of either assay carried an OR of 2.0.

Finally, moderate levels of either rheumatoid factor or anti–citrullinated protein antibodies had an OR of 2.0 for the eventual prescription of a DMARD; high levels had an OR of 4.0.

In phase II, an "expert panel" of 12 rheumatologists related the above clinical and laboratory factors to the "probability of developing 'persistent inflammatory and/or erosive arthritis that is currently considered to be RA.'"

The panel also looked at duration of symptoms (longer or shorter than 6 weeks) and the number and size of joints (large or small), in addition to the variables that were assessed in phase I. Using a computer program, the panel assigned each variable a point value of 1-100, with high scores indicating greater likelihood of RA.

Finally, phase III aimed to utilize the results of phases I and II "to develop a scoring system that would be applicable to newly presenting patients with undifferentiated inflammatory arthritis, to permit identification of those with a high probability of developing persistent and/or erosive RA."

This final scale assigns points in the following manner:

► One swollen "large joint" (defined as shoulders, elbows, hips, knees, and ankles) gets 0 points; involvement of 2-10 large joints gets 1 point.

► Involvement of 1-3 "small" joints (defined as metacarpophalangeal joints, proximal interphalangeal joints, second to fifth metatarsophalangeal joints, thumb interphalangeal joints, and wrists) gets 2 points, regardless of large-joint involvement; involvement of 4-10 small joints gets 3 points.

► Involvement of more than 10 joints, including at least one small joint, gets 5 points.

► Both a negative rheumatoid factor (RF) test and a negative anti–citrullinated protein antibody test (ACPA) gets 0 points, whereas having a "low-positive" RF or ACPA (defined as lower than three times the upper limit of normal) gets 2 points. A "high-positive" of either test gets 3 points.

► A normal CRP and normal ESR get 0 points, whereas at least one abnormal test gets 1 point.

► Symptom duration of fewer than 6 weeks gets 0 points; duration of 6 weeks or longer gets 1 point.

Scores of 6 or more out of 10 are classified as "definite RA."

Commenting on the new criteria in an interview, Dr. Eric L. Matteson, who is a professor of medicine at the division of rheumatology at the Mayo Clinic in Rochester, Minn., and was not involved in the study, said, "A major useful feature is that the new guidelines do not require multiple joints to be inflamed before a diagnosis can be [made] of early inflammatory rheumatoid arthritis."

Indeed, a patient may score 6 points without multiple joint inflammation, according to the new guidelines.

The authors also pointed out that symmetry is not a criterion for diagnosis, as it did not show significance in either phase of the new guidelines' development. Nevertheless, they wrote, "Inevitably,… the greater the number of involved joints the higher the likelihood of bilateral involvement."

When Dr. Matteson was asked what was missing from the new guidelines, he pointed to a lack of awareness of extra-articular components of RA, which also can occur early in the course of the disease.

"When they do [occur], they can be very useful in identifying the disease, and they are important markers and predictors of disease severity and need for therapy," he said.

The guidelines also lack biomarkers for treatment response, he added.

Several of the guideline authors disclosed financial and other relationships with multiple pharmaceutical companies; Dr. Matteson stated that he had no financial disclosures relative to his comments. ■