



Issue 5: Medication adherence in Rheumatoid Arthritis

The primary treatment target in rheumatoid arthritis (RA) is achieving a state of clinical remission, defined as the absence of signs and symptoms of significant inflammatory disease activity. In some cases, very low disease activity may be sufficient as a target such as patients who have been stable with long standing disease or who have significant risks for further intensification of treatment or older individuals with RA who are functioning well and where the long term risk of low grade synovitis is not a concern.

Why isn't every patient in remission with RA?

Early initiation and long term administration of disease-modifying anti-rheumatic drugs (DMARDs) and in some cases biologic agents are recommended for most patients. [1, 2] When taken as prescribed, these therapies are more likely to yield disease remission, as shown by lack of joint swelling and pain, normal inflammatory markers (erythrocyte sedimentation rate [ESR] and/or C-reactive protein [CRP]), and lack of radiographic progression.

How frequently do you think that RA patients are non-adherent with their RA medications (ie. not taking them as prescribed)?

Up to 70% of RA patients do not fully comply with taking their medications as directed, and such non-adherence can adversely impact treatment outcomes. [3-6]

Why are patients non-adherent to treatment?

Reasons for non-adherence may include patient's views about rheumatoid arthritis as a disease; beliefs that drugs do not work or have too many adverse effects; unrealistic or uninformed expectations of risk; lack of self-efficacy; lack of social support; cost of medications, and poor patient-provider relationships. [6, 7]

An important factor contributing to non-adherence is a differing perception of disease activity between physicians and patients. Physicians' perceptions of disease activity are strongly driven by the swollen joint count, while the patient's perception is driven by pain and functional disability. [8] In one study, nearly one-third of RA patients differed from their physicians to a meaningful degree in the assessment of global disease severity, with higher depressive symptoms being associated with more discordance. [9] In fact, in a Canadian study there was a negative correlation between patients and physicians with respect to global assessment of disease. [19] This is important because with the increasing availability of effective therapies, some concordance between patients and providers about assessments of disease activity is needed for effective compliance to treatment in RA. Changes in medications are often made assuming the patient is complying with prescribed therapies which may not be true.

Unlike diseases such as diabetes or hypertension, for which numerical targets are available, there is no single gold standard for measuring RA disease activity. Composite scores such as the Disease Activity Score 28 (DAS 28), which includes the patient global assessment of disease severity as measured on a visual

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Faculty:

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Patient profiles: What would you do?

Patient profile #1: Mary, a 50-year old patient with RA, has been prescribed celecoxib twice daily, but she takes it only once or twice a month. She does not complain of joint pain.

[How would you address medication adherence in this situation?](#)

Patient profile #2: Elizabeth has a problem with co-payment for her RA medication. As a result, she takes her medication every 10 days instead of every week. She has pain that is 2/10, HAQ=0, 0 SJC, 0 TJC and ESR and CRP are normal.

[How would you address medication adherence in this situation?](#)

Patient profile #3: Linda's spouse

analogue scale (VAS), are routinely used in clinical trials but are less commonly used in practice. [9] A study involving 200 participating rheumatologists found that despite current EULAR recommendations, most patients with DAS 28 >3.2 had no intensification of their RA treatment. [10] When treatment changes were made, they may have been due to several reasons: physician's evaluation of RA activity, patient's disease activity evaluation, and other factors such as disease duration, patient expectations and mode of practice of rheumatologists. Also, in a large Australian survey of patients with RA and rheumatologists, it was found that RA treatment was often not altered when DAS was elevated as the patient assessment of disease activity was not thought to be from active RA but was from other pain such as mechanical pain or damage. [18]

How can I improve adherence in my patients?

- Education about RA and its treatment
- Frank discussion about expectations of a therapy
- Discussion of goals of treating RA (short and long term)
- Simplifying treatment regimens
- Lack of judging patients about non-adherence
- Allowing for some flexibility in treatment (patient self efficacy is improved if there are some treatment choices AND adherence that is not total is OK if the therapeutic target is achieved and maintained)
- Providing easy aids for timing of medications, side effects and expectations
- Maintaining trust and providing a therapeutic relationship

What strategies do you use when discussing treatment compliance with patients?

Educating patients about their disease and its management can promote an understanding of the risks and benefits of therapy and encourage adherence. [3, 11-13] Patient involvement in the decision to take a medication is often overlooked, but patient preferences for mode and frequency of administration are important considerations for treatment success. [3, 14, 15] It is therefore necessary to elicit patient preferences, concerns about medications, and ensure that they possess a clear understanding of treatment risks and benefits.

Fear does not improve adherence so telling a patient that if they don't take treatment they could have bad outcomes will not usually change their belief system or actions.

Good physician-patient communication correlates with better adherence, [16] and patient trust in their physicians may have a greater effect on confidence in DMARD decision than DMARD-specific knowledge and disease-related factors. [17]

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has lost his job, and she cannot afford her RA medications, so she admits to missing doses about half the time. She also admits that a friend got very sick taking drugs that are similar to what she is receiving and this scares her. She now has 12 swollen/tender joints.

[How would you address medication adherence in this situation?](#)

References

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