Treating Rheumatoid Arthritis to Target

Patient profile

Helen is a 45-year old woman diagnosed with rheumatoid arthritis (RA) 2 months ago. On physical exam she has 9/28 swollen joints and 12 /28 tender joints; she also complains of pain in her feet with evidence of synovitis in 5 MTP joints. She rates her overall disease activity at 7/10; she is RF positive and anti-CCP positive and her ESR is at 45 and her CRP at 2.2 mg/dL. She had to miss several days of work in the last 6 weeks. Her GP prescribed naproxen 500 mg BID and some codeine.

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Rheumatoid arthritis (RA) is a chronic disease that is estimated to affect approximately 1% of Canadians. 1 Articular and non-articular manifestations of RA lead to reduced functional capacity and disability. 2 As a result, patients with RA experience significant productivity losses, impaired psychological well being, and poorer health-related quality of life. 3-5

Traditionally, the pharmacological management of RA involved a symptom-alleviating approach with changes in dosage or the addition of medications only if symptoms progressed. 6 However, dramatic strides in RA management have now made long-term remission and prevention of irreversible joint damage a realistic goal. Important developments over the last two decades have included the advent of biologic therapies that can alter the clinical course of RA, together with significant advances in the availability of tools to help guide clinical decisions toward optimal outcomes. 7-9

Current guidelines recommend a targeted approach to RA management. 10,11 Aiming at specific predefined therapeutic targets in diseases such as diabetes and hypertension has been associated with a reduced risk of organ failure, but in the past, such targets had not been defined for RA management. In 2010, an international Treat to Target (T2T) task force formulated consensus recommendations aimed at improving the management of RA in clinical practice, thus providing guidance for treatment to target. 11 The T2T task force, and also the European League Against Rheumatism (EULAR) 2010 guidelines, 12 refer to evidence from various randomized controlled studies and observational studies showing that RA patients who attain remission have better outcomes than patients who have residual disease activity. The T2T initiative resulted in 10 recommendations (see table below).

<table>
<thead>
<tr>
<th>Table. Treating rheumatoid arthritis to target: recommendations of an international task force 11</th>
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<tbody>
<tr>
<td>1. The primary target for treatment of rheumatoid arthritis should be a state of clinical remission.</td>
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<td>2. Clinical remission is defined as the absence of signs and symptoms of significant inflammatory disease activity.</td>
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<td>3. While remission should be a clear target, based on available evidence, low</td>
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References

disease activity may be an acceptable alternative therapeutic goal, particularly in established longstanding disease.

4. Until the desired treatment target is reached, drug therapy should be adjusted at least every 3 months.

5. Measures of disease activity must be obtained and documented regularly, as frequently as monthly for patients with high/moderate disease activity or less frequently (such as every 3 to 6 months) for patients in sustained low disease activity or remission.

6. The use of validated composite measures of disease activity, which include joint assessments, is needed in routine clinical practice to guide treatment decisions.

7. Structural changes and functional impairment should be considered when making clinical decisions, in addition to assessing composite measures of disease activity.

8. The desired treatment target should be maintained throughout the remaining course of the disease.

9. The choice of the (composite) measure of disease activity and the level of the target value may be influenced by consideration of comorbidities, patient factors, and drug-related risks.

10. The patient has to be appropriately informed about the treatment target and the strategy planned to reach this target under the supervision of the rheumatologist.

Clinical remission is defined as the absence of signs and symptoms of significant inflammatory disease activity. In some patients, e.g., those with long-standing disease, complete remission may not be realistic or achievable; for such patients, low disease activity may be an acceptable alternative goal. For these patients, some residual joint tenderness or a single swollen joint may be compatible with a state of remission. The Canadian Rheumatology Association 2011 guidelines also recommend that remission should be the goal of RA treatment; when this is not possible, treatment should aim for minimal disease activity while controlling symptoms, halting damage, preventing disability, and improving quality of life.

Maximal clinical benefit with drug therapy in RA is usually not achieved before 3 months of treatment. By this time, if at least a state of low disease activity is not attained, treatment should be amended. A change of drugs is not always necessary, because dosage adjustment of an existing medication may be sufficient for achieving further benefit. Methotrexate (MTX) is the preferred and most frequently used first line therapy for RA, and remains an anchor drug to enhance or maintain the efficacy of biologic agents. Patients who respond inadequately to MTX may be treated sequentially with another DMARD, combination of DMARDs, or a biologic agent.

Treatment decisions should be guided by using composite measures of disease activity; these may include the disease activity score (DAS) or the DAS employing 28 joint counts (DAS28), the simplified disease activity index (SDAI) and the clinical disease activity index (CDAI). X-rays should be obtained 6-12 monthly to estimate progression of joint damage. Intensification of treatment may be warranted if joint damage appears to be progressing despite achieving the desired target such as low disease activity.

A treatment algorithm as recommended by the T2T task force is provided in the figure below.
Patient profile (contd.)

With her regimen of daily naproxen and codeine as needed, Helen complains that the relief from her symptoms is unsatisfactory.

Therapy with MTX is initiated, with the MTX dosage being escalated to 25 mg/week over 2 weeks. Helen’s treatment is adjusted as needed to achieve a target of clinical remission.

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