British Society for Rheumatology and British Health Professionals in Rheumatology Guideline for the Management of Rheumatoid Arthritis (the first two years)


KEY WORDS: Rheumatoid arthritis, Guideline, Management, Disease-modifying anti-rheumatic drug therapy, Multidisciplinary care.

Scope and purpose of the guideline

The current guideline provides practical evidence-based advice on recommended interventions in RA. The objective is to provide a framework of care for managing RA, including control of synovitis, symptom control, self-management, physical functioning, psychosocial functioning and screening/monitoring. The primary target of this guidance is health professionals and managers; however, it is also relevant to patients with RA. The guideline is limited to the first 2 yrs of RA. This is a short summary of the whole guideline. The full guideline is available on the journal website (see supplementary material for full guideline). The current guideline does not include psoriatic arthritis, disease-modifying anti-rheumatic drugs (DMARDs) or biological therapy in RA because these areas are described in separate British Society for Rheumatology (BSR) guidelines [2–4].

Guideline for managing early RA

We have produced 24 evidence-based recommendations (using Royal College of Physicians guidelines and the Appraisal of Guidelines Research and Evaluation instrument) [5, 6], each given a grade of recommendation (from A to C), and a flowchart to illustrate the care pathway for patients with RA (Fig. 1).

Assessment/planning phase

(1) A diagnosis of RA should be made as early as possible, on the basis of persistent joint inflammation affecting at least three joint areas, involvement of the metacarpophalangeal (MCP) or metatarsophalangeal (MTP) joints or early morning stiffness of at least 30 minutes. (C)

(2) Patients with suspected early synovitis should have rapid access to a multidisciplinary team including specialists in rheumatology, and members from both primary and secondary care in order to provide a seamless service. (B)

(3) Access to individual elements of the multidisciplinary service should be available according to the patient need. (B)

(4) Patients with RA should be given a plan of care from diagnosis, including a commitment to training patients to self-manage some aspects of disease. (C)

(5) Specialist rheumatology nurses can provide ideal support for patients in accessing elements of the multidisciplinary team and in providing important lifestyle advice. (C)

(6) RA is a significant independent risk factor for ischaemic heart disease. Other risk factors for ischaemic heart
Early RA management pathway

**ASSESS**
- Triage/diagnosis of early RA
- If not RA

**PLAN**
- Refer to specialist RA secondary services
- Initiate care
- Based on Programme of treatment/care

**STABILIZE**
- Follow-up clinics

**DELIVER**
- Change/add DMARD in response to changes in disease status
- Education to encourage self-care/expert patient programme
- Protocols for intervention: direct access to physio/orthotics/doctor/nurse/podiatrist advice

**MONITOR/REVIEW**
- * Stabilize DMARD therapy: patient, GP, clinical nurse specialist, practice nurse monitor toxicity
- * Fast access to specialist services (i.e. Nurse-led clinics)
- * Protocols from all members of the MDT regarding access, trigger points for referrals, etc.
- * Ongoing educational programme to enable the person to engage when ready.
- * Define/agree duration of DMARD therapy and consider step-down/weaning off agreement in collaboration between primary- and secondary care MDT members.
- * Screening for IHD/cholesterol/BP/diabetes, osteoporosis, cancer in primary-care setting.
- * Screening for orthotic/podiatry needs by patient.

**OUTCOME**
- Communicate outcome and copy letter to patient
- Alternative secondary care pathway

* Protocols for intervention: direct access to physio/orthotics/nurse/GP, rheumatologist, pharmacist, podiatrist, psychologist, dietician
* OT advice on joint protection and fatigue management, help with functional difficulties, psychological support and work instability.
* Nurse-led clinics, help-lines, fast-track access to acute/specialist services, i.e. dyspnoea on methotrexate, acute flare-up, cardiovascular risk assessment. GPs and nurse practitioners to have easy access and advice or urgent appointments in secondary care.
* Medically establish and monitor DMARD efficacy; consider joint injections/bridge steroid use when changing therapy
* Pharmacist’s advice, orthotic, podiatry services accessible and jointly working with physiotherapy.

**Early synovitis clinic**
- Early visits
- GP with specialist interest
- Nurse Specialist
- Rapid access clinic

**3–6 months**
- Pharmacy
- Orthotics
- Nursing
- Medical
- Psychology
- Dietician
- OT
- Physio
- Podiatry

**6–12 weeks**
- Commence/monitor DMARD
- Joint injections
- Bridge IM steroids
- Analgesia/antiflammatory relief
- Self-help organizations
- Education re. treatment

**Electronic health care and MDT documentation information system**

**Multidisciplinary team (MDT) approach**

**Electronic health care and MDT documentation information system**

**Early synovitis clinic**

**Early RA management pathway**

**Patient with joint pain visits GP**

**6–12 weeks**
- Refers to

**Alternative secondary care pathway**

**>12 months**
- up to 2 yrs

**Annual review**
- in collaboration with the patient, primary- and secondary-care members of the multidisciplinary team
- Consider postal/telephone or hospital reviews

**FIG. 1. Algorithm for management of early RA.**
Deliver, stabilize and monitor care

(7) All patients should have their disease and its impact assessed and documented at onset. Once established on DMARD therapy, patients should have a formal assessment of response to treatment, in order to justify continuing therapy or changing it. Remission should be defined and documented when achieved, in order to plan reduction or maintenance therapy. (B–C)

(8) Patients should be established on disease modifying therapy as soon as possible after a diagnosis of RA is made. Therapy should incorporate escalating doses, intra-articular steroid injections, parenteral methotrexate and combination therapy, rather than sequential monotherapy; progression to biologic (anti-TNF-α) therapy should be according to need [4]. (A)

(9) Systemic steroids have an important early role in controlling synovitis or bridging disease control between different DMARD therapies but long-term use is not justified. (B)

(10) Patients with RA require assessment of pain (A). Long-term use of non-steroidal anti-inflammatory drugs (NSAIDs) should be at the lowest effective dose (A). NSAIDs should be avoided in individuals at high risk of cardiovascular morbidity, and used with caution in others who cannot be managed with analgesia, steroid injections and one or more DMARDs. (B)

(11) Patients with RA require early assessment of sleep patterns. Early management of sleep disturbance should include tricyclic agents, behavioural therapy and exercise. (B). Consider the impact of fatigue on quality of life in early RA. (B)

(12) Evidence for effectiveness of complementary therapy is conflicting. (B)

(13) Timing and format (group/individual/written) of education to meet individual needs should be considered. (A). Patients should be offered a cognitive behavioural approach to patient education, delivered at the appropriate time, to promote long-term adherence to management strategies (C). Patients should be helped to contact support organizations such as the National Rheumatoid Arthritis Society (NRAS), Arthritis Care (AC) and the Arthritis Research Campaign (ARC). (B)

(14) Patients should be encouraged to pace activities and recognize the limits of physical activity, facilitating a realistic readjustment of expectations. Patients should be helped to participate in exercise programmes. (C)

(15) Aerobic exercise should be encouraged to help combat the effects of RA on muscle strength, endurance and aerobic capacity, without, in the short-term, exacerbating disease activity or joint destruction. (B)

(16) Hydrotherapy should be accessible to maximize positive effects on pain, function and self-efficacy. (C)

(17) Transcutaneous electrical nerve stimulation (TENS) use in the RA patient may be effective in pain relief, but trials lack standardization. (C)

(18) Heat and cold applications may provide short-term symptomatic relief of pain and stiffness, but there is no grade of recommendation of long-lasting benefit. Paraffin wax baths and exercise are beneficial for hands in arthritic conditions. (C)

(19) Heat and cold applications may provide short-term symptomatic relief of pain and stiffness, but there is no grade of recommendation of long-lasting benefit. Paraffin wax baths and exercise are beneficial for hands in arthritic conditions. (C)

(20) Joint protection, energy conservation and problem-solving skills training should be taught early. (B)

(21) Hand function should be maintained and improved with hand exercises and devices to improve efficiency. Occupational Therapy (OT) can help when problems at work are due to arthritis. Altering work methods, posture, pacing and assistive devices can improve functional ability. (C)

(22) Painful and/or swollen hands and wrists should be splinted, but the role of splinting at other times remains uncertain. (C)

(23) Foot care can relieve pain, maintain function and improve quality of life using safe, cost-effective treatments. An annual foot review is recommended for patients at risk of developing serious complications. (B)

(24) Health professionals should provide opportunities to discuss sexuality and relationship issues where these are affected by RA. (C)

This guideline provides a framework to standardize care for patients with RA, and can be used to argue for an increase in resources or reorganization of services as appropriate, in order to improve care for all patients with RA, wherever they live in the UK.

We would recommend that audit of the RA guideline should include the assessment of the impact of the pathway on the following outcomes: synovitis; symptom control; erosive change; quality of life; self-efficacy.

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References


