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Guidelines

British Society for Rheumatology and British Health Professionals in Rheumatology guideline for the management of rheumatoid arthritis (after the first 2 years)

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Executive summary

Scope and purpose of the guideline

RA in its severe form is a considerable health burden [1]. Patients with established RA, which has an annual estimated incidence of 30–54/100 000 in women and 13–25/100 000 in men [2], require effective coordination of health and social services to support them at work, or at home through the variable course of their illness. The current guideline follows directly from the first guideline on early management of RA [3]. It deals with the long-term management of RA in primary and secondary care to provide seamless support for patients. A strong emphasis is made on enabling patients to self-manage some aspects of their condition and make informed treatment choices.

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These guidelines inform service delivery on evidence-based care and can provide an important framework in the development of Integrated Care Pathways to enable RA, to be managed effectively in all care settings.

We propose a model of care for patients including the use of DMARDs or biologic agents, ongoing education and specialist management, with increasing emphasis on shared care between patients, primary care and secondary care [4].

The goals of therapy supported by this guidance are to: (i) control synovitis; (ii) control symptoms; (iii) promote self-management; (iv) improve physical functioning; (v) improve psycho-social functioning; (vi) monitor for drug toxicity; and (vii) manage and screen for comorbidity.

The guidance is to be used for adults with established RA and do not deal with early RA, other forms of arthritis or give details of drug therapy. The target audience for this guidance is health professionals in primary and secondary care, healthcare commissioners and patients.

A short summary of the guideline follows below, and should be read in conjunction with our earlier guideline on managing RA in the first 2 yrs [3]. The full guideline is available from the BSR website. An algorithm for the guideline is shown in Figs 1 and 2.

We have produced 20 evidence-based recommendations [using the Royal College of Physicians guidance (http://www.rcplondon.ac.uk/college/ceeu/conciseGuidelineDevelopmentNotes.pdf) and the Appraisal of Guidelines Research and Evaluation instrument (www.agreecollaboration.org)] with each given a grade of evidence (from A to D) and a strength of recommendation (from 1 to 3); and a flowchart to illustrate the care pathway for patients with RA. The recommendations are as follows:

(1) The aim of therapy is to minimize disease activity (strength of evidence 1, grade of recommendation A).

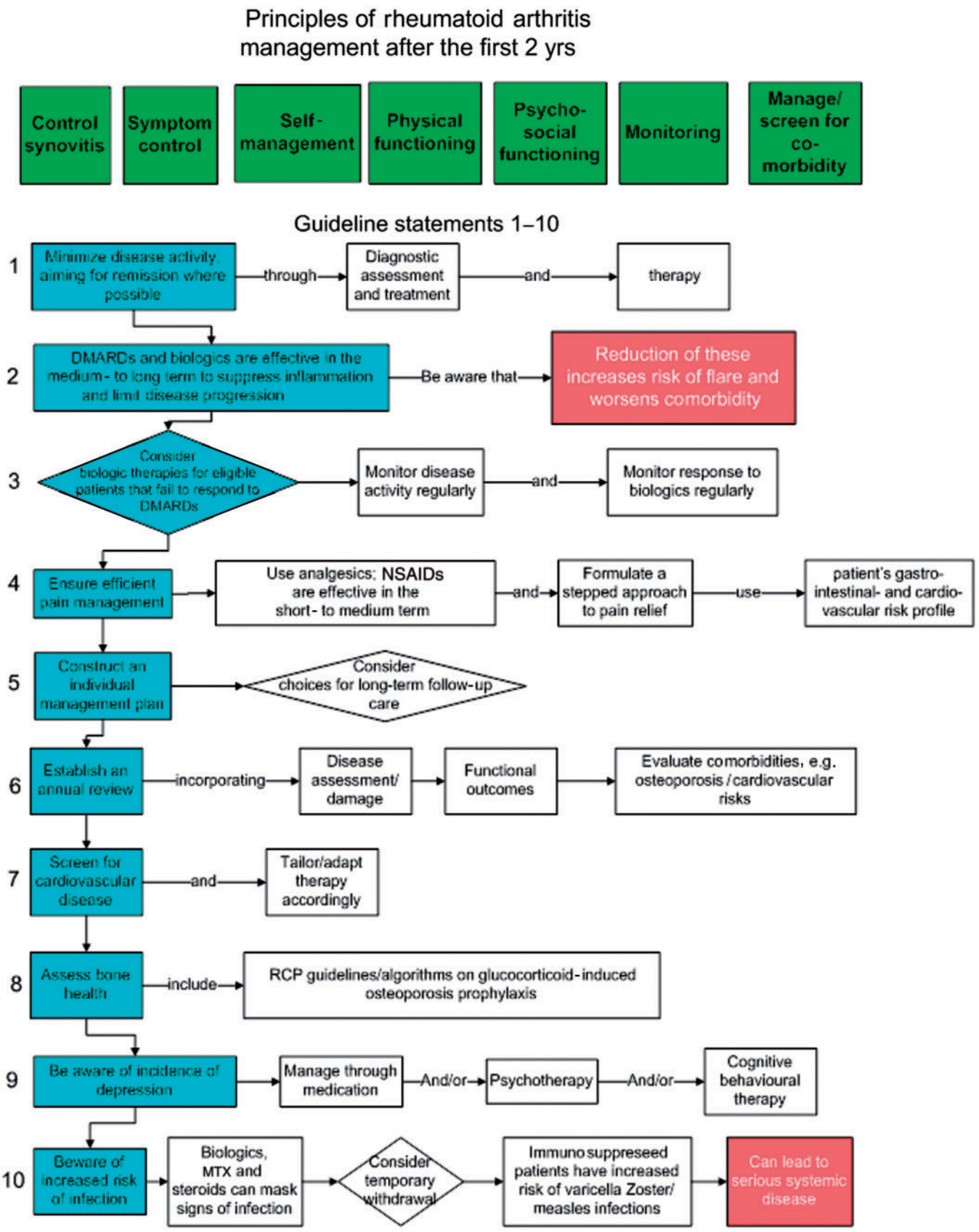

FIG. 1. Algorithm of guidelines for the management of established RA, based on statements 1–10 (to be read in conjunction with guidelines on management of early RA).

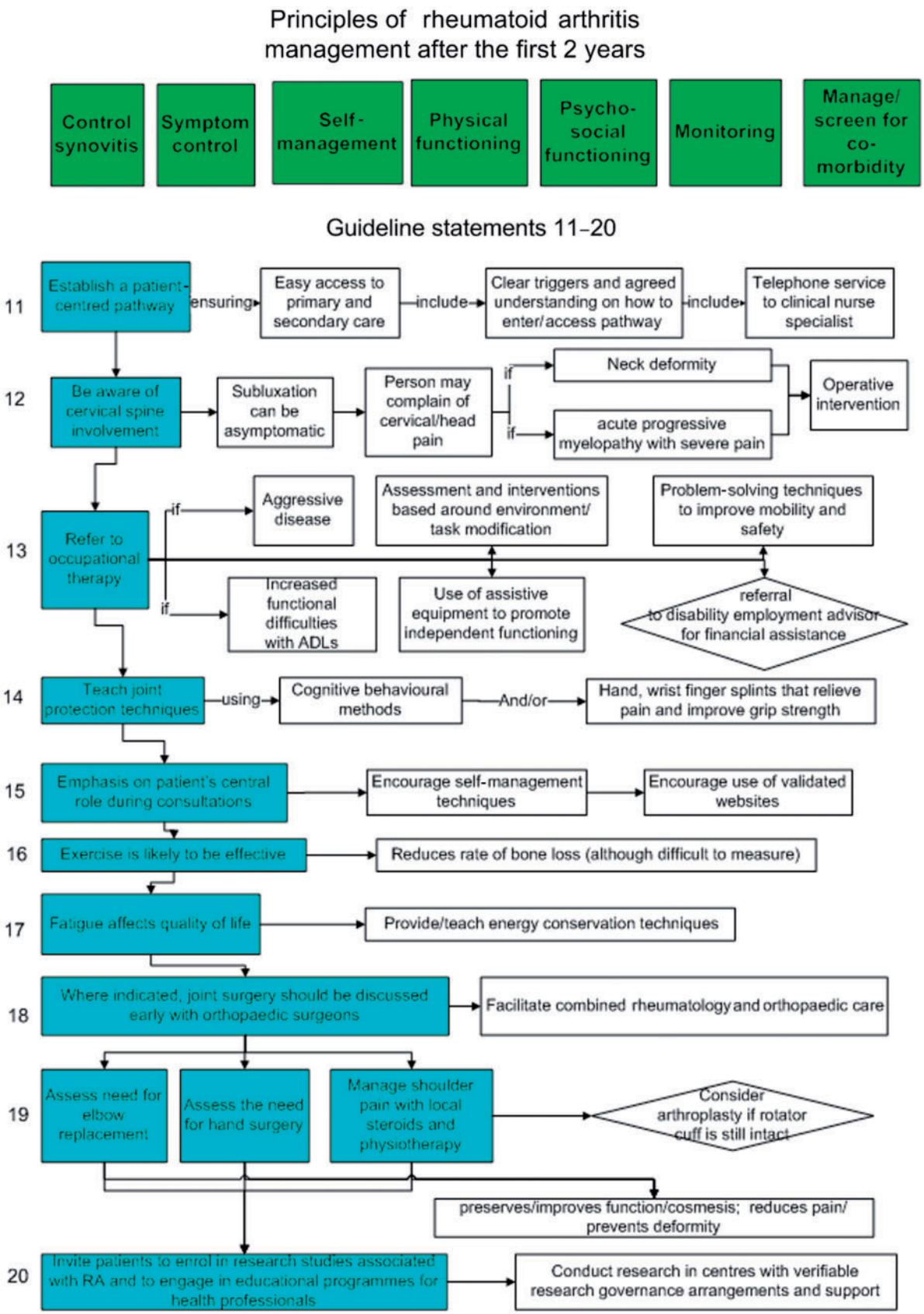

FIG. 2. Algorithm of guidelines for the management of established RA, based on statements 11–20 (to be read in conjunction with guidelines on management of early RA).

(2) DMARDs and biologic therapies are medium- to long-term treatments (1, A) whose withdrawal increases the risk of flare and disease progression (2, B).
(3) Biologic therapy is an important treatment option for patients who fail to respond to DMARDs, but an adequate response is a requirement for longer term continuation (1, A).
(4) Patients need a stepped approach to pain relief using analgesics, and in the short term, additional NSAIDs co-prescribed with a proton pump inhibitor (1, A).
(5) Patients need an individualized management plan including choices for long-term follow-up care (3, C).
(6) An annual review is recommended, incorporating disease assessment, damage, functional outcomes, patient goals and evaluation of comorbidity (3, C).
(7) Patients should be screened and managed for cardiovascular disease (2, A).
(8) We recommend the Royal College of Physicians guidelines on idiopathic and glucocorticoid-induced osteoporosis (1, A).
(9) Patients with coexistent depression should be considered for anti-depressants and cognitive behavioural therapy (2, B).
(10) Immunosuppressive therapy may exacerbate and mask infection, and temporary withdrawal should be considered during active infection (3, C).
(11) Patients need rapid, self-initiated access to primary or secondary specialist expertise (2, 3, C) including telephone advice (3, C).
(12) Most patients with cervical spine involvement can be treated conservatively, but neck deformity, acute or progressive myelopathy and/or severe intractable pain are indications for surgery (2, B).
(13) Occupational therapy should be offered to promote independent function (2, 3, C) for those with aggressive disease or if difficulties are experienced in activities of daily living or employment (3, C); interventions include environmental and home assessment, task modification, problem-solving exercises to improve mobility, functioning and safety (1, A) and use of assistive equipment (2, 3, C).
(14) Joint protection techniques should be taught or reinforced, using cognitive behavioural methods (1, A). Wrist splints relieve pain and improve grip strength during some activities (1, A). Finger splints may improve function (3, C).
(15) Patients have a central role in managing their disease (3, C); supported by the use of key educational resources, patient organizations and self-management techniques (2, B).
(16) Exercise is effective in improving function and reducing the rate of bone loss (2, B).
(17) Fatigue may respond to energy conservation techniques (3, C).
(18) Combined rheumatology and orthopaedic care is recommended when surgery is considered, with replacement of failing joints progressing from lower to upper limb (4, D); in most cases, DMARDs should not be stopped (2, B).
(19) Initial management of shoulder problems is with steroid injections and physiotherapy, but surgery should be considered if symptoms persist (2, B); arthroplasty is effective for pain relief but functional improvement depends on an intact rotator cuff (2, B); elbow replacement is very effective for pain relief and to restore function (2, B); hand surgery is most useful for preserving and improving function, for pain refractory to medical therapy, preventing deformity and aiding cosmesis (3, C).
(20) Patients should have an opportunity to enrol in research studies in centres with verifiable research governance arrangements and support (4, D) and to take part in specialist musculoskeletal training programmes for health professionals (2, B).

The guideline provides a framework to standardize and deliver care for patients with established RA, and may be used to justify service provision or reorganization for patients with RA in any part of the UK. The full version, available at *Rheumatology* online (doi:10.1093/rheumatology/ken450b), includes recommendations for research. The guideline will be reviewed in 2011.

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