

The Primary Care Perspective

Katherine Margo, MD

Introduction

Recent developments in the management of rheumatoid arthritis (RA) have the potential to significantly influence clinical decision-making by primary care physicians (PCPs), especially when deciding whether or not to initiate therapy or when selecting an antirheumatic agent (conventional disease-modifying antirheumatic drug vs a biologic). While it is less likely that a PCP would prescribe a biologic, it is important for PCPs to be familiar with the available treatment options for RA, given the high cost of biologic therapies and the potential for adverse events with antirheumatic agents. Although guidelines and management strategies tend to have the rheumatologist in mind, these developments also impact PCPs, as patients with rheumatologic conditions typically present to their PCP first.

American College of Rheumatology/European League Against Rheumatism RA Classification Criteria¹

The recently released American College of Rheumatology/European League Against Rheumatism RA classification criteria may help clinicians screen patients with early signs of RA who would benefit from antirheumatic therapy. These criteria can also minimize the inappropriate use of antirheumatic agents in patients who are at low risk of developing RA and, thus, would not necessarily benefit from such therapy.

These criteria can be very useful for PCPs by providing a reference when evaluating patients at initial stages of RA. This is important because accurate diagnosis of a rheumatic disease can be challenging, as the signs and symptoms are not always specific to a particular disease state. Any criteria that can help differentiate those patients who may need more aggressive approaches to care can be very helpful. This may mean confirming the need to use an antirheumatic agent or deciding whether the patient should be referred to a rheumatologist.

It is important to note that these criteria were not intentionally designed to be the sole diagnostic criteria for PCPs. However, certain criteria, such as evaluating the affected joints and specific serologic assays, can be easily incorporated with

other diagnostic measures to design the optimal management plan. Of course, the physician's experience and discretion, as well as specific patient factors, will also play an important part in patient management decision-making.

These criteria do not provide any guidance on treatment with specific antirheumatic agents. Therefore, PCPs will have to decide whether to initiate treatment themselves or refer the patient to a specialist. One concern is that there is a general shortage of rheumatologists. For example, in my area (Philadelphia), the waiting time for an appointment is typically 3 to 4 months or more. Also, rural PCPs often cannot easily refer a patient to a rheumatologist. Therefore, many PCPs opt to initiate therapy, unless it is an unusual or complicated case that requires greater attention.

PCPs should make an effort to incorporate these criteria into their diagnostic approach. The major obstacle to this is making PCPs aware of the existence and accessibility of these criteria. Facilitating the acceptance of these criteria into clinical practice necessitates increasing awareness on the release of this information. This can be facilitated through continuing medical education programs, review articles in primary care journals, and informative consultant letters to PCPs when corresponding about a particular patient.

Treat-to-Target Recommendations²

Treat-to-target recommendations emphasize the need to start therapeutic intervention early with frequent reassessment and adjustment of treatment to ensure that each patient has a chance to meet the goal of disease remission. Meeting this goal may require early, aggressive treatment; frequent follow-up visits; and therapeutic adjustments.

The impact of these new treatment paradigms will depend on how well PCPs utilize them in clinical practice. It is important for PCPs to be familiar with current guideline recommendations to identify patients at greatest risk of developing debilitating RA and to know when initiation of treatment or referral to a specialist is needed.

Reports

When a patient has very active RA, it is probably more reasonable to shift the responsibility of patient management to a rheumatologist. However, as mentioned previously, this would depend on the availability and accessibility of a rheumatologist. In areas where a rheumatologist may not be easily accessible, the PCP can be expected to play a greater role in managing patients with RA.

It is important to emphasize that when a PCP and a rheumatologist are actively involved in the management of a patient, communication between them is critical to help meet treat-to-target goals. Communication between physicians is often less than optimal, which can have a detrimental impact on patient care. Better communication between the rheumatologist and the PCP can improve the continuity of care, including improved monitoring of the progression of disease and need for therapeutic adjustment. This can also reduce the potential for adverse events associated with antirheumatic agents. In areas with poor access to a rheumatologist, better communication can help shift some responsibility from the rheumatologist to the PCP, thus potentially reducing the number of office visits to the rheumatologist.

PCPs are willing to manage, and capable of managing, patients at early stages of RA, and can play an important role in reducing the burden of this disease, both for the patient and for the healthcare system.

Author Affiliation: University of Pennsylvania School of Medicine, Philadelphia, PA.

Funding Source: Supported by an educational grant from Genentech and Biogen Idec.

Author Disclosure: Dr Margo reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design; drafting of the manuscript; and critical revision of the manuscript for important intellectual content.

Address correspondence to: Katherine Margo, MD, University of Pennsylvania Health System, HUP-34th St and Spruce St, 2nd Floor Gates, Philadelphia, PA 19104. E-mail: katherine.margo@uphs.upenn.edu.

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