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Editorial

Treating rheumatoid arthritis to target: Evidence-based recommendations for enhanced disease management

Tratamiento certero de la artritis reumatoide: recomendaciones basadas en la evidencia para un mejor tratamiento de la enfermedad

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The approach to managing rheumatoid arthritis (RA) is still variable. Questions or issues that frequently arise relate to the application of types and sequences of therapeutic agents as well as to the extent and frequencies of control examinations, types of assessments and needs for therapeutic adaptations. In light of these occasional ambiguities, recommendations for the management of rheumatoid arthritis have been recently published.[1] In addition, an international expert committee elaborated a guidance document adopting a "treat to target" (T2T) approach for RA; in line with a respective presentation of the T2T strategy, detailed standard procedures were provided to enable the implementation into daily clinical practice by the rheumatology community.[2]

While the definition of quantifiable treatment targets at center stage is new to RA management, stringent therapeutic aims have already been implemented in a number of other chronic diseases: in diabetes care, aiming for an HbA1c below 7.0% is widely recognized to be the task in every counseling visit, since the achievement of this threshold is understood to drive long-term disease outcomes. Similar proceedings are used in treating hypertension, hyperlipidemia, and other conditions, as opposed to the formulation of adverse outcomes to avoid in the distant future, an absolute number that displays the level of good disease control, or, if not met indicates the need for treatment escalation, is well perceivable for doctors and patients alike. Presumably, this facilitates shared treatment decision-making, and also encourages patients to be adherent and responsive during their chronic condition.

The adoption of T2T for RA has been initiated by an international task force of 20 experts in rheumatology and a patient with RA, who first convened in 2008. As an initial step, the group assigned a systematic literature review (SLR) to compile all published evidence on targeted treatment in RA, when compared to standard care.[3]

In the process of the systematic literature search, the screening of 5881 titles and abstracts identified in electronic databases resulted in 76 articles for fulltext inspection. Finally, 7 studies that provided direct evidence on targeted treatment were included in the review.[4–10] While the data were scarce for long-standing disease,[10] available evidence unanimously substantiated the benefit of targeted treatment in early RA (ERA).[3–8] Strategy-driven arms showed significantly better outcomes in all trials, when disease activity was taken into account. One study also reported better functional outcomes.[5] Five trials investigated radiographic endpoints, three of them showed significant benefits in the targeted treatment arm.[5,6,9]

Especially the interval to schedule follow-up visits and ascertain response to therapy, as well as the definition of therapeutic success by specification of treatment targets were backed by a body of evidence from the literature: all ERA trials adopted follow-up intervals between one and three months in their targeted treatment arms,[4–9] and in long-standing disease four months were chosen to be the maximum interval for re-assessment.[10] Therapy had to be amended, if targeted disease activity thresholds were not met within this period. The targets were remission or at least low disease activity (LDA), some trials also adopted a set of individual targets like combined laboratory and joint count thresholds.

This systematic search on available information served as a basis for subsequent discussions among the steering committee to formulate an initial set of T2T recommendations for RA disease management. Inviting a broader panel of more than 60 international rheumatologists and several additional RA patients, including participants from Europe, North and Latin America, Japan and Australia, the steering committee presented a draft document for further discussion and refining during a Delphi-like process in March 2009. The final document[2] that originated from this complex consensus finding process provides guidance for routine outpatient care. It comprises 4 overarching principles and 10 recommendations.

Along with anchoring every treatment change to be a shared decision between patient and doctor, the core statement of this document is the postulated necessity for further adjustment of therapy at every follow-up visit until the therapeutic target is reached.

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This approach is particularly applicable for newly diagnosed RA, but also has to be maintained throughout the whole course of disease. Importantly, treatment success has to be ascertained at least every 3 months, and an increased frequency of visits is suggested if patients are in high or moderate disease activity. Patients in sustained remission (or LDA) should be seen by a specialist about every 6–12 months to document continuous sufficient disease control by obtaining composite disease activity scores that include joint counts. The advocated treatment target is remission, defined as the absence of signs and symptoms of significant inflammatory disease activity. Achieving remission is stated to be of paramount importance in ERA, however in longstanding disease that had proved to be refractory, low disease activity (LDA) may be an acceptable alternative target. In addition to ensuring successful suppression of inflammation by validated compound disease activity indices, the consideration of structural damage and functional limitation in all treatment decisions is strongly emphasized. Also, co-morbidities, and other individual patient-related factors, as well as drug-related risks should be taken into account.

Notably, this call for targeted treatment is devoid of any particular drug recommendation or any preference for specific treatment escalation approaches, like adding-on drugs versus switching, etc. Rather, the T2T guidance document defines the therapeutic goal to strive for and establishes standard procedures to ensure ideal utilization of all available drugs. Details can be accessed via the references provided here.

Most experts recognize that consistent suppression of disease activity is linked to better functional and radiographic outcomes. Rheumatologists have a growing number of synthetic and biologic disease modifying drugs at hand, yet rapid change of therapy if needed has not been fostered in treatment guidelines. According to the SLR, unanimous evidence speaks in favor of strategic targeted treatment adjustment to reach satisfying disease control. The broad consensus among the international rheumatologists' community in the process of developing this set of recommendations will hopefully result in a widespread adoption of T2T in clinical practice and contribute to optimized RA care.

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