Joint Bone Spine 81 (2014) 287–297

Available online at ScienceDirect www.sciencedirect.com

Elsevier Masson France EM|consulte www.em-consulte.com/en

Recommendations

Recommendations of the French Society for Rheumatology for managing rheumatoid arthritis

Cécile Gaujoux-Viala[a,*,1], Laure Gossec[b,1], Alain Cantagrel[c], Maxime Dougados[d], Bruno Fautrel[b], Xavier Mariette[e], Henri Nataf[f], Alain Saraux[g,h], Sonia Trope[i], Bernard Combe[j]

[a] Department of Rheumatology, Nîmes University Hospital, EA 2415, Montpellier I University, 30029 Nîmes, France
[b] Sorbonne Universities, UPMC Univ Paris 06, GRC 08, institut Pierre Louis d'épidémiologie et de santé publique; AP–HP, Department of Rheumatology, CHU Pitié-Salpetrière, 75013 Paris, France
[c] Department of Rheumatology, Purpan Hospital, CHRU de Toulouse, Paul Sabatier Toulouse III University, UMR Inserm 1043-CNRS 5282, 31059 Toulouse, France
[d] Paris Descartes University – Department of Rheumatology –Cochin Hospital, Assistance Publique – Hôpitaux de Paris – INSERM (U1153): épidémiologie clinique et biostatistiques, PRES Sorbonne Paris-Cité, 75014 Paris, France
[e] Department of Rheumatology, Paris-Sud Universities Hospital, AP–HP, Inserm U 1012, Paris Sud University, 92276 Le Kremlin Bicêtre, France
[f] Cabinet de rhumatologie, 78200 Mantes la Jolie, Yvelines, France
[g] Department of rheumatology, CHU de la Cavale Blanche, boulevard Tanguy-Prigent, 29609 Brest, France
[h] EA 2216, Bretagne Occidentale University, 29200 Brest, France
[i] Association nationale de défense contre l'arthrite rhumatoïde (ANDAR), 75014 Paris, France
[j] Department of rheumatology, Lapeyronie Hospital, CHRU de Montpellier, Montpellier I University, UMR 5535, 34295 Montpellier, France

ARTICLE INFO

Article history:
Accepted 23 April 2014
Available online 27 June 2014

Keywords:
Rheumatoid arthritis
Recommendations
Treatment
Biologics
Glucocorticoid therapy

ABSTRACT

Introduction: This article reports the latest recommendations of the French Society for Rheumatology (SFR) regarding the management of rheumatoid arthritis (RA).
Methods: New recommendations were developed by hospital- and community-based rheumatologists having extensive experience with RA and a patient self-help organization representative. They rest on the recently issued EULAR recommendations and a literature review.
Results: Points emphasized in the 15 recommendations include the need to share treatment decisions between the rheumatologist and the patient, the acquisition by patients of self-management skills, remission or minimal disease activity as the treatment target, the need for initiating disease-modifying drugs as early as possible, and the usefulness of regular disease activity assessments to allow rapid treatment adjustments if needed (i.e., tight disease control). First-line methotrexate monotherapy is recommended, with concomitant short-term glucocorticoid therapy if indicated by the risk/benefit ratio. Patients who fail this approach (no response after 3 months or target not achieved after 6 months) can be considered for another synthetic disease-modifying antirheumatic drug (DMARD: leflunomide or sulfasalazine), combined synthetic DMARD therapy, or methotrexate plus a biologic, depending on the prognostic factors and patient characteristics. If the first biologic fails, switching to a second biologic is recommended. In the event of a sustained remission, cautious dosage reduction of the biological and/after synthetic DMARDs is in order.
Conclusion: These recommendations are designed to improve the management of patients with RA.

1. Introduction

Rheumatoid arthritis (RA) is the most common inflammatory joint disease in adults, with an estimated prevalence of 0.3% to 1% in the general population of adults [1]. RA runs a chronic course marked by flares of synovial membrane inflammation that can eventually cause joint destruction, thereby impairing quality of life and causing disability. In addition, RA is associated with an estimated decrease in life expectancy of 10 years [2–5]. The latest French recommendations for managing RA were published in 2007 [6]. Since then, there have been several major changes in concepts (e.g., treat-to-target approach, dynamic treatment adjustment, and treatment optimization) and

* Corresponding author. Tel.: +33 4 66 68 31 20.
E-mail address: cecile.gaujoux.viala@chu-nimes.fr (C. Gaujoux-Viala).
[1] The first two authors contributed equally to this work.

http://dx.doi.org/10.1016/j.jbspin.2014.05.002
1297-319X/

treatments (new data on existing treatments and introduction of new drugs). The publication of new recommendations is therefore timely.

These recommendations are intended for physicians who provide care to RA patients, i.e., chiefly rheumatologists and primary-care physicians. They should also prove useful to health authorities and patient self-help organizations. They deal with a range of issues extending from the diagnosis to the overall management of RA but focus chiefly on the drug treatment strategy.

2. Methods

The French Society for Rheumatology (SFR) convened a task force composed of 8 hospital-based rheumatologists, 1 community-based rheumatologist, and 1 representative of a patient self-help organization. These 10 individuals came from various geographic regions throughout France. Their work referred to the 2007 recommendations issued by the French National Authority for Health (HAS) and the HAS guidebook for chronic diseases (#22) [6] but relied chiefly on the recently published European League Against Rheumatism (EULAR) recommendations for managing RA [7]. In particular, the task force directed careful attention to the results of the three vast systematic literature reviews that were performed to prepare the EULAR recommendations by assessing the efficacy of synthetic disease-modifying antirheumatic drugs (DMARDs) [8], efficacy of biologics [9], and safety data [10], respectively. The task force developed the recommendations in 2013, improved them by conducting several consensus-building rounds via email, and submitted them to a review group composed of 31 experts who included hospital- and community-based rheumatologists, SFR members, primary-care physicians, and a patient self-help organization representative. The comments and suggestions made by the review group were used to develop the final version of the recommendations. The level of evidence and grade of each recommendation were determined [11].

3. Results

Three general principles and 15 recommendations were developed (Table 1) and recapitulated in algorithm format (Fig. 1).

3.1. General principles about the management of rheumatoid arthritis (RA)

3.1.1. The optimal management of patients with RA requires a dialogue between the rheumatologist and patient to ensure that the patient receives the information and education needed to share in his or her management decisions

RA is a chronic disease and therefore requires that the patient contributes to his or her own management and follow-up (Table 1). The sharing of medical decisions is the foundation of the partnership between the patient and physician. To take informed decisions regarding their own management, in partnership with the physician, the patient must receive relevant information and education. Therapeutic patient education is at the core of this recommendation: it promotes patient self-sufficiency and the emergence of the patient as a fully-fledged partner in the management process [6]. Therapeutic patient education can be delivered during formal sessions or via other means, particularly when formal sessions are not available.

3.1.2. The rheumatologist is the specialist who should be in charge of managing patients with RA. The primary-care physician plays a crucial role in detecting RA and in providing follow-up in conjunction with the rheumatologist

The rheumatologist is the specialist who should treat and monitor patients with RA. However, the primary-care physician is in an unique position to detect potential early RA and to rapidly refer patients with suspected RA to the rheumatologist. An early diagnosis followed by prompt treatment initiation is key to improving the outcomes of RA management. Thus, the availability of effective and fast-moving chains of care is imperative [12]. The primary-care physician also plays an essential role in organizing and coordinating the individualized management strategy, most notably regarding treatment monitoring and comorbidity management. Patients with RA are at high risk not only for disabilities related to their joint disease, but also for cardiovascular and respiratory disease, infection, lymphoma, and osteoporotic fractures [13,14].

3.1.3. The high cost of RA, its consequences, and its treatments for both the individual and society should be considered when making treatment decisions

The treatment of RA is costly, particularly since the advent of biologics [15,16]. However, the disease itself generates high indirect costs due to loss of productivity, work incapacitation, and surgical procedures. The treatment decisions should therefore take into account not only the costs of treatment, but also the cost to individuals and society of suboptimal disease management. Biologics are highly effective and can therefore decrease the mid-term and long-term costs of RA, for instance by decreasing the time spent off work and the need for surgical procedures [17,18]. Thus, the treatment decisions should be based chiefly on efficacy and safety data, while also factoring in the costs of management.

3.2. Recommendations

3.2.1. Diagnosis and organization of the management of RA

3.2.1.1. Recommendation 1. A diagnosis of RA should be:

- considered in patients with specific clinical findings such as joint swelling (clinical arthritis), morning stiffness lasting longer than 30 minutes, and a positive hand or forefoot squeeze test;
- confirmed by laboratory tests (erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], anti-citrullinated protein antibodies [ACPA], and rheumatoid factors [RFs]) and imaging studies (radiographs with or without ultrasonography), after ruling out the differential diagnoses.

Optimal patient outcomes are obtained by initiating DMARD therapy early after symptom onset [19].

Early recognition of suspected RA by the primary-care physician followed by prompt patient referral to a rheumatologist is therefore crucial. Clinically, the most telling finding is synovitis, particularly at the finger joints and wrists. A positive squeeze test provides valuable orientation: the pain is caused by putting pressure across the metacarpophalangeal and/or metatarsophalangeal joints [20].

Confirmation of the diagnosis of RA relies on a set of converging arguments with special attention to the absence of clinical and laboratory data pointing to another inflammatory joint disease (Table 2). The most useful criteria are those developed jointly by the American College of Rheumatology (ACR) and EULAR for classifying RA [21] (Fig. 2). In patients with clinical synovitis in at least one joint and no alternative diagnosis that better explains the findings, a score $\geq$6/10 indicates RA (Fig. 2). Another important key to the diagnosis is the presence of specific antibodies (RFs and ACPA), which must be assayed (Table 2, Fig. 2). Imaging studies should consist of anteroposterior radiographs of the hands and