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New Rheumatoid Arthritis Guidelines in the Works for 2015

Pam Harrison | November 27, 2014

BOSTON — An American College of Rheumatology (ACR) panel is working on new rheumatoid arthritis guidelines that will include first-time information on glucocorticoids and the oral Janus kinase inhibitor tofacitinib.

Amy Miller, senior director of quality for the ACR told *Medscape Medical News* to expect the new guidelines in the spring of 2015.

Key recommendations from the current draft, which has not yet been peer-reviewed, were presented at the ACR 2014 Annual Meeting by Jasvinder Singh, MD, from the University of Alabama at Birmingham.

"The panel strongly recommended a treat-to-target strategy, as opposed to a nontargeted approach, in both early and established rheumatoid arthritis," Dr Singh reported.

For many patients the target will be low disease activity. "In some cases, however, another target may be chosen based on patient comorbidity and risk tolerance," Dr Singh explained.

Although most rheumatologists are already well versed in diagnosing and treating rheumatoid arthritis, "it is always good to have the standard available for reference," Joseph Flood, MD, president of the ACR, said in an interview. "The guidelines are written not only for rheumatologists, but also for all healthcare providers who treat rheumatoid arthritis," he pointed out.

"Eventually, they will be available to practitioners the world over, as in many parts of the world there are few or no rheumatologists," Dr Flood explained. The guidelines can also help rheumatologists demonstrate the need for certain changes in medications to insurers, as well as to patients and their caregivers.

First Glimpse at New Recommendations

In early rheumatoid arthritis — defined as a disease duration of less than 6 months — the panel strongly recommended disease-modifying antirheumatic drug (DMARD) monotherapy for DMARD-naive patients with low, moderate, or high disease activity.

For patients with moderate or high disease activity who have a flare, the panel recommended glucocorticoid use at the lowest possible dose for the shortest period of time to provide the best benefit–risk ratio for the patient.

Patients who fail DMARD monotherapy and still have moderate to high disease activity should receive a combination of traditional DMARDs, a tumor necrosis factor (TNF) inhibitor with or without methotrexate, or a non-TNF-inhibitor biologic with or without methotrexate.

If these patients experience a rheumatoid arthritis flare, short-term glucocorticoids are again recommended.

The panel conditionally recommended adding low-dose glucocorticoids to the treatment regimen if these combination options are not effective and disease activity remains moderate to high.

The draft treatment algorithm for established rheumatoid arthritis is similar to that recommended for early disease, Dr Singh reported.

For DMARD-naive patients with established disease, DMARD monotherapy, usually methotrexate, is recommended as first-line treatment for those with low, moderate, or high disease activity.

After DMARD failure, the panel strongly recommends the combination of traditional DMARDs, TNF inhibitor with or without methotrexate, non-TNF-inhibitor biologic with or without methotrexate, or tofacitinib plus methotrexate.

If disease activity remains moderate to high in these patients, physicians can consider adding low-dose glucocorticoids. Short-term glucocorticoids can also be used for rheumatoid arthritis flares.

Patients who fail a single TNF inhibitor should next receive a non-TNF-inhibitor biologic with or without methotrexate, or another TNF inhibitor with or without methotrexate. Those who fail on a non-TNF inhibitor biologic should receive another non-TNF-inhibitor biologic with or without methotrexate.

Introducing Tofacitinib

Next in line for those who fail multiple TNF inhibitors is a non-TNF-inhibitor biologic with or without methotrexate or tofacitinib with or without methotrexate.

Patients who fail a TNF inhibitor and non-TNF-inhibitor biologic should receive another non-TNF-inhibitor biologic with or without methotrexate or tofacitinib with or without methotrexate.

Those who fail treatment with several non-TNF-inhibitor biologics should receive tofacitinib with or without methotrexate or a TNF inhibitor with or without methotrexate, provided they have not previously received a TNF inhibitor.

The panel addressed a number of clinical scenarios in which patients with rheumatoid arthritis have current or previously treated comorbidities, the presence of which can alter treatment decisions.

High-Risk Patients, Complicated Cases

For patients with previously treated or untreated nonmelanoma skin cancer, a combination of DMARDs or a non-TNF-inhibitor biologic is favored over a TNF inhibitor. For those with a previously treated or untreated melanoma, a TNF inhibitor is favored over tofacitinib.

Recommendations become more specific for rheumatoid arthritis patients with a previously treated lymphoproliferative disorder, Dr Singh pointed out. For these patients, the panel recommended combination DMARD treatment over a TNF inhibitor, but they also recommended a non-TNF-inhibitor biologic — specifically abatacept, tocilizumab, and most strongly, rituximab — over a TNF inhibitor.

In contrast, treatment recommendations are the same for patients with or without a previously treated solid organ malignancy.

Patients with active hepatitis B or C infection receiving effective antiviral therapy can receive a DMARD, TNF inhibitor, non-TNF-inhibitor biologic, or tofacitinib, Dr Singh reported.

Patients in New York Heart Association class III or IV heart failure should preferentially receive a combination of DMARDs, non-TNF-inhibitor biologic, or tofacitinib over a TNF inhibitor. The same holds true for those with worsening heart failure already receiving a TNF inhibitor.

For patients with a history of serious infection, a consensus was reached on the recommendation of combination DMARD therapy over a TNF inhibitor and abatacept over a TNF inhibitor.

In contrast, for the same patient group, no consensus was reached on recommendations for the use of rituximab or tocilizumab over a TNF inhibitor.

"Ideally, patients 50 years and older should receive the herpes zoster vaccine before biologic therapy," Dr Singh noted.

However, live attenuated vaccines, such as the herpes zoster vaccine, should not be given to patients with early or established rheumatoid arthritis if they are on any biologic therapy.

The panel also strongly recommended continuing therapy with traditional DMARDs, TNF inhibitor, non-TNF-inhibitor biologics, or tofacitinib in patients with established rheumatoid arthritis and low disease activity who are continuing on methotrexate.

For those in remission and continuing on methotrexate, the panel recommended that physicians taper treatment, regardless of the regimen.

"At the same time, the panel strongly recommended that not all therapies be discontinued," Dr Singh emphasized, because "clinical experience suggests that only a very small minority of patients with established rheumatoid arthritis are able to discontinue all treatment."

"I think the guidelines improve the overall care of people with rheumatoid arthritis and help form the basis for demonstrating the value of the care we provide," said Dr Flood. "And they help to tell us what the expected standard of quality of care is. If the ACR does not set the evidence-based standard for quality of care for patients with rheumatoid arthritis, then who could?"

The guidelines are in development by the American College of Rheumatology. Dr Singh and Dr Flood have disclosed no relevant financial relationships.

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