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LETTER TO THE EDITOR

Implementing combination DMARDs strategy in early RA not as nice as we like?

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Sir, there is evidence that therapy with a combination of DMARDs and prednisolone results in better outcomes in patients with early RA than does treatment with a single DMARD [1].

The National Institute for Health and Clinical Excellence (NICE) of UK has also recommended that appropriate patients with newly diagnosed rheumatoid arthritis (RA) should be offered a combination of DMARDs (including methotrexate) plus short-term glucocorticoids as first-line treatment, ideally within 3 months of the onset of persistent symptoms [2].

NICE also recommends monthly measuring of disease activity (using a composite score such as DAS28) until treatment has controlled the disease to a level previously agreed with the RA sufferer.

Having introduced an updated local protocol for early RA management on the basis of these guidelines (aimed at early but not immediate introduction of combination therapy), we performed an audit to assess the practicalities of our adherence to the use of combination therapy and monthly DAS28 monitoring.

We collected data retrospectively for the first 65 new RA patients considered for our protocol on a standard protocol audit form was assessed (from Nov 2009 to Aug 2011).

Of the total number of patients ($n = 65$), all had DAS-28 performed at base line, (mean DAS28-5.20). Out of sixty-five, sixty-four patients were felt suitable for combination therapy. Fifty-seven patients were commenced on methotrexate as per protocol preference (7.5 mg weekly increasing to 15 mg weekly over 6 weeks). Eight patients commenced sulfasalazine as per personal preference. All patients were offered steroids, with an uptake rate on first visit of $n = 47$ (72 %).

Planned 1-month follow-up appointment was only achieved in $n = 23$ patients (predominantly due to patient (not clinician)-related factors). Although $n = 16$ patients had DAS-28 > 3.2 (considered a threshold for DMARD alteration), only one patient proceeded to combination therapy at this visit (predominantly whilst awaiting continuing efficacy or dose increase of MTX). Out of 23 patients seen at second visit, 8/23 (35 %) received steroid therapy.

For the third visit (planned at a further 1-month interval), 21/64 (33 %) patients were seen within the time frame of approximately 4 weeks later; 13/21 (62 %) had DAS-28 > 3.2. Only four of these 'eligible' patients (31 %) commenced combination therapy.

At 3 months, final DMARD allocation in the 65 patients was methotrexate ($n = 46$), sulfasalazine ($n = 7$), combination ($n = 8$), leflunamide ($n = 1$); two patients were not on any DMARD and one awaiting review.

This audit highlights difficulties with the commencement of combination therapy. In the real world setting, a number of factors particularly patient and therapy related factors can interfere with an aspiration to commence and escalate combination therapy in RA patients. Our study emphasis the importance of working towards individual patient agreed outcomes and ensuring flexibility of timing of appointments to achieve most effective use of patient and clinician time.

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