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CLINICAL

Guidelines for the management of rheumatoid arthritis beyond the first two years

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TITLE British Society for Rheumatology and British Health Professionals in Rheumatology guideline for the management of rheumatoid arthritis (after the first 2 years)

AUTHORS Luqmani R, Hennell S, Estrach C et al. on behalf of the British Society for Rheumatology and British Health Professionals in Rheumatology Standards, Guidelines and Audit Working Group

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SUMMARY

Luqmani et al.'s paper, which was commissioned by the British Society for Rheumatology (BSR), aims to provide a care framework for the management of rheumatoid arthritis (RA) when the disease has entered its chronic phase. The current guideline follows directly from the first guideline on the early management of RA. A strong emphasis is made on enabling patients to self-manage some aspects of their condition and make informed treatment choices.

The proposed model includes the use of traditional disease-modifying drugs (DMARDs) or biological agents, ongoing education and specialist management, with increasing emphasis on shared care between patients, primary care and secondary care. The goals of therapy supported by this guidance are to:

(i) Control synovitis;
(ii) Control symptoms;
(iii) Promote self-management;
(iv) Improve physical functioning;
(v) Improve psychosocial functioning;
(vi) Monitor for drug toxicity; and
(vii) Manage and screen for comorbidity.

The guidance is to be used for adults with established RA and does not deal with early RA, other forms of arthritis or give details of drug therapy. The full guideline is available from the BSR website (http://www.rheumatology.org.uk/guidelines). Twenty evidence-based recommendations have been proposed.

The guideline provides a framework to standardise and deliver care for patients with established RA, and may be used to justify service provision or reorganisation for patients with RA in any part of the UK. The full version, available at *Rheumatology* online (doi:10.1093/rheumatology/ken450b), includes recommendations for research. The guideline will be reviewed in 2011.

OPINION

About 1% of the adult population suffers from RA,[1] a disease that severely reduces the quality of a patient's life and whose cure remains elusive. There have been exciting recent developments in our ability to help the unfortunate sufferers, but their benefits and limitations need to be kept in mind by all who are involved in the management of such patients. The goals of looking after patients with established RA are somewhat different from those one would have when confronted with early disease. The BSR has come up with a timely framework proposal which would help in the optimal use of resources within the UK and (with some modification) in other parts of the world.

The guidelines draw upon a huge research database and provide a useful overview of the integration of therapeutic interventions, patient education, the importance of screening for co-existing cardiovascular disease, depression and fatigue, and the kind of help available from surgical intervention and occupational therapists.

Several important messages are to be learnt from this comprehensive effort of a team of experts. These include:

i) The need to continue therapy with DMARDs and biologic therapies even when the disease is seemingly quiet;[2]
ii) The caution about using non-steroidal anti-inflammatory drugs in those with cardiovascular and gastrointestinal risk factors;[3]
iii) The heightened awareness of co-morbidity due to development of cardiac disease, osteoporosis and depression; and

iv) The range and limitations of modern surgical techniques when seeking help for physical disabilities caused by this pernicious disease.

An attempt is made to suggest pathways for the provision of optimal care through a shared approach between the patient, primary care services, ancillary care and specialist rheumatology services, given the resource constraints everywhere. This is where we reach the realm of idealism wherein the best possible services are available for all and sundry. This is obviously not possible everywhere, even in the developed world, but the goals are certainly laudable and the paper does well to at least list the requirements until future medical advances make our jobs easier.

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Combination angiotensin-converting enzyme inhibitor and angiotensin receptor blockers: too much of a good thing?

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TITLE Renal outcomes with telmisartan, ramipril, or both, in people at high vascular risk (the ONTARGET study): a multicentre, randomised, double-blind, controlled trial

AUTHORS Mann JFE, Schmeider RE, McQueen M et al.

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SUMMARY

This study is the first to report renal outcomes in patients with cardiovascular disease but a low burden of advanced renal disease, using the angiotensin-converting enzyme inhibitor (ACEI) ramipril at 10 mg/day, the angiotensin receptor blocker (ARB) telmisartan at 80 mg/day, or both. More than 8,500 subjects were randomised to each therapeutic group and followed for a mean of 56 months. The primary outcome measures of the Global Endpoint Trial (ONTARGET) prospective randomised controlled study were death from cardiovascular disease, myocardial infarction, stroke or hospitalisation for heart failure. The analysis of the primary cardiac outcomes was published in a prior study,[1] which found that telmisartan was equivalent to ramipril, and the combination was associated with more adverse events.

The current study has focused on secondary analysis of a composite renal outcome of dialysis, doubling of serum creatinine or death in this cohort. Urine albumin-to-creatinine ratio and serum creatinine were measured before run-in and during follow-up. The glomerular filtration rate (eGFR) was estimated using the four-variable Modification of Diet in Renal Disease (MDRD) formula. The baseline eGFR was 73.6 ml/min/1.73m^2, with a minority (1.02%) having an eGFR <30 ml/min/1.73m^2 and the majority (75.58%) having an eGFR >80.9 ml/min/1.73m^2. Microalbuminuria was present in 13.1% of participants and macroalbuminuria in 4.0%. The prevalence of chronic renal disease in this cohort was therefore not high.

The frequency of combined renal endpoints were similar in the ramipril (13.5%) compared with the telmisartan (13.4%) groups, but was significantly higher in the combination group (14.5%, p=0.037). The frequency of the secondary renal endpoint of doubling of serum creatinine alone was also significantly higher in the combination group (2.49%, p=0.038) compared with the ramipril (2.03%) and telmisartan (2.21%) groups. The need for acute dialysis, i.e. temporary need for dialysis <2 months, was also higher in the combination group (hazard ratio 2.19, 95% confidence interval 1.13–4.22 compared with ramipril alone) but did not differ between the ramipril and