RhED Talks Uncharted Territory: Management of Rheumatoid Arthritis and Comorbidities

Narrator:

Welcome to CME on ReachMD. This segment, RhED Talks—Uncharted Territory: Management of Rheumatoid Arthritis and Comorbidities is provided by Forefront Collaborative and supported by an educational grant from Pfizer. This activity focuses on the management of rheumatoid arthritis and comorbidities.
The target audience for this activity is rheumatologists. Other healthcare professionals, including physician assistants and nurse practitioners who treat patients with rheumatoid arthritis, may also benefit from participation.

Your host and moderator is Dr. Matthew Birnholz. Dr. Birnholz will speak with Dr. Alvin F. Wells, Director of the Rheumatology and Immunotherapy Center, Adjunct Clinical Professor at Marquette University, and Adjunct Assistant Professor of Rheumatology at Duke University. Also joining us is Dr. Sheetal Desai, Program Director of Rheumatology and Associate Clinical Professor of Medicine in the Division of Rheumatology at UC Irvine Health.

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This recording took place at a conference attended by rheumatologists, where participants could ask the speakers questions in real time.

Dr. Birnholz:

Welcome to CME on ReachMD. Today’s presentations and discussion focus on the management of rheumatoid arthritis and comorbidities. I’m Dr. Matt Birnholz, host and moderator.
Dr. Desai:
Good morning.

Dr. Birnholz:
Great to have you both.

Dr. Wells:
Thank you. Glad to be here.

Dr. Desai:
Yes, thank you.

Dr. Birnholz:
Now, to introduce or to set a preface for our talk today, I'm going to talk a little bit about some of the treatment goals for RA. Now, the treatment goals for RA have historically focused on reduction in pain and joint symptoms. And fortunately, the last 2 decades have witnessed a dramatic improvement in the treatment options available for patients with RA, with disease remission now considered a realistic goal for many patients, and many patients with RA have 1 or more comorbid conditions that complicate the diagnosis and management of RA.

Now, in a study of 1355 US adults with RA, healthcare quality process measures for diabetes, congestive heart failure, myocardial infarction, and gastrointestinal tract bleeds indicated that there was suboptimal care. Now, although the American College of Rheumatology does provide some guidance about RA treatment in patients with comorbidities, there are many gray zones that do exist in respect to managing comorbid conditions in these patients, which creates a challenge in clinical practice and a need to establish a forum within the medical community to identify optimal approaches to care for these patients and, of course, to facilitate future research and guideline development.
So, with that preface in mind, let me welcome both of you again.

Dr. Wells:

Thank you.

Dr. Desai:

Yes, thank you.

Dr. Birnholz:

Dr. Wells, I know that you're going to begin with a presentation on updated ACR recommendations for management of comorbidities in patients with rheumatoid arthritis. Let me hand it over to you.

Dr. Wells:

Thank you. Thank you, Matt. So, to take a step back... Remember, in 2015 the ACR published their 2015 recommendations or guideline for the management of rheumatoid arthritis, and essentially what that is, a group of experts got together and reviewed the body of literature and came up with 32 recommendations: 7 recommendations for treating patients with early rheumatoid arthritis, there were 15 recommendations for treating patients with established rheumatoid arthritis, and then 10 recommendations on how to manage the comorbidities in patients with rheumatoid arthritis.

Now, as rheumatologists, we all know that patients with RA do have significant comorbidities. We get concerned about cardiovascular disease, pulmonary disease; we worry about gastrointestinal disease, like you alluded to; we worry about infections and also malignancy. To give you an idea about what some of these comorbidities would do, for example, we know that cardiovascular disease is a big burden in the US, and if you take some patients with rheumatoid arthritis, especially those with what we call seropositive—they have a positive rheumatoid factor or they have a positive anti-citrullinated peptide antibody, the so-called ACPA antibodies—and those patients that are ACPA-positive compared to those that are ACPA-negative, they are at increased risk, say, for having ischemic heart disease, and the odds ratio—some of the studies show that odds ratio is 2.5 times greater if they have
the antibody versus those who do not. And the same thing related to death from cardiovascular
disease. Those patients who are ACPA-positive, they actually have 1.7 times the odds ratio of having
death from cardiovascular disease if they have ACPA positivity.

So, as we were talking earlier in general conversation, you know, when you're dealing with patients with
rheumatoid arthritis, and if they have comorbid cardiovascular disease, you want to increase that odds
ratio. If we have patients who have disease for more than 10 years, if a patient who has ACPA
positivity or if they have what we call extraarticular manifestations, you want to multiply their risk factor
by some number. Some guidelines, like for the EULAR guidelines, recommend multiplying the risk
factor by 1.5. Suffice it to say, that takes you to a different level if they do have cardiovascular disease.

The guideline that came out in 2015 addressed several different things, and there are 5 ones they really
kind of focus on: They talk about congestive heart failure; they talk about hepatitis B, hepatitis C; they
talk about malignancies; and they talk about infections. And really, the guidelines give you some help
with the rheumatologists who, like both of us, deal with them every day, how do we deal with those
conditions? For example, congestive heart failure: We all know that we have great drugs for treating
rheumatoid arthritis, but if somebody has a comorbid condition consisting of congestive heart failure,
they recommend not using an anti-TNF antagonist. Again, that's because of the possibility for
exacerbation of their disease. And now the good thing is we do have other molecules and other agents
that we can use to treat those patients.

For the first comorbidity, if they have congestive heart failure, not to use anti-TNF. We'll talk, and we
can bring this up in the discussion later, didn't talk about NSAIDs or anything along those lines, but I'd
like to maybe get some thoughts along those and what do we do in those patients?

Next we talk about hepatitis B, really sort of straightforward guidelines. So, if a patient has hepatitis B
and if they are on concurrent immunosuppressive therapy for the disease, you can treat them with
whatever you want to. And the same thing with hepatitis C. Now, of course, the recommendation from
the CDC is to screen patients who are what we call the baby boomers for hep C, and if they're positive,
treat them. The guidelines say if they have hepatitis C and if they are currently being actively treated,
you can give them whatever drug. It doesn't matter, whether DMARD, a biologic drug, or which of the
biologics you can use.

And then when it comes to the last 3—so with infections and with malignancies, and definitely what we call the serious infections—that’s where the guidelines give you several more options. For example, with malignancies, they break it down for solid tumors—things like breast cancer, colon cancer, prostate cancer—versus the lymphoproliferative diseases. And in patients with rheumatoid arthritis, if they have lymphoproliferative disorders, they recommend not using anti-TNF agents. You can use DMARDs, and in some cases you can actually use rituximab as well. Of the solid tumors, particularly patients who have been treated, now the oncologists will tell us if a patient has had cancer 3-5 years out, they can be considered cured, and any new cancer after 5 years, they consider that new primary tumor. So, again, if somebody has a solid tumor—breast, colon malignancy—you can give whatever drug you want.

And then the thing that gives us the most headaches, I think, on a day-to-day basis is infections. And it’s not just the sniffles and sneezes that we worry about. We worry about more what we call the serious infections, and those are ones where patients have to be hospitalized; they have to get parenteral antibiotics; or if a patient is in the hospital, they can prolong the hospital stay. So what they recommend if somebody has a serious infection or a history of those, you want to use a DMARD or maybe a non-TNF biologic drug, and they’d recommend abatacept as one of the ones that can be used.

I think all together, when you take a look at the guidelines—I pointed out those 5 key things, so congestive heart failure, malignancies, hepatitis B, hepatitis C, and serious infections—it does help the practicing rheumatologists to give you some guidance because it is getting very, very difficult with all the different agents that we have available to treat our patients.

Dr. Birnholz:

That’s a fantastic discussion.

Dr. Wells:
Thank you.

Dr. Birnholz:
Round of applause for Dr. Wells.

Dr. Wells:
Thank you.

Dr. Desai:
Excellent job.

Dr. Birnholz:
I want to open up the floor now to some Q&A that we can follow up on this, and I'll get Dr. Desai into it as well because I know you probably have some questions, and you can even contribute to some of these answers. One question that came in from a participant, I'll direct this to Dr. Wells: What do you wish the guidelines recommended or addressed that are currently not in the 2015 ACR guidelines on RA?

Dr. Wells:
If we take a step back, one of the things I struggle with is the use of NSAIDs and corticosteroids. Last year the FDA strengthened their warnings on NSAIDs and say that now we all know about the GI bleed, we all know about the renal insufficiency, but now you really have to stress the cardiovascular disease. You have got to tell them about the risk for heart attacks or strokes. So, one of the comorbid conditions that's addressed in the guidelines is congestive heart failure, but they didn't talk about the NSAIDs. And some older data, I hadn't reviewed it for a while, but older data exists that said the patient treated with NSAIDs at the prescription dose that we use, the incidence of edema—peripheral edema —can be as high as 14%, so that means those patients could be triggered to get hypertension, and could go on to get cardiovascular disease and, of course, congestive heart failure. So, because we use
these drugs almost like they're water—NSAIDs, corticosteroids—and again, compared to our European colleagues, a lot more corticosteroids more for induction, which you talk about a bridge therapy for other drugs, so I wish they had some more guidance on some of the other more daily things. I think they kind of overweighted on the biologic drugs because that's where a lot of political interest is from the pharmaceutical companies as well as from insurance payers, but there are other drugs we use all the time, other than just the DMARDs and the biologic drugs, so that's one thing. And I'd be curious to see, Sheetal, what do you say about those or what else you think is missing?

Dr. Birnholz:

What do you think, Dr. Desai?

Dr. Desai:

I think the biggest thing that I think is missing is the cardiovascular risk factors and assessment of them.

Dr. Wells:

Right.

Dr. Desai:

We don't have any specific recommendations for hypertension, hyperlipidemia, for just risk evaluation for CAD in general.

Dr. Wells:

Right, right.

Dr. Birnholz:

Why don't we take a representative general case along the lines that I'm sure you see all the time,
especially considering the cardiovascular concerns which, of course, in America are... you're going to come across quite frequently. Let's say that we have a patient: She's a 52-year-old woman; she has RA; she's on methotrexate, meloxicam, prednisone 7.5 mg; and she's prediabetic; she has hypertension; her BMI is 32. How do you work up this patient? Where do you start? And how do you really keep the cardiovascular concerns that you've just both been talking about in full frontal view?

Dr. Desai:
If we're going based on our recommendations—the American College of Rheumatology 2015 recommendations—we actually don't have any of these issues addressed within our College. But when you're looking at a patient with a BMI of 32, prediabetic, already on prednisone at doses of 7.5 mg a day and NSAIDs, those are probably the 2 medications that Dr. Wells brought up that probably does absolutely need to be modified, and her treatment needs to be augmented to include disease-modifying drugs and possibly biologic responders so that she can be titrated lower and, hopefully, off of the prednisone and the NSAID.

Dr. Wells:
One of my goals, and we do this in the clinic, we have a weight loss program where we get patients involved in. So, someone who has a BMI over 30, they are considered diagnostic as obese, and they qualify for the obesity drugs. I try to help the primary care doctors to use these drugs, and they don't. They're reluctant. They would more likely put this lady on metformin or a cholesterol drug. But if she lost 10, 20, or 30 pounds, her disease goes away. And also, studies show that patients, if they're overweight, they're less likely to respond to some of the biologic drugs. So we are very aggressive in talking about that. We do bring up the smoking. We talk about that. That's even a bigger challenge to get patients to stop. And again, I agree, my goal would get her off the prednisone and even maybe making sure that the NSAID she's using is going to be only, only as a prn, as an as-needed basis.

Dr. Birnholz:
And for those who are just joining us, you're listening to CME on ReachMD. I'm your host, Dr. Matt Birnholz, and today I'm speaking with Dr. Alvin F. Wells and Dr. Sheetal Desai.
And, Dr. Desai, I'm going to turn to you now so that we can continue with the presentation components
of our talk today, and you're going to be talking about a global perspective on the recommendations for the management of comorbidities in patients with rheumatoid arthritis.

Dr. Desai:

Let me begin with why I became interested in this in the first place. It was a couple years back. I had a 67-year-old female patient with rheumatoid arthritis. She was seronegative for rheumatoid factor and CCP, the 2 commercially available lab tests we have for rheumatoid arthritis. She was well controlled on methotrexate and 1 other oral disease-modifying drug, was not on prednisone, and I think was taking an intermittent NSAID. Her other past medical history was really just osteoarthritis, a remote history of bladder cancer, and carpal tunnel. And so I had referred her for carpal tunnel evaluation because it was bothering her considerably, and on her preop assessment with the dobutamine stress test, she actually failed it miserably. And by the end of the week, she had a cath done, and about 2 weeks later she had a 5-vessel CABG. And looking back at her, I was actually... I didn't know about any of this, actually. I was consulted as an inpatient right after she had the 5-vessel CABG to help modify some of her therapy at that time, and I was quite surprised because I had just seen her several months back and had no idea whatsoever that she was that high risk for heart disease.

So, in beginning to evaluate comorbidities in rheumatoid arthritis, I think all of us in rheumatology are well aware that it is quite common. The CDC in 2009, based on national health surveys, said that about 47% of patients in the United States with arthritis have a comorbidity. In rheumatoid arthritis specifically, in 2014, a beautiful study called the COMORA study—C O M O R A, which stood for comorbidities in rheumatoid arthritis—was actually published, and this was an international observational study carried out in 17 countries, 5 continents, where they actually screened about 4000 patients with RA and they looked at their comorbidities, and they found a very high prevalence of many comorbidities, most of which that we’re quite aware of—anything from depression to GI ulcerations to ischemic heart disease, hypertension, hyperlipidemia, smoking. More interestingly, what they found is that recommendations on how to manage these comorbidities varied both within the country and between countries, and there was no uniform consensus on how to manage this multitude of comorbidities that they were actually seeing.

When I was faced with this problem with this patient and I actually reviewed the literature, then I went back to the American College of Rheumatology to see, in our country, what recommendations do exist.
We had treatment recommendations for rheumatoid arthritis going as far back as 2008, and then they were updated in 2012. And what Dr. Wells eloquently outlined were the updated recommendations in 2015 that were just released, but I want to highlight that these recommendations that were released by our American College were about the treatment of rheumatoid arthritis predominantly. And then embedded in the article was a beautiful table on several areas of comorbidities in rheumatoid patients that Dr. Wells touched upon—from CHF to hepatitis B and C, serious infections and malignancies—and how do we manage those patients from a therapeutic, decision-making perspective with rheumatoid arthritis. So, if your patients have rheumatoid arthritis and CHF, New York Heart Association Classifications III or IV, you will likely avoid TNF agents in them. If they have a history of malignancy, you might feel more inclined to actually give them Rituxan than you will other biologics. [Note: Brand name: Rituxan®. Generic name: rituximab.] If they have, like he said, hepatitis B or C, you will change your recommendation strategies based on that. But what they didn't really talk about in that article is how do you actually manage the comorbidities, not how do you manage the rheumatoid arthritis in the setting of the comorbidities, and that's what I was actually quite surprised about. And they did not touch upon things like hypertension, which is quite prevalent in our patients with rheumatoid arthritis; they didn't touch upon hyperlipidemia, did not touch upon smoking, did not touch upon the most concerning modifiable risk factor that we have, which is for cardiovascular disease, and that's what I was quite surprised about.

So then I decided to go to the literature and see what other societies around the world actually have available and if they have any recommendations, and in doing so there were a lot of recommendations both from the European Union (EULAR), from Britain, but the ones that I actually like the most that really provided some insight on how to manage these patients actually came from Brazil and Canada. So, in 2012, the Brazilian Society of Rheumatology actually published an entire article on how to manage comorbidities in RA. Okay, so not just a table, but an entire article on what to do. They have 13 recommendations on these, and it's quite impressive.

I brought the recommendations with me because some of the recommendations I really liked a lot, and I'm going to try to highlight those for you here. One of the recommendations were that—we all know that cardiovascular disease is quite prevalent and may be silent in patients with rheumatoid arthritis—as it was in my 67-year-old patient that I brought up who one day I saw and 2 months later had a 5-vessel CABG—and they actually recommend screening all patients above the age of 50 with RA, irrespective of their other risk factors, with ultrasounds of their carotid arteries looking at the intima-
media thickness, looking for silent plaque that you may have no idea they have. And then a further recommendation was if they have anything at all, that their LDL goal should actually be less than 100—so really viewing these RA patients as CAD risk equivalents and coming out and directly saying that. They had osteoporosis guidelines where they said any individual above the age of 50, irrespective if they are a male or a female, because of the known rate of osteoporosis in RA patients, because of just underlying RA pathogenesis as well as the treatments that we use for them with prednisone, that you should be screening all of them with a baseline DEXA. And that was very nice, because as I was telling Dr. Wells earlier, I definitely screen my females above the age of 50 with DEXAs because of their age and the known risk factors after menopause, but I don't know if I'm adequately screening my male counterparts with rheumatoid arthritis above the age of 50 with routine DEXAs. So I was quite impressed with the Brazilian guidelines. Those were released several years ago.

And then just last year the Canadians actually had a comorbidity initiative that they published just on rheumatoid arthritis, psoriasis, and psoriatic arthritis. It was actually a combined initiative between not just rheumatologists but dermatologists as well, and they reviewed the entire literature. They came up with very well evidence-based recommendations, and they came out with 19 recommendations, which echoed exactly what the Brazilians had said when it came to cardiovascular disease. They said that rheumatoid patients should be considered just like diabetes patients, and they are a CAD equivalent, and their goal LDL should be less than 100. They talked about more aggressive screening for osteoporosis in these patients. But what I liked is they extended it further. They talked about regular assessment of BMIs. They said all patients with rheumatoid arthritis should have their BMI assessed, and if their BMI is in a range that is concerning, that you should actually modify them. They talked about smoking cessation and the fact that all patients with rheumatoid arthritis should actually be inquired about smoking, and if they do smoke, that should be something that's modified. And what was even more interesting is they talked about depression. The rates of depression in rheumatoid arthritis, psoriasis, psoriatic arthritis, we're all very aware of—if you talk to any rheumatologist—that there are higher rates of depression in these subgroups.

But are we screening for depression? Honestly, I'm not screening for depression. I do try to screen for smoking on a regular basis. I honestly am not calculating a BMI in all my patients that walk in the door. And if it's calculated in the medical record, I may not be directly addressing it, but I'm definitely not evaluating patients for risk factors for depression. And they talk about the prevalence of depression. We know about the prevalence of depression based on prior studies, the COMORA study, and how
prevalent it is all over the world in patients with rheumatoid arthritis, but in this set of recommendations they talk about a regular routine assessment of depression in patients, and then if they are high risk, to refer them on for further evaluation and management.

So, I really like those recommendations, and I really urge you... We have excellent recommendations already put forth by the American College of Rheumatology, but I feel that they are limited in scope, and they are much more directed at how do you manage patients that have those comorbidities in terms of RA treatment, not necessarily on how you specifically manage those comorbidities, and really looking at it from a global perspective.

We’ve known that cardiovascular disease is a major cause of death in patients with RA going back as far as the 1950s. Here we are in 2000 era, and we have amazing treatment options in the last 2 decades for rheumatoid arthritis. How we treat patients with rheumatoid arthritis is completely different, and we are actually quite adept at controlling disease. However, the number one cause of morbidity and mortality in this age 60-70 years later is still cardiovascular disease. The number one cause of death in patients with rheumatoid arthritis is cardiovascular disease. And although I think it's absolutely necessary that we have to treat rheumatoid arthritis aggressively, which is what we're doing, I think the fact that we've not changed the overall morbidity and mortality for these patients really begs the question: Are we managing the comorbidities as aggressively in this era? And I think we really need to do a better job at doing that.

Dr. Birnholz:

Let me then open it up again. With respect to the international guidelines versus American guidelines, this gray zone that we talk about for managing comorbidities in rheumatoid arthritis patients, if I'm understanding you correctly, from the international perspective or stage, it's sort of obliterated. It's not so much gray on that side; whereas, in the American guidelines, it is still a little bit gray.

Dr. Desai:

Within our College, if you ask any of our colleagues that are here today at any of the meetings, the national meetings, they all agree. They will all tell you that we all agree, as a group of rheumatologists
practicing in the United States, and actually worldwide, that rheumatoid arthritis is a CAD equivalent. But just like you said, when it comes to recommendations put forth by our College, we don’t have those recommendations inked in. So I don’t know if I feel comfortable in notes when I see patients actually writing that rheumatoid arthritis is a CAD equivalent and putting an addendum to my primary care physicians that if you see my patients with rheumatoid arthritis, their goal LDL needs to be less than 100, or conversely, with our cardiologists, I don’t know if they actively treat our RA patients with a goal of an LDL below 100 unless, of course, they have hypertension, hyperlipidemia, or a known history of diabetes already. And so, I feel like having those guidelines by our national society empowers us as rheumatologists now that our treatment algorithms for RA are so complex that we can’t practice primary care in most of our patients with rheumatoid arthritis, but we can actually empower our PCPs and our cardiologists with these guidelines and actually help direct them in how to manage our patients and comanage our patients. And I actually wish we had that, because I would very happily dictate those into my note.

Dr. Birnholz:

Dr. Wells, any additional thoughts?

Dr. Wells:

Yes, it even is more complicated because was it in 2014 the American College of Cardiology came out with some new guidelines about hypertension. Some studies have shown that in the elderly patients, actually, if the blood pressure is too low, there might be a slight increased risk of dementia. So, now they are saying a patient over the age of 65 that you can tolerate a little higher blood pressure. You want it around 140 for systolic, which is a little bit different than what we are taught. But the caveat that comes up is: Okay, what do I do if that same 65-year-old lady has rheumatoid arthritis? Do I still want that blood pressure that high? Do I want to talk about aspirin? Do I want to do all these other different things?

Dr. Desai:

And just to add back, going back to my patient, the 67-year-old female with rheumatoid arthritis, she was not hypertensive, did not have diabetes. But just as a learning point, when I was going back through—because I was trying to figure out why was her risk factor so high, was it just age alone—and
when I went back over the prior several years of her LDL and her cholesterol profiles, what was interesting was her LDL was about 137, 140, not really high, wasn't something that actually stuck out in my mind when I was seeing her, wasn't something that clearly stuck out in her PCP's mind, but reevaluating this more on an international platform, would I have looked at that LDL and should I have recommended that—listen, she's RA, she's had if for a long period of time, she's a CAD risk equivalent, and you should actually get that LDL below 100? I did not recommend that. The primary care physician had no idea about that. And I often wonder, is that someone that should have been treated more aggressively when it came to hyperlipidemia?

Dr. Birnholz:
Well, you bring up a great point about bringing the primary care physician into the mix here. Clearly, there's a lot of interactions between where the primary care physician transitions to rheumatology in terms of the rheumatologist's expertise being brought in. Where does that interaction start and stop? Are there any conflicts? What would the rheumatologists be expected to take ownership of?

Dr. Desai:
I think primary care sometimes are a little confused at where we lie with treating their underlying comorbid conditions, probably because of the history of rheumatology and us being the PCPs for our patients for a long time. I would say, myself included, the majority of us post-2000 are now purely subspecialists, given the complexity of all the therapies that we use to treat our patients with rheumatoid arthritis, and that's where I find not having recommendations a little bit difficult. I feel that a lot of the onus relies on our PCPs in managing the hypertension, the hyperlipidemia, the evaluation for coronary risk factors. However, I feel like they need to actually be tailored to what we would recommend so they know what to look for or how tightly to control them.

Dr. Wells:
And I think it depends on your interaction with your primary care doctor. So, for example, if I see somebody who has a blood pressure that's elevated, I feel that I have to act on that, that I think it's irresponsible for me to send that patient out the door and expect him to follow up, so we actually do that, and we actually contact the primary care doctor. I say, “Hey, we might give you a dose of medication. I want you to see your doctor later today or later this week to follow up on that.” There are
some doctors who I've called and they've said, “Hey, Dr. Wells, no, we'll just take care of that,” so they want to be more aggressively involved. Like some of our drugs are on the elevated lipid profile, so do we treat those or do we send those to the primary care? I think it depends on your region and what interaction you have with your primary care. But just like you say, we've got to have them involved from day 1. They've got to know the risk factors of these drugs. They have to know the comorbid conditions and know that these people are at a higher risk for all of our different things, infections, etc, and we want to be more aggressive in treating and managing them, and definitely with the follow-up as well.

Dr. Birnholz:

And, Dr. Desai, as a West Coast acolyte, what’s your experience been?

Dr. Desai:

Yes, so I feel like what Dr. Wells is doing is amazing, but I don't think that that's something that's shared amongst all rheumatologists around the country. I think having focus on weight loss and evaluating BMIs is excellent, but I don't think it's necessarily done frequently or routinely enough. And the thing is, is not having recommendations that are put forth by your Society makes it a bit difficult to recommend that to the PCP. So treatment of RA has become increasingly complex in the last 2 decades with all the biologic responders that we've had hitting the market, but it's a phenomenal time to treat RA. But at the same time, if we don't have the time to treat the hypertension, the hyperlipidemia, to evaluate for smoking cessation or for osteoporosis risk factors, we really need to rely on our primary care physicians. And unless we delineate what we want them to look for and what we want them to do, it probably will not be done.

Dr. Desai:

So, I think we just got a question regarding rheumatoid arthritis.

Dr. Wells:

Okay.
Dr. Desai:

There’s a patient with high-activity rheumatoid arthritis and interstitial lung disease, bronchiectasis resulting in infections, had pneumonia and influenza 3 months ago, on Plaquenil and prednisone 10 mg a day, but it's not controlling the disease. [Note: Brand name: Plaquenil. Generic name: hydroxychloroquine]. What would you use next?

Dr. Wells:

I would send the patient to California to see Dr. Desai. No, so I think the first thing is I want to treat the underlying infection, and if they’re afebrile and the infection is under control, at least stable, then I’m okay with a little bit more wiggle room with what I would use. If you look at the guidelines, what they say with the serious infections, they recommend abatacept over the TNF antagonists and then maybe even tofacitininb over the TNF antagonist, so you've got some other things you can use.

Dr. Birnholz:

Well, before we wrap up, there was one key phrase that I heard earlier, which resonated. And, Dr. Wells, you’ve mentioned the concept of getting involved, and I want to return to that idea and ask both of you: How would you help the rheumatoid arthritis and rheumatology community get more involved in talking about and promoting this discussion about this gray zone of comorbidities from the American guidelines perspective?

Dr. Wells:

You know, I'm a big fan of educating the patients. I think having through a TV commercial, through ads, through all these different things, not so much about a specific therapy but it's going to be about the overall healthcare. I think one of the things that we’re seeing now as our healthcare coverage changes in this country, that patients are going to be empowered to do more things. So, now some of the insurance companies are incentivizing patients. If you lose weight, we're going to give you this incentive—if you get your cholesterol under control, if you stop smoking. And that needs to be nudged up a notch based on what our patients with rheumatoid arthritis say, educating them about these risks. I would love to be able to have resources in my office to help us start the conversation. I'm only doing it now on a patient-per-patient basis. I'd love it to be kind of a global thing.
So, I think that's what we really need to do, but it's going to be education of our patients and say, “Hey, you might have heart disease or you might not, but if you have a family history and you have these other things like rheumatoid arthritis and, particularly, a positive ACPA, that you definitely need to be more aggressive in managing some of these other things and doing preventative care.”

Dr. Birnholz:

And, Dr. Desai?

Dr. Desai:

I definitely agree with Dr. Wells, and I would add that I think I want to empower the group of rheumatologists in our country to run with what they're aware of and realize that primary care physicians really look to us for PCP recommendations, kind of prior to 2000 when we were actually considered primary care physicians for our patients with rheumatic diseases. And since treatments for rheumatoid arthritis have really taken off, we have actually become a true subspecialist, and we are not PCPs for our patients, for the most part, across the country. And I think we need to remind our colleagues of that and remind them that if you truly feel strongly about modifying risk factors for our patients that we need to probably put it in our notes.

And I've just recently started this, is adding a section under RA that says comorbidities and then highlighting what I think are the recommendations, that these patients are a CAD equivalent, and we all agree upon this, and I would really like them to be tightly controlled when it comes to hypertension, hyperlipidemia, and when it comes to other modifiable risk factors such as smoking and BMI. And I think by doing that, we can then empower our primary care folk to take care of these patients even better.

Dr. Birnholz:

Well, with that, I want to thank my guests, Dr. Wells and Dr. Desai. We’ve been discussing national and international perspectives on managing comorbidities for patients with rheumatoid arthritis.
Doctors, it's been wonderful having you both on the program.

Dr. Wells:
Thank you, my pleasure.

Dr. Desai:
Thank you very much.

Narrator:
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