

RESULTS from the **ANALYSIS** of **PRINCIPLES** and **RECOMMENDATIONS** of the

“Treat to Target” International Program for the treatment of rheumatoid arthritis in a consensus by the Caribbean Association for Rheumatology (CAR) in 2015

coordinated by Dr. Amanda King for



Caribbean
Association for
Rheumatology



Treat- to- target has been a very useful **management strategy** for **Diabetes Mellitus and hypertension** for many years.

Having a specific, objective goal for **Rheumatoid arthritis** means that patient, rheumatologist and other health professionals can share information more accurately and can be motivated together to make adjustments to management to achieve the target.

It is imperative that the target means what we intend it to mean, i.e. remission or low-disease activity and that the target is possible to achieve. We have seen targets shift over the years both in diabetes and hypertension and we can expect this in rheumatology also but we would like to get as close to the most appropriate target as current expertise allows.

DAS
28



This is most often used by **Caribbean rheumatologists** but is not accurate if the feet are involved. Some Caribbean rheumatologists use CDAI, SDAI or RAPID 3. A few are not routinely doing any disease-activity score, citing lack of time in the very busy public clinics as a reason.



The Caribbean association for rheumatology (CAR) is a non-profit organization which was officially registered in November 2014. However we have had a growing number of rheumatologists showing interest since we first started collaborating in 2007.

We NOW have

64 persons
in an email group.

The majority of this group are from the French Antilles and do not have the same needs as those working in English-speaking islands. Numbers change but currently there are twelve (12) in the English-speaking islands. We have had regular scientific CAR meetings since 2008 and we also meet at the ACR.

In **OCTOBER 2014**, T2T guidelines and recommendations were emailed to all “CAR email associates” who were asked to fill in the questionnaire attached.



22 “MEMBERS”

of CAR met at the Marliave restaurant in Boston in November 2014, while at the ACR.



DR. KING, (a “member”) did a short presentation and we discussed T2T.

All “members” agreed with the Overarching principles. We added a fifth principle which is **“EARLY INTERVENTION IS THE KEY TO SUCCESS”**.

The comment was made that it is not practical for some patients to see the rheumatologist monthly since they live far away and cannot afford the transportation cost, specialist fees (if private patients) and time lost from work (recommendation 4 and 5).

One rheumatologist who agreed with the recommendations, answered “no” to recommendation 1 and 4 in the second (application) segment of the questionnaire. This referred to applying the recommendations in daily practice. The member said the cost of drugs, in particular biologics, precludes adjustment every three months and prevents attainment of the target of clinical remission.

We subsequently received

14
completed
questionnaires

- **10** from rheumatologists in English-speaking Caribbean islands,
- **2** from French Antilles
- **2** from Dutch.

We, in the Caribbean appreciate that there will be some patients who will never achieve remission with synthetic DMARDs. Many of these patients have no insurance and cannot afford biologics. Perhaps adoption of T2T and dissemination to Governments of the region may influence policy as it relates to provision of biologics eg subsidies, removal of taxes and working with the pharmaceutical companies such that more people will be helped and continue to be productive members of society.

We also have the experience of early management with synthetic DMARDs resulting in better outcome and remission in many cases.



We recognize that **COST-EFFECTIVE MANAGEMENT** requires education



1

Rheumatologists will

- Teach health professionals to recognize RA and show evidence for the **“window of opportunity”** to encourage rapid referral.
- Have practical sessions on “The squeeze test” and disease- activity measurement eg DAS 28.
- Provide written information on monitoring of the different DMARDs.
- Demonstrate how shared-care will work (as it does in the UK and elsewhere)

This will continue to be done locally and may also be done regionally as was done in Barbados in October 2014 and is planned for Trinidad in May 2015.

2

Rheumatologists will spearhead a public education/ awareness campaign through the media. This can be done locally through the various non- profit organizations, eg HOPE foundation in Barbados, St. Lucia Arthritis and Lupus Association (SLALA) in St. Lucia. It should also be done regionally. Sponsorship for this may be sought from pharmaceutical companies. Public education may be the most effective strategy for getting patients to present early.

3

Rheumatologists will encourage the teaching of **“Self-management”** to patients so that they will be empowered to be pro-active, seek the care they require and comply with management. Stanford’s “Chronic disease-self-management program” (C.D.S.M.P) is taught in St. Lucia and will be introduced to Grenada in November 2015. Therapeutic education for patients affected by chronic inflammatory rheumatic disorders (TEP-CIR) is in place in Guadeloupe.



OVERARCHING PRINCIPLES

A. The treatment of RA must be based on a shared decision between patient and rheumatologist.

B. The primary goal of treating the patient with RA is to maximize long term HR-QOL through control of symptoms, prevention of structural damage, normalization of function and social participation.

C. Abrogation of inflammation is the most important way to achieve these goals.

D. Treatment to target by measuring disease activity and adjusting therapy accordingly optimizes outcomes in RA.

E. Early intervention is the key to success

RECOMMENDATIONS

RECOMMENDATION

LEVEL OF AGREEMENT

1.

The primary target for treatment of rheumatoid arthritis should be a state of clinical remission.

95%

2.

Clinical remission is defined as the absence of signs and symptoms of significant inflammatory disease activity.

96%

3.

While remission should be a clear target, based on available evidence low disease activity may be an acceptable alternative therapeutic goal, particularly in established, long-standing disease.

85%

4. Until the desired treatment target is reached, drug therapy should be adjusted at least every 3 months. **85%**

5. Measures of disease activity must be obtained and documented regularly, as frequently as monthly for patients with high/moderate disease activity or less frequently (such as every 3 to 6 months) for patients in sustained low disease activity or remission. **83%**

6. The use of validated composite measures of disease activity, which include joint assessments, is needed in routine clinical practice to guide treatment decisions. **92%**

7. Structural changes and functional impairment should be considered when making clinical decisions, in addition to assessing composite measures of disease activity. **96%**

8. The desired treatment target should be maintained throughout the remaining course of the disease. **86%**

9. The choice of the (composite) measure of disease activity and the level of the target value may be influenced by consideration of co-morbidities, patient factors and drug related risks. **91%**

10. The patient has to be appropriately informed about the treatment target and the strategy planned to reach this target under the supervision of the rheumatologist. **96%**



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