NHS
National Institute for Health and Clinical Excellence

Quick reference guide

Issue date: February 2009

Rheumatoid arthritis

The management of rheumatoid arthritis in adults

NICE clinical guideline 79
Developed by the National Collaborating Centre for Chronic Conditions

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Rheumatoid arthritis: the management of rheumatoid arthritis in adults' (NICE clinical guideline 79).

This guidance updates NICE technology appraisal guidance 72 (published November 2003) and partially updates NICE technology appraisal guidance 27 (published July 2001).

Who should read this booklet?

This quick reference guide is for rheumatologists, GPs and other staff who care for people with rheumatoid arthritis.

Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Chronic Conditions, which is based at the Royal College of Physicians. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for patients and carers, and tools to support implementation (see page 10 for more details).

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NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Contents

Introduction

Rheumatoid arthritis (RA) is a painful, progressive disease that can cause disability. The Guideline Development Group considered a clinical diagnosis of RA as more useful than the 1987 American Rheumatism Association classification criteria. This is because early persistent synovitis in which other pathologies have been ruled out needs to be treated as if it is RA to minimise damage to joints.

For the purposes of this guideline, 'recent-onset' refers to disease duration of up to 2 years, and 'established' refers to disease duration of longer than 2 years.

Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow people to reach informed decisions about their care. The decisions people make should be respected. Verbal and written information should cover the risks and benefits of treatment options, improve people's understanding of RA and counter misconceptions. People should have the opportunity to take part in existing educational activities, including self-management programmes. Follow Department of Health advice on seeking consent if needed. If the person agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Key priorities for implementation

Referral for specialist treatment

- Refer for specialist opinion any person with suspected persistent synovitis of undetermined cause. Refer urgently if any of the following apply:
  - the small joints of the hands or feet are affected
  - more than one joint is affected
  - there has been a delay of 3 months or longer between onset of symptoms and seeking medical advice.

Disease-modifying and biological drugs

- In people with newly diagnosed active RA, offer a combination of disease-modifying anti-rheumatic drugs (DMARDs) (including methotrexate and at least one other DMARD, plus short-term glucocorticoids) as first-line treatment as soon as possible, ideally within 3 months of the onset of persistent symptoms.
- In people with newly diagnosed RA for whom combination DMARD therapy is not appropriate[1], start DMARD monotherapy, placing greater emphasis on fast escalation to a clinically effective dose rather than on the choice of DMARD.
- In people with recent-onset RA receiving combination DMARD therapy and in whom sustained and satisfactory levels of disease control have been achieved, cautiously try to reduce drug doses to levels that still maintain disease control.

Monitoring disease

- In people with recent-onset active RA, measure C-reactive protein (CRP) and key components of disease activity (using a composite score such as DAS28) monthly until treatment has controlled the disease to a level previously agreed with the person with RA.

The multidisciplinary team

- People with RA should have access to a named member of the multidisciplinary team (MDT) (for example, the specialist nurse) who is responsible for coordinating their care.

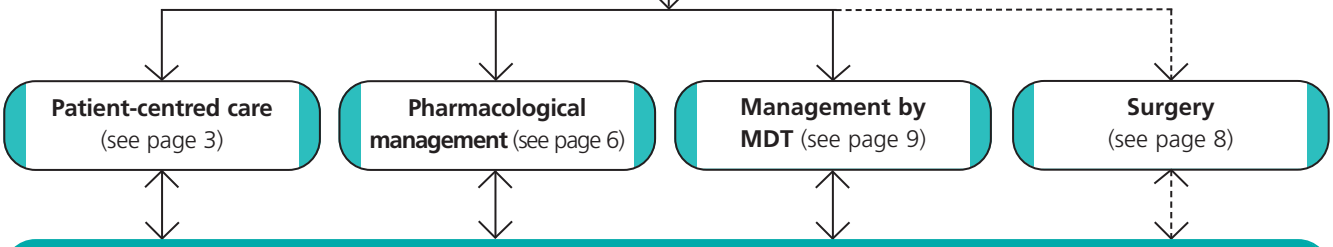
[1] For example, because of comorbidities or pregnancy, during which certain drugs would be contraindicated.

Care pathway

Referral, diagnosis and investigations

Indication	Action
Suspected persistent synovitis of unknown cause.	Refer for specialist opinion.
Suspected persistent synovitis of unknown cause, plus any of the following: • small joints of hands or feet affected • more than one joint affected • symptoms were present for 3 months or longer before presentation.	Refer urgently for specialist opinion, even if the person has a normal acute-phase response or is negative for rheumatoid factor.
Synovitis on clinical examination plus suspected RA.	Offer to test for rheumatoid factor.
Persistent synovitis affecting hands and feet.	X-ray.
Suspected RA plus negative rheumatoid factor.	Consider testing anti-cyclic citrullinated peptide (CCP) antibodies to inform decision-making about starting combination therapy (see page 6).

RA diagnosed



Monitoring and review

All people with RA

- Offer annual review to:
  - assess disease activity and damage, and measure functional ability
  - check for comorbidities such as hypertension, ischaemic heart disease, osteoporosis and depression
  - check for complications such as vasculitis and disease of the cervical spine, lung or eyes
  - organise cross-referral within the MDT
  - assess the need for referral for surgery (see page 8)
  - assess the effect RA is having on the person's life.
- Measure CRP and key components of disease activity regularly to inform decision-making about increasing or decreasing treatment.

Recent-onset active RA

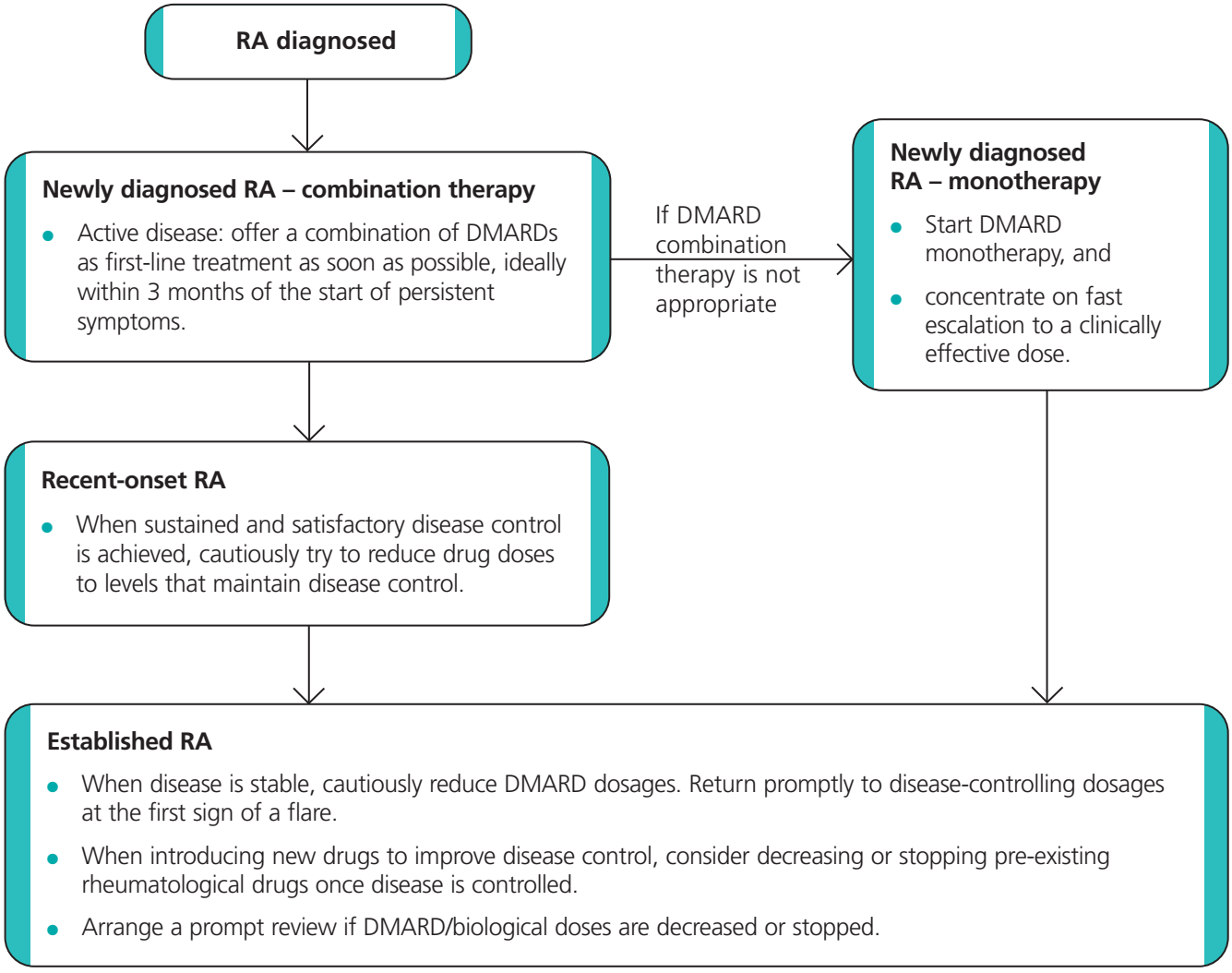
- Measure CRP and key components of disease activity monthly until disease is controlled to an agreed level.

Controlled established RA

- Offer review appointments at a frequency and location suitable to people's needs.
- Make sure people:
  - have access to additional visits for flares
  - know when and how to access specialist care rapidly
  - have ongoing drug monitoring.

Pharmacological management

DMARDs and biologicals



Biologicals

- Anakinra is not recommended for treating RA, except in a controlled, long-term clinical study[2].
- Patients already receiving anakinra should continue therapy until they and their consultant consider it is appropriate to stop[2].
- Do not offer anakinra with tumour necrosis factor-α (TNF-α) therapy.

[2] These recommendations are adapted from 'Anakinra for rheumatoid arthritis' (NICE technology appraisal guidance 72). The Guideline Development Group reviewed the evidence on anakinra but made no changes to the recommendations. See NICE technology appraisal guidance 126, 130 and 141 for other recommendations on biologicals (see 'Related NICE guidance' section for details).

Glucocorticoids

- Offer short-term treatment for flares.
- Consider short-term treatment if people are not already taking glucocorticoids as part of DMARD combination therapy.
- For established RA, continue long-term treatment only when:
  - complications have been fully discussed, and
  - all other treatments have been offered.

Symptom control

- Offer analgesics if pain control is not adequate.
- If offering a non-steroidal anti-inflammatory drug (NSAID) or a cyclo-oxygenase 2 (COX-2) inhibitor, offer a standard drug as a first choice. Co-prescribe with a proton pump inhibitor (choose the least expensive drug)[3].
- Prescribe NSAIDs/COX-2 inhibitors at the lowest effective dose for the shortest time possible[3].
- Because of the potential gastrointestinal, liver and cardio-renal toxicity of NSAIDs/COX-2 inhibitors:
  - take into account individual patient risk factors, including age, when choosing the drug and dose
  - assess and/or monitor patient risk factors
  - consider other analgesics if the patient is already taking low-dose aspirin for another condition[3].
- If NSAIDs/COX-2 inhibitors do not control symptoms satisfactorily, review the DMARD/biological drug regimen.

[3] These recommendations replace the rheumatoid arthritis aspects only of 'Guidance on the use of cyclo-oxygenase (Cox) II selective inhibitors, celecoxib, rofecoxib, meloxicam and etodolac for osteoarthritis and rheumatoid arthritis' (NICE technology appraisal guidance 27). They are adapted from 'Osteoarthritis: the care and management of osteoarthritis in adults' (NICE clinical guideline 59).

Surgery

Referral for surgery	
Indication	**Action**
Any of the following that do not respond to optimal non-surgical management: • persistent pain because of joint damage or other soft-tissue cause • worsening joint function • progressive deformity • persistent localised synovitis.	Offer to refer for an early specialist surgical opinion.
Any of the following: • imminent or actual tendon rupture • nerve compression • stress fracture.	Offer to refer for a specialist surgical opinion before damage or deformity becomes irreversible.
Suspected or proven septic arthritis.	Offer urgent combined medical and surgical management.
Symptoms or signs suggesting cervical myelopathy.	Request an urgent MRI scan and refer for a specialist surgical opinion.

- Do not let concerns about the long-term durability of prosthetic joints influence decisions to offer joint replacements to younger people.
- If offering surgery, explain that the main expected benefits are:
  - pain relief
  - improvement, or prevention of further deterioration, of joint function, and
  - prevention of deformity.

The multidisciplinary team

- Offer people with RA access to:
  - an MDT for periodic assessments[4] of the effect of RA on their lives and help to manage the condition
  - a named member of the MDT who is responsible for coordinating their care
  - psychological interventions (for example, relaxation and cognitive coping skills)
  - specialist occupational therapy, with periodic review[4], if they have:
    - difficulties with everyday activities, or
    - problems with hand function
  - specialist physiotherapy, with periodic review[4], to:
    - improve general fitness and encourage regular exercise
    - learn exercises for joint flexibility, muscle strength and managing other functional impairments
    - learn about the short-term pain relief from methods such as transcutaneous electrical nerve stimulators (TENS) and wax baths
  - a podiatrist for assessment and periodic review[4] if they have foot problems. Offer functional insoles and therapeutic footwear if indicated.

Diet and complementary therapies

- Inform people who wish to experiment with their diet that there is no strong evidence their RA will benefit. However, they could be encouraged to eat a Mediterranean-style diet.
- If a person with RA decides to try complementary therapies, this should not prejudice the attitudes of members of the MDT or affect the care offered. Advise people:
  - there is little evidence for the long-term efficacy of complementary therapies
  - they should continue with their normal treatment.

[4] See 'Monitoring and review' on page 5.

Implementation tools

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CG79).

- Slides highlighting key messages for local discussion.
- Costing tools:
  - costing report to estimate the national savings and costs associated with implementation
  - costing template to estimate the local costs and savings involved.
- Audit support for monitoring local practice.

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG79

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N1790 (quick reference guide)
- N1791 ('Understanding NICE guidance').

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at www.nice.org.uk/CG79

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see www.nice.org.uk

Published

- Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women. NICE technology appraisal guidance 160 (2008). Available from www.nice.org.uk/TA160
- Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. NICE technology appraisal guidance 161 (2008). Available from www.nice.org.uk/TA161
- Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 67 (2008). Available from: www.nice.org.uk/CG67
- Abatacept for the treatment of rheumatoid arthritis. NICE technology appraisal guidance 141 (2008). Available from www.nice.org.uk/TA141
- Osteoarthritis: the care and management of osteoarthritis in adults. NICE clinical guideline 59 (2008). Available from www.nice.org.uk/CG59
- Adalimumab, etanercept and infliximab for the treatment of rheumatoid arthritis. NICE technology appraisal guidance 130 (2007). Available from www.nice.org.uk/TA130
- Rituximab for the treatment of rheumatoid arthritis. NICE technology appraisal guidance 126 (2007). Available from www.nice.org.uk/TA126
- Hypertension: management of hypertension in adults in primary care (partial update of NICE clinical guideline 18). NICE clinical guideline 34 (2006). Available from www.nice.org.uk/CG34

Under development

- Tocilizumab for the treatment of rheumatoid arthritis. NICE technology appraisal guidance (publication expected October 2009).
- Certolizumab pegol for the treatment of rheumatoid arthritis. NICE technology appraisal guidance (publication expected February 2010).

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