Guidelines for arthritis: ten years on

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ABSTRACT – More than ten years have passed since the first UK guidelines for the management of rheumatoid arthritis were published. Since then many different guidelines have been produced, including contributions from the American College of Rheumatology and the Scottish Intercollegiate Guidelines (SIGN) network. These give similar recommendations on management. For example, they all stress the need for starting disease-modifying drugs early. The North American guidelines codify the range of acceptable practice, rather than giving specific detailed recommendations. By contrast the SIGN guidelines are more prescriptive and delineate what the authors consider to be 'best clinical practice'. The next step is to introduce guidelines that focus on specific aspects of care, rather than defining the whole range of management options. This is already happening with the introduction of guidelines for high cost treatments such as immunotherapy directed at anti-tumour necrosis factor.

A decade has now passed since the first UK rheumatology guidelines were published in this journal[1,2]. What impact have the guidelines had and what remains to be done? One striking feature has been the publication of a large number of guidelines for treating rheumatic diseases, and in particular arthritis. A number of these have been published by the American College of Rheumatology (ACR) and deal with referral[3], the management of rheumatoid arthritis (RA)[4] and osteoarthritis[5], and monitoring drugs[6]. There have also been some European and multinational guidelines[7,8] and, more recently, UK and international publications have dealt with general standards of care[9] and specific aspects of management such as monitoring drug therapy[10] and the use of immunotherapy to inhibit tumour necrosis factor[11]. The most recent UK guideline, from the Scottish Intercollegiate Guidelines Network (SIGN), deals with the management of early RA[12].

NSAID and DMARD

All these different guidelines give broadly similar advice on management. This is most obvious for the drug treatment of RA. A simplified comparison of advice is shown in Table 1. The three sets of guidelines, two from the UK and one from North America, all recommend using non-steroidal anti-inflammatory drugs (NSAIDs), though tempering such therapy with care in patients at risk of serious gastrointestinal adverse reactions. They also all recommend using disease-modifying anti-rheumatic drugs (DMARDs). In all three guidelines there is agreement that DMARDs should be started early in the course of RA, within approximately three months of diagnosis in active disease.

There are three broad differences between the guidelines. The ACR guidelines are most inclusive and appear to codify a wide range of acceptable practice. The SIGN guidelines are more proscriptive and attempt to delineate what the authors consider to be best practice. The BSR/RCP/DoH recommendations are rather blander and simply indicate broad areas of agreement about good clinical practice. In addition the UK guidelines attempt to place more weight on clinical evidence from randomised clinical trials whilst the ACR approach is more descriptive of current practice.

The major difference between these guidelines relates to the use of systemic steroids. The ACR guidelines are fairly positive about steroids, the SIGN guidelines are consistently negative towards them and the BSR/RCP/DoH recommendations are neutral, noting their advantages and disadvantages.

Some experts consider that the benefits of steroid therapy, in particular short courses of high dose steroids or long courses of low dose steroids, justify the long-term risks of adverse effects like infection and osteoporosis. Other experts may hold precisely the opposite opinion. At present there is no way of

Key Points

- **There are many different guidelines for the management of rheumatoid arthritis**
- **They give similar recommendations on how the disease should be managed**
- **North American guidelines codify the range of acceptable practice**
- **The SIGN guidelines are more prescriptive and delineate what the authors authors consider to be 'best clinical practice'**
- **The next step is to introduce guidelines that focus on specific aspects of care, rather than defining the whole range of management options**

resolving the issue. Either approach can be justified and falls within the umbrella of acceptable practice. A reasonable conclusion is that the belief that there is an identifiable best practice is incorrect. It may be more sensible to define a range of acceptable practice that can be based on the available published clinical evidence.

Guidelines for treatment

The general guidelines give helpful information about the generalities of specialist management of arthritis. They have undoubted value in defining the nature of overall specialist care and establishing the facilities that are required for its delivery. They are, however, usually too vague to use in clinical audits. Tightly written and proscriptive guidelines on how to deal with a narrow aspect of clinical care are far better for establishing audit protocols. An example that can be readily used in rheumatoid arthritis is the Royal College of Physicians guidelines on the use of bone protective agents to prevent the development of osteoporosis in patients taking systemic steroids[13]. It is possible to use these guidelines to define whether or not patients have received acceptable standards of care and to define ways of improving them in the light of audit experience.

So far, the various guidelines for the management of arthritis have made little immediate impact. Few publications have been based on the guidelines and little is known about whether or not they are used in defining the place of clinical practice. There have also been attempts to set simple standards for care in the specialist management of arthritis in the UK, particularly led by the British League Against Rheumatism[9]. They too have probably had limited impact. This does not mean that the guidelines have been ineffective. My impression is that they have set the scene for delivering and maintaining high quality care and have created a favourable environment for practising evidence based medicine.

What is now needed is to take the most important aspects of disease management in arthritis and to produce guidelines that define their role in care. Many of the current published clinical guidelines vary a great deal in quality. This is certainly not the case with the main guidelines for the management of arthritis which are based on a close review of the scientific literature. The current guidelines in arthritis consider only clinical effectiveness and take little or no account of cost effectiveness; they are also complicated to follow. Other considerations are the NHS's priorities, which is a relative and not an absolute criterion, the broad balance between benefits and costs, and the potential impact on other NHS resources. By the end of 2002 NICE should have produced guidance on the use of COX-2 NSAIDs and immunotherapies in patients with arthritis. The next steps for the specialty include the role of combination therapy with DMARDs, the optimal specialist monitoring of arthritis, and the most appropriate use of joint replacement surgery. Instead of

Table 1: Comparison of three guideline recommendations for drug therapy in rheumatoid arthritis

	BSR/RCP/DoH	ACR	SIGN
Non-steroidal anti-inflammatory drugs (NSAIDs)	Good evidence of efficacy Minimise use in elderly Gastro-protection in at risk patients	Recommended as part of the initial treatment of RA Choice of NSAID based on cost, duration of action and patient preference Gastro-protection in at risk patients	Good evidence of efficacy Lowest dose compatible with symptom control Gastro-protection in at risk patients
Disease modifying anti-rheumatic drugs (DMARDs)	Good evidence of efficacy. Additional effects on x-ray damage with sulphasalazine and cyclosporin	Recommended for all RA patients whose disease is active despite adequate treatment with NSAIDs No preference of any specific DMARD but hydroxychloroquine, sulphasalazine and methotrexate often preferred by rheumatologists	Good evidence of efficacy Sulphasalazine and methotrexate drugs of first choice
Early DMARDs	Weak evidence for early use	Should be started within 3 months of disease onset in patients with active disease	Good evidence that early DMARDs maintain function and reduce later disability
Combination DMARDs	Weak evidence for combination therapy	Controversial issue Used by many rheumatologists More studies needed	Insufficient evidence for routine use of combination DMARDs in early RA
Systemic steroids	Good evidence of efficacy but side effects unacceptably high	Highly effective in active RA Use limited by toxicity	Not recommended for routine use as no sustained clinical or functional benefit and high risk of long term toxicity

further general guidelines for the management of rheumatoid arthritis, osteoarthritis and related disorders, we need specific guidelines on the use of particular forms of management.

Guidelines can be used to improve the quality of care or to ration the use of expensive treatments. There have also been numerous recommendations on how guidelines should be produced[14] together with examples of problems in their implementation in routine practice; for example the difficulty in implementing guidelines for the management of back pain in primary care[15]. By contrast, setting criteria for embarking on a particular type of therapy or undertaking a specific procedure may be helpful in improving the overall standard of care. A good example of this is the development of explicit standards for hip replacement surgery[16]. It is likely that international agreement would produce similar recommendations, in line with the uniformity of views about the role of new treatments such as immunotherapy. It is inevitable that some rationing of high cost treatments may result from such guidelines, but I anticipate that this a natural expectation of all involved. The main issue is to ensure that such rationing is neither irrational nor excessive.

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