Can intervention modify adverse lifestyle variables in a rheumatoid population? Results of a pilot study

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Abstract

Background: Rheumatoid arthritis (RA) is associated with significant excess morbidity and mortality. Cardiovascular disease is the commonest cause of premature death in patients with RA. In recognition of this, blood pressure, weight, and smoking history are routinely ascertained in the clinic and appropriate advice and treatment started.

Aims: To ascertain if attending a specialist nurse, in addition to routine medical care, would increase the success in dealing with lifestyle variables in a cohort of patients with RA.

Methods: Twenty two consecutive patients starting treatment with the disease modifying antirheumatic drug (DMARD) sulfasalazine were invited to attend an additional clinic dealing with lifestyle factors every 12 weeks over a 48 week follow up. Smoking and alcohol history, baseline demographic and metrology assessments were determined for all patients. Body mass index (BMI) was calculated, blood pressure recorded, function assessed by the Health Assessment Questionnaire (HAQ), and social deprivation determined by the Carstairs Index. Patients were advised on exercise and diet, and serum cholesterol was measured.

Results: Twenty women and two men, with a mean age of 52 years and mean disease duration of five years, were enrolled. Eight patients smoked and, unfortunately, none were persuaded to discontinue. Fifteen of the cohort were already taking regular exercise; one additional patient began swimming regularly. At baseline, 10 patients were found to have a high cholesterol, with a mean of 6.8 mmol/l. A 14% reduction in mean cholesterol was achieved by dietary modification, and three patients were prescribed statin treatment. Obesity is a major problem in our population and 15 of the patients had grade I obesity with a mean BMI of 30.6; five of these gained a further 4.5 kg. Six patients with previously untreated hypertension were identified, but unfortunately five remained hypertensive and only two had received anti-hypertensive drugs.

Conclusions: Educating patients in order to change lifestyle habits and influence outcome is a long term challenge facing all healthcare workers. In our cohort, most adverse lifestyle factors had already been recognised and discussed by the general practitioner or at prior clinic visits. Additional advice and input led to only modest improvement.

METHODS

Background

The Centre for Rheumatic Diseases acts as a local referral unit for the East End of Glasgow, an area with a high prevalence of cardiovascular disease, as well as a tertiary referral centre for rheumatology in the west of Scotland.
Assessments
Twenty two consecutive patients starting treatment with sulfasalazine as a disease modifying agent for RA were invited to attend an additional clinic dealing with lifestyle factors. They were assessed at baseline, then every 12 weeks over a 48 week follow up. Smoking and alcohol history, baseline demographic and metrology assessments were determined for all patients. Weight and height were measured (and BMI calculated) and blood pressure recorded. Blood was analysed for erythrocyte sedimentation rate (ESR), C reactive protein (CRP), lipid profile, glycated haemoglobin, in addition to regular monitoring of bloods for the effect of sulfasalazine, including renal and liver function. Function was determined using the modified HAQ. Social deprivation was assessed with the Carstairs Index, which is a composite score derived from the postcode and based on overcrowding, male unemployment, car ownership, and social class, ranging from the most affluent group 1, to the most deprived group 7. Risk factors for the development of osteoporosis were ascertained.

Interventions
Patients were advised on stopping smoking and provided with a generic “Quitter’s pack” containing further advice and telephone numbers if necessary. Guidance on safe levels of alcohol consumption was given and restricted to <3 units a day for men and <2 units a day for women. Patients were encouraged to take regular exercise, 20 minutes 3 times a week, and were invited to attend a weekly swimming group organised by patients, for patients with arthritis, but under the auspices of a physiotherapist. Dietary advice was given verbally and reinforced by the provision of generic information booklets advising on low fat, high fibre diets containing at least five portions of fruit and vegetables a day. If a specific dietary problem was identified, review was arranged with a dietician. Any change in BMI was noted.

Cardiovascular status
In addition to details on smoking, exercise, and BMI, blood pressure was measured at each visit and, if abnormal, follow up was arranged through the patients’ general practitioner with appropriate treatment instituted by the primary care doctor. Fasting lipids were measured in all patients and, if abnormal, follow up was arranged through the patients’ general practitioner with appropriate treatment instituted by the primary care doctor. Fasting lipids were measured in all patients and, if abnormal, the consensus guidelines of the Royal College of Physicians of Edinburgh were applied with appropriate dietary advice and treatment instituted.

All patients completed 48 weeks of follow up. All adverse and beneficial effects were recorded.

RESULTS
Twenty four consecutive patients starting treatment with sulfasalazine were invited to take part. Two patients refused because of the time involved, and thus 20 women and two men were enrolled. Table 1 shows the demographic data at baseline. The 22 patients had a mean age of 52 years (median 50, range 32–80) and mean disease duration of five years (median 4, range 6 months to 13 years). Most patients had received no previous DMARDs (range 0–4). All patients were starting treatment with sulfasalazine as a disease modifying agent and had active disease as judged clinically by a mean articular index of 7 (median 6, range 0–24), and mean duration of morning stiffness of 150 minutes (median 60, range 0–960). Investigations showed a mean baseline ESR of 31 mm/1st h (median 24, range 1–72) and mean CRP of 27 mg/l (median 20 mg/l, range 6–85).

All patients were treated with sulfasalazine. By 48 weeks, eight of the 22 had discontinued treatment. The reasons for discontinuation were nausea in three, abnormal liver function tests in two, leucopenia (total white cell count <4×10^9/l), and a drug induced lupus illness characterised by rash, mouth ulcers, fever each in one patient. All adverse events resolved on drug discontinuation. One patient temporarily discontinued sulfasalazine owing to pregnancy and restarted after a postpartum flare. Of the 14 patients continuing to receive treatment, the median daily dose at 48 weeks was 2.5 g.

In patients with established RA, the use of oral steroids is limited in our practice—only one patient was taking oral prednisolone in a dose of 5 mg/day. Nineteen patients received a mean of two intra-articular injections of steroid (range 1–5) and six also received intramuscular steroid during the study period, bridging the time for new DMARD treatment to be effective. All patients were treated with non-steroidal anti-inflammatory drugs.

Comorbidity
Osteoporosis risk factors
Ten of the 14 post-menopausal women were receiving hormone replacement therapy for osteoporosis. One other woman was receiving an oral bisphosphonate and three were also taking oral calcium and vitamin D3 supplements. Neither of the male patients had osteoporosis.

Depression
Two patients had pre-existing depression treated with anti-depressant drugs.

Cardiovascular disease
Three patients at baseline had ischaemic heart disease and all were treated with aspirin and a statin. One further patient sustained a non-fatal myocardial infarction during the study period.

Respiratory disease
Four patients had chronic obstructive pulmonary disease, treated with appropriate inhaled bronchodilators and steroids.

Diabetes
One patient had type II diabetes; no additional cases were identified during the 48 week period as determined by glycated haemoglobin and urine analysis for glycosuria.

Hypertension
Sixteen patients were normotensive at baseline. One patient became hypertensive after hormone replacement therapy. Six previously untreated patients were hypertensive at baseline (defined by systolic blood pressure >140 mm Hg, and/or diastolic blood pressure >90 mm Hg). By week 48, five of these six patients were still hypertensive and only two had been treated with anti-hypertensive drugs despite advice to the patients to attend their GP or practice nurse.

Hyperlipidaemia
Ten patients with dyslipidaemia were identified, defined by a fasting cholesterol of >5.2 mmol/l (range 5.3–9.55). For the cohort as a whole, the mean serum cholesterol was 5.1 mmol/l. Two patients also had hypertriglyceridaemia. At baseline,
three of the patients were being treated orally to lower lipid levels; all had sustained a previous cardiovascular event. All 10 were advised by a dietician on a lipid lowering diet.

Three of the original 10 patients with hypercholesterolaemia did not have a repeat sample at six months or 48 weeks. In the seven with paired samples, mean cholesterol fell from 6.8 mmol/l to 5.8 mmol/l, with a mean reduction in each patient of 14%, as expected by diet alone. Treatment with an oral statin was also subsequently started in two patients at the end of the study.

**BMI (weight in kg divided by the square of the height in metres) is a reliable measure of abnormal body mass. Fifteen patients had a BMI >25 (range 26.2–41.7), with a mean BMI in this group of 30.6, falling to 30.3 at week 48 (not significant). In this group, nine patients managed to lose a mean of 3.4 kg in weight, with a mean reduction in BMI of 1.4. However, five patients gained a mean of 4.5 kg in weight, with a mean BMI increase of 1.8. None of the 15 obese patients returned to a normal BMI.**

**Dietary factors, including obesity, coronary heart disease, hypertension, cerebrovascular events, malignancies, and osteoporosis, are influential in most important public health problems of Western society. Our patients were all advised on dietary modifications, including lowering fat, increasing fibre, an adequate calcium intake, the use of fish oil supplements, and the role of antioxidants.**

**Exercise may be difficult for a patient with painful, swollen joints, but a balance of rest and exercise is important and achievable in most circumstances in order to reduce pain and improve endurance for physical activities and cardiovascular fitness.**

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