

## Newly updated advice on using DMARDs for RA

### INTRODUCTION

Shared decision-making between patients and doctors is a central focus of newly updated recommendations on treating rheumatoid arthritis with disease-modifying antirheumatic drugs (DMARDs). The updated recommendations, produced by the European League Against Rheumatism (EULAR), also take into account recent research on the benefits and safety of these widely used drugs.

### WHAT DO WE KNOW ALREADY?

When someone has rheumatoid arthritis (RA), their immune system—which normally fights infection - mistakenly attacks their joints. This makes their joints swollen, stiff, and painful. DMARDs are medicines that help stop this happening. They do this by reducing damage to the joints and helping prevent irreversible disability. That's why they are called disease modifying.

DMARDs are the main treatment for RA, and there are many different types. These include:

- ▶ Older, standard types, which are synthesised chemically and are thus called conventional synthetic DMARDs. These include methotrexate, sulfasalazine, and leflunomide.
- ▶ Newer types, which often fall under the category of biological DMARDs. These large molecules are made from cells in cultures. They include inhibitors of tumour necrosis factor (TNF) (adalimumab, certolizumab, etanercept, golimumab and infliximab), abatacept, tocilizumab, and rituximab.

With so many options to consider, deciding on a treatment approach can be a challenge, particularly since research doesn't provide clear answers on which DMARDs work best and are safest. To help with this, the EULAR convened a task force of doctors specialising in RA (rheumatologists), other experts, and patient representatives to review the current research and provide guidance. They have now released their recommendations, which are an update of those published in 2010.

### WHAT DO THE RECOMMENDATIONS SAY?

The updated recommendations emphasise the importance of doctors and patients working together to find the best care approach, stressing that treatment must be based on a shared decision between the patient and their rheumatologist. Other key principles are:

- ▶ Rheumatologists are the specialists who should primarily care for people with RA.
- ▶ Rheumatologists should weigh up the economic, social, and individual costs of the disease and its treatment when considering treatment decisions.

The recommendations also go into detail about the best approaches to treating RA with DMARDs. Some highlights:

- ▶ Patients should start taking DMARDs as soon as they are diagnosed with RA.
- ▶ The aim of the treatment should be remission or low disease activity
- ▶ Doctors should monitor patients every one to three months when their RA is active. If a patient has not improved enough after three or did not reach an agreed therapeutic target at six months, their treatment should be adjusted.
- ▶ Methotrexate should be the first DMARD doctors and patients consider. If a patient can't take methotrexate, sulfasalazine and leflunomide are other preferred options. These are all conventional synthetic DMARDs, and they can be taken alone or combined.
- ▶ Patients and doctors can consider using corticosteroids called glucocorticoids at low doses, as part of the patient's initial treatment (along with DMARDs). But these drugs should be reduced and stopped as soon as possible.
- ▶ If the first treatment approach doesn't work well enough, other synthetic DMARDs can be tried. If this falls short, biological DMARDs can be considered. However, these drugs can be considered sooner for patients who have more active RA with a poorer prognosis.
- ▶ Biological DMARDs are usually used along with methotrexate.
- ▶ If one biological DMARD doesn't help, another can be tried.
- ▶ If biological DMARDs haven't helped, a DMARD called tofacitinib can be considered in countries that have approved this drug (currently not approved in the EU region due to questions on the benefit-risk ratio).
- ▶ If a patient is no longer taking corticosteroids and their RA is not active (they are in remission), the dose of their biological DMARD may be reduced.
- ▶ If a patient has been in remission for a long time, their synthetic DMARD dose may be reduced. However, this is a decision that should be carefully considered by the patient and their doctor.

- ▶ When treatment needs to be adjusted, other things need to be taken into account along with a patient's disease activity. These things include any other illnesses the patient may have, the possible side effects of current or previous treatment, and the development of joint damage over time.

#### HOW RELIABLE ARE THE RECOMMENDATIONS?

These recommendations are based on a thorough review of the current research and knowledge, as well as discussions among experts and patient representatives. They should provide reliable guidance on the best approach to treating RA with DMARDs, based on what current research and experience tell us.

#### WHAT DOES THIS MEAN FOR ME?

If you have RA, these recommendations provide useful insight into what treatments you are likely to be offered and when. They also emphasise that you, as a patient, should have a voice in your treatment. If you have any questions or concerns, be sure to speak with your rheumatologist.

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