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Guidelines for the management of RA: breadth versus depth

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Abstract

The comprehensiveness of clinical guidelines is a major determinant of their usefulness, but covering a broad range of topics in depth can prove difficult.

Clinical guidelines are recommendations of current 'best practices'. Guidelines are most often produced by professional organizations and are based on a synthesis of the medical literature, supplemented with expert opinion when the evidence is thin. They can be focused, such as the American College of Physicians guidelines for screening for osteoporosis in men,[1] or can be very diverse and include recommendations on diagnosis, evaluation, treatment and monitoring. The newly published British Society for Rheumatology (BSR) and British Health Professionals in Rheumatology (BHPR) guidelines for the management of patients with rheumatoid arthritis (RA) after the first 2 years of disease[2] complement earlier guidelines from these societies on the management of new-onset RA.[3] Whereas the earlier guidelines emphasized the treatment of active synovitis, the scope of these guidelines is broad and includes 20 recommendations that range from the use of analgesics to access to care.

In contrast to guidelines for RA management published by the American College of Rheumatology,[4,5] the new BSR and BHPR guidelines do not detail recommendations specifically regarding antirheumatic medications. Although recommendations are included on the need for treatment to suppress RA activity and achieve clinical remission, the guidelines go beyond medication use and include recommendations on the use of orthopedic surgery, occupational and physical therapy, and patient education.

Three aspects of the guidelines are noteworthy. First, prominent consideration is given to the management of comorbid conditions. Recommendations are made to screen patients for cardiovascular risk factors and aggressively treat identified risks, to evaluate and treat osteoporosis, and to treat depression when it is present. These recommendations emphasize the need to care for the whole person. The concept of an annual review is presented (although with limited evidence to support its usefulness), at which stock is taken of the long-term trajectory of the patient's health, including patient goals and the status of comorbid conditions. Second, the guidelines emphasize the importance of the patient as an active partner in their care. Patients are included as part of the target audience for the guidelines, along with clinicians and health planners. Education about the disease is recommended for all patients, using hospital-based programs, structured self-management classes, or peer-to-peer counseling. These programs could include social support, and can teach patients ways to be more participatory in their interactions with health-care providers, but these interventions were not

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specifically addressed.[6] Third, the guidelines recommend continued monitoring of RA activity to ensure the disease is stable, and rapid access to care (including telephone advice) in the event of flares or worsening of the patient's condition. Although the guidelines are clear on what good monitoring should afford patients, they are less clear on how best to organize health care delivery to achieve these goals. The most appropriate roles of primary-care providers, specialized nurses and rheumatologists, how responsibilities are best divided among these providers, and coordination of care, were left as open questions.

Are the new guidelines from the BSR and BHPR for the management of established RA useful? Guidelines provide evidence and recommendations to inform clinical decisions. Good guidelines are unambiguous, directive, actionable, targeted to a particular patient group and specific question, and have measurable consequences. The Appraisal of Guidelines Research and Evaluation (AGREE) collaboration has developed a framework for assessing the quality of clinical guidelines that takes into account these and other criteria (Box 1).[7]

Box 1

AGREE domains for assessing the quality of clinical guidelines[7]

- Clarity of statements of scope and purpose
- Involvement of all relevant stakeholders in the development of the guidelines
- Rigor with which supporting evidence was gathered and synthesized
- Clarity of presentation of the recommendations
- Consideration of barriers and costs of implementing the guidelines
- Editorial independence of guidelines development

The new BSR and BHPR RA guidelines seem to satisfy the AGREE standards for defining the scope of the guidelines, identifying the patients for whom the guidelines were developed, including all stakeholders, using systematic methods to search for medical evidence, linking evidence to each recommendation, having an external review of the guidelines and plans for updating, providing summaries and tools to use in the application of the guidelines, and having editorial independence.

They do, however, fall short on several of the AGREE standards. The objectives were general, rather than focused on specific questions. No information was provided on the selection criteria for the literature review, or for including or excluding studies. The methods used to go from literature evidence to recommendation were not stated, nor how areas of disagreement were handled. These points possibly were addressed, but the number of recommendations might have limited the level of detail that could be included in the report. The balance between potential benefits and harms, and different options for management, were noted for only a few recommendations. The administrative barriers and costs of implementing the guidelines were considered only generally, and these considerations were not specified for each recommendation. These points may have suffered because the scope of the guidelines led to an exchange of depth for breadth.

Most importantly, not all of the recommendations provide concrete and precise descriptions of the management option appropriate for a given situation. For example, the recommendation that "immunosuppressive therapy may exacerbate and mask infection, and temporary withdrawal should be considered during active infection" leaves open the questions of to which patients, which infections, which immunosuppressive agents, and which circumstances this guideline applies. The recommendation that "fatigue may respond to energy conservation

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techniques" does not tell the clinician when or in which patients these techniques should be used. "The aim of therapy is to minimize disease activity" states the goal, but is not directive or actionable. Because they don't tell clinicians what they should do, these particular recommendations might be less useful in practice.

The publication of the 2009 BSR and BHPR guidelines coincided with the publication of guidelines on the management of RA by the Royal College of Physicians.[8] The latter provide recommendations for both early and established RA, have a broad scope that includes diagnosis, and address pharmacological as well as non-pharmacological management, surgery, and multidisciplinary care, but do not include recommendations on service delivery or management of comorbid conditions. In this way, the two sets of guidelines are somewhat complementary. The Royal College of Physicians guidelines provide clear directions, expose how the evidence led to the recommendation, and assess barriers to and costs of the application of individual recommendations: they have both breadth and depth.

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