The new 2012 German recommendations for treating rheumatoid arthritis

Differences compared to the European standpoint

On the verge of this year’s German Society of Rheumatology congress in Bochum, the new German guidelines for the medical treatment of rheumatoid arthritis have been published [1]. Based on the 2010 EULAR recommendations (EUropean League Against Rheumatism) [2] and subsequent evidence from an additional systematic literature research [3] and expert consensus, they provide not only information concerning state-of-the-art treatment of rheumatoid arthritis (RA) but also a modification of the hitherto common treatment algorithm in Germany [4].

Although the predominant part of the single EULAR recommendations remains unchanged, recent data from the current systematic literature research resulted in distinct rephrasing of the original EULAR recommendations (Tab. 1, 2). In addition, differences in the German statutory order and a somewhat different status of approval have been followed. These new guidelines have been approved by a...
Treatment should be aimed at reaching a target of remission or low disease activity as soon as possible in every patient; as long as the target has not been reached, treatment should be adjusted by frequent (every 1–3 months) and strict monitoring. When adjusting treatment, factors apart from disease activity, such as progression of structural damage, comorbidities and safety concerns should be part of the first treatment strategy in patients with active RA. Intensive medication strategies should be considered in every patient, although patients with poor prognostic factors have more to gain.

In cases of sustained long-term remission, cautious titration of synthetic DMARD dose could be considered, as a shared decision between patient and doctor. Patients with RA for whom a first TNF inhibitor has failed should receive another TNF inhibitor, abatacept, rituximab, or tocilizumab.

DMARD naïve patients with poor prognostic markers might be considered for combination therapy of MTX plus a biological agent. Treatment with synthetic DMARDs should be started as soon as the diagnosis of RA is made. Patients with RA for whom a first TNF inhibitor has failed should receive another TNF inhibitor, abatacept, rituximab, or tocilizumab. Treatment of patients with RA should aim at the best care and must be based on a shared decision between the patient and the rheumatologist.

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EULAR and German guidelines conform that adding glucocorticoids to DMARD monotherapy or combination therapy is beneficial for the patient. As evidence concerning doses and duration of glucocorticoid-bridging therapy is not available, both recommendations remain general and lack a more specific advice. The EULAR recommendation 7 emphasizes the importance of prognostic factors for the further treatment decisions. A biological DMARD can be added to a synthetic DMARD if poor prognostic factors were taken into account.

DMARD disease-modifying antirheumatic drug, GCs glucocorticoids, MTX methotrexate, RA rheumatoid arthritis, TNF tumor necrosis factor.
are present in DMARD inadequate responders. Otherwise, a switch to another synthetic DMARD strategy should be considered. At this point, the German guidelines strongly recommend a combination treatment of several DMARDs in DMARD inadequate responders but also allow a biological DMARD as part of the combination therapy if poor prognostic factors are present. The conclusion of both guidelines is similar, even if the order of the German statements accentuates the possibility to primarily utilize the full potential of synthetic DMARD combination.

According to the available evidence and the approval as first biological agents, the initiation of a biological therapy was mainly equalized with the initiation of a TNF (tumor necrosis factor) inhibitor in EULAR recommendation 8. This priority status of TNF inhibitors has been withdrawn in the German guidelines as the more recent biologic DMARDs abatacept and tocilizumab provided equivalent evidence for their efficacy and safety and are also approved as first-line biological agents. As indirect treatment comparison show similar efficacy for all biological agents except for anakinra, no specific agents are recommended at this point for preferable first-line therapy. The switch to a second biologic treatment after an inadequate response to the first biological therapy remains identical in the EULAR and German guidelines – as second TNF inhibitor, abatacept, rituximab or tocilizumab are possible agents without a specific ranking. However, full efficacy and safety data for a change to a defined second biologic agent following abatacept or tocilizumab are still lacking.

In the case of rheumatoid arthritis refractory to several DMARDs and biological agents, azathioprine, cyclosporin A and cyclophosphamide are specifically recommended by EULAR due to existing evidence on their efficacy, of course with respect to their individual toxicity. However, German recommendation 10 has been rephrased to a more general statement in order to also enable the application of other treatment options with the necessary reduction of evidence level to expert opinion.

The final recommendations conform to the EULAR statements, even if recommendations 12 and 13 are combined in the German guidelines – specific suggestions concerning the procedure in case of a sustained remission are not provided due to the lack of evidence. Intensive treatment strategies and treatment adjustment considering structural progression, comorbidities and safety concerns are self-evident. EULAR recommendation 14 refers to DMARD naïve patients again and creates the possibility to begin a biologic agent in combination with MTX as a first treatment strategy in individual patients with poor prognostic factors. By reason of order, this exceptional case was included and discussed in recommendation 3 of the German guidelines.

The aligned treatment algorithm summarizes the recommendations and represents the current practice subjected to the different strategy steps in the course of the disease (Fig. 1).

Taken together, the new 2012 German recommendations provide an update of the current evidence for the medical treatment on rheumatoid arthritis on the basis of the 2010 EULAR recommendations, providing an evidence-based real-life set of recommendations for the use in the daily practice of every rheumatologist in (and outside of) Germany.
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Conflict of interest. On behalf of all authors, the corresponding author states the following: speakers honoraria from Abbott (K.A.); honoraria for consultation, speaking honoraria, and/or reimbursement of travel costs from Abbott, BMS, MSD, Mundipharma, Pfizer, UCB, Roche (K.K.); honoraria from Abbott, BMS, Chugai, MSD, Pfizer, Roche, UCB (U.M.-L.); honoraria from Abbott, BMS, Chugai, MSD, Pfizer, Roche, UCB (J.W.).

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Fig. 1 ▲ Algorithm based on the German 2012 recommendations for the medical treatment of rheumatoid arthritis. ABC abatacept, ADM adalimumab, CEZ certolizumab, ETC etanercept, GOM golimumab, INX infliximab, RIX rituximab, TOZ tocilizumab, GC glucocorticoids, CIA ciclosporin A, HCQ hydroxychloroquine, LEF leflunomide, MTX methotrexate, SSZ sulfasalazine, TNF TNF inhibitors. *high disease activity, especially in combination with poor prognostic factors, **in case of MTX contraindication, ADM, CTZ, ETC are also approved in monotherapy, ***in case of MTX contraindication, TOZ is also approved in monotherapy and has demonstrated similar efficacy in monotherapy as well as in combination with MTX

Ausschreibung
Reisestipendium der DGORh

Die Deutsche Gesellschaft für Orthopädische Rheumatologie (DGORh) schreibt auch 2013 ein Reisestipendium aus.

Das Stipendium ist mit 1.000 Euro dotiert. Vorgesehen ist die Unterstützung einer internationalen Studienreise mit dem klinischen Schwerpunkt auf dem Gebiet der Orthopädischen Rheumatologie.

Voraussetzungen für eine Bewerbung: orthopädische Assistentinnen im fortgeschrittenen Ausbildungsstadium oder Fachärztinnen für Orthopädie/Unfallchirurgie mit Interesse an der „Orthopädischen Rheumatologie“.

Die Erfahrungen aus dieser Studienreise sollen publiziert und im Rahmen der Mitgliederversammlung der DGORh vorgetragen werden.

In der Bewerbung soll das mit der Reise angestrebte orthopädisch-rheumatologische Ziel erläutert werden.

Einsendeschluss für die Bewerbung ist der 31.04.2013

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