Rheumatoid Arthritis scope SH subgroup discussions **Date: 24/05/16 Time: 10:00–13:00**	
Topic	**Stakeholders response**
3.1 Population: **3.1.1 Groups that will be covered:** • Adults with rheumatoid arthritis **3.1.2 Groups that will not be covered:** • Patients with other causes of chronic inflammatory polyarthritis	Is the population appropriate? • Are there any specific subgroups that have not been mentioned? *Transition from children to adult services was mentioned, but the groups thought there were no specific issues relating to RA. The stakeholders were content with leaving the descriptor as 'adults' without specifying an age and allowing implementation locally.* *The stakeholders were in agreement with the groups listed.*
3.3.1 Key clinical issues that will be covered: 1 Investigations for recognising rheumatoid arthritis. 2 Identification of the prognostic factors that indicate patients at greatest risk of persistent, damaging, erosive and progressive disease, and whether poor-prognosis patients should be managed differently. 3 Pharmacological treatments for managing rheumatoid arthritis including: a. Analgesics: non-steroidal anti-inflammatory drugs (NSAIDs), paracetamol and opiates b. Conventional disease-modifying anti-rheumatic drugs (DMARDs) 4 Non-pharmacological treatments relevant to rheumatoid arthritis including: a. Diet (folic / folinic acid supplementation) 5 Timing of referral for surgery.	These are the key areas of clinical management that we propose covering in the guideline. Do you think this is appropriate, acknowledging we must prioritise areas for inclusion? ***Areas covered:*** *Prognosis:* • *This was considered to be an important issue. It was suggested that prognostic factors such as depression or rate of disease progression should be included. It was felt that Key Clinical Issues 1 and 2 were linked and could be dealt with by diagnosis and stratification, but agreed they were important to update.* • *It was noted that poor prognosis is about more than 'persistent, damaging, erosive and progressive disease', which focusses on disability and is an out of date way of looking at RA.* • *The difference between X-ray progression and quality of life was highlighted by one group.* • *One group felt that patients with poor prognosis may require more frequent reviews and earlier access to psychosocial support (eg psychological treatment), not necessarily more intensive pharmacological treatments. The other group felt that it may be difficult to treat patients with poor prognosis differently because of*

6 Monitoring on-going activity of rheumatoid arthritis. **3.3.2 Key clinical issues that will not be covered:** 1 Biological DMARDs and corticosteroids as pharmacological treatments for managing the condition. 2 Podiatry and physiotherapy as non-pharmacological treatments relevant to rheumatoid arthritis. 3 Support for patients and carers in managing rheumatoid arthritis through education, self-management and the provision of information and advice. 4 Location and frequency of review. 5 Non-specialist referral to specialist services. 6 Non-pharmacological treatments relevant to rheumatoid arthritis including: a. Occupational therapy b. Complementary and alternative interventions or approaches. **7** Multidisciplinary teams.	*the restrictions of the existing NICE TA.* • *One group felt that psychosocial interventions for those with depression may improve outcomes, but there is unlikely to be much evidence on this. A cross-referral to the depression guideline may be appropriate.* • *Loss of work was suggested by one group as a prognostic factor* • *One group member suggested that there are more biomarkers available since the original guideline publication, such as inflammatory/blood tests.* *Pharmacological treatment:* • *One group was happy to include all analgesics in one question. It was noted that it is important to include risk data when looking at analgesics.* • *The other group raised that the use of combination therapy is an area from the last guideline that has not been implemented fully around the country.* • *It was noted that there are likely to be some new DMARDs licensed soon.* • *Both groups wanted a focus on treat to target and felt that the target in the current guideline ("a level previously agreed with the patient") was not helpful. DAS < 3.2 was suggested.* • *One group requested that sequencing advice needs to include how long a drug should be tried before stopping and trying something else, and noted that there is recent evidence on sequencing (e.g. the TACIT trial).* • *One group suggested that administration methods should also be examined.* *Non-pharmacological:* • *The groups noted that folic acid supplementation should be considered with methotrexate, and not with diet as it was specific to methotrexate treatment. It was agreed that the evidence in this area had not changed and did not need review.* • *One group mentioned vitamin B injections – the group participant was advised to identify any new evidence in this area in public consultation.* • *One group questioned whether lifestyle (in terms of cardiovascular risk) and smoking should be considered within non-pharmacological treatments. The topics of vitamin D and omega 3:6 ratio were also raised but not agreed upon.*

	• *The College of Occupational Therapists have a new guideline on hand and wrist orthoses, which are not currently mentioned in this guideline (this is a review of evidence and not new research). If there are any relevant new studies from this review, the College will identify those in public consultation.* *Timing of referral:* • *One group was interested in early referral to specialist services and noted that the current wording of 'persistent synovitis' was delaying this as it was misinterpreted. It was noted that the current recommendation states 'urgent referral' which was considered appropriate. However they discussed that there was no new evidence regarding timing of referral to surgery, and this was covered in detail in the original guideline. The groups agreed that this area did not need updating.* *Monitoring:* • *The groups felt that 'monitoring' was a very large question and would encompass a number of issues and points along the disease pathway (e.g. diagnosis, stable chronic disease, unstable chronic, annual review, location and frequency of review, remission).* • *It was noted that it is important to maintain quality of life as well as low disease activity* • *It was felt that location and frequency of review could be updated as part of monitoring of disease.* • *It was noted that there was a call for proposals from NIHR on a gait rehabilitation programme (HTA funding stream – commissioning decision to be made September/October 2016), there is also a relevant literature review including around 70 studies* ***Areas not covered*** • *The exclusion of biologicals from the review noting the TAs was accepted, and it was confirmed that the TAs cover any biosimilars* • *Steroids:* ○ *One group noted the inconclusive wording of the current glucocorticoids*

	recommendation ("consider offering…") it was requested that this be revisited. ○ *It was felt that steroids should be included in advice on reaching treatment targets/goal-directed therapy* ○ *It was noted that there may be new evidence that would strengthen the recommendation not to give steroids long term* ○ *It was requested that the recommendations on early introduction of short-term steroids should be reviewed as stronger recommendations may be appropriate* • *It was felt that the recommendations regarding exercise/physiotherapy/podiatry were broadly sufficient currently.* • *One group noted that there was new evidence (NIHR study) examining changes to referral pathways, and that the criteria for referral may need to be reviewed.* • *It was felt that the current recommendation for multidisciplinary teams would be difficult to improve upon due to a lack of evidence.*
Further Questions:	
1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?	
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2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?	
- *Timing of referral to surgery.*	
3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?	
- *One group felt that pharmacological treatment is diverse in practice across the country.*	
5. Which area of the scope is likely to have the most marked or biggest health implications for patients?	

- *A shift in focus to treat to target.* - *Broadening the prognostic factors to include psychosocial factors.* - *A move to on-going active monitoring of progression/activity/outcomes for all RA patients* - *Self-management supportive pathways (preventing the need for surgery).*
6. Which practices will have the most marked/**biggest cost** implications for the NHS?
• *Monitoring (to determine how aggressive treatment will be)* • *Imaging* • *Early referral to specialists.* • *The cost effectiveness of different sequence strategies* • *Targeted approach versus current practice*
7. Are there any **new practices** that might **save the NHS money** compared to existing practice?
- *Early arthritis clinics and better early treatment.*
10. If you had to delete (or de prioritise) two areas from the Scope what would they be?
• *Timing of referral for surgery*
11. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?
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12. The following outcomes are taken from a published core outcome set. Are these acceptable? 1 Swollen joints 2 Tender joints 3 Patient global assessment / health-related quality of life 4 Physician global assessment 5 Pain 6 Function

7 Radiological progression
8 Acute Phase Reactant – ESR or CRP
9 Adverse events (including mortality)

One group felt that it would be helpful to include outcomes around psychological state/mood, fatigue, sleep and participation (ability to engage in chosen activities including work). An outcome of adherence or education was also highlighted. It was noted that radiological progression should also include other imaging (not just X-rays).

One group suggested that work/return to work should be an outcome but agreed that this may be covered by quality of life. The DAS composite score was also discussed. It was suggested this could be reported as a secondary outcome if the individual components were not reported.

14. Any comments on guideline committee membership?

Full members

- 4 Rheumatologists
- 2 General practitioners
- 1 Community-based nurse
- 1 Hospital-based nurse
- 1 Pharmacist
- 2 Patient/carer members

Co-opted expert member

- Orthopaedic surgeon (special interest in foot and ankle)
- Radiologist

- *Both groups felt that an allied health professional (podiatrist, physiotherapist or occupational therapist) would be helpful as a full member.*
- *One group felt that the two nurses could just be specialist RA nurses. The other group felt that 1 specialist RA nurse (hospital-based) would be sufficient (no need for an additional community-based nurse).*
- *One group suggested that a liaison psychiatrist or other mental health representative might be useful – this might be the AHP representative.*
- *The group were aware of specialist RA surgeons (not defined by the area of the body, but by RA). Agreed however that if timing of referral to surgery was not being updated, a surgeon would not be required.*
- *It was highlighted that the pharmacist should be one with a specialist interest in RA and that 1 of the GPs should be a GP with Specialist Interest.*

15. Are there any areas that you think should be included for the purposes of the quality standard? Are there any service delivery or service configuration issues that you think are important?
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16. Other issues raised during subgroup discussion for noting:
One group discussed the need to refocus the guideline recommendations. They felt that the focus should not be 'on the drugs' but rather on monitoring and management with a treat to target approach. They agreed that the interventions are secondary to the assessment of prognosis and ongoing active monitoring. *One group raised that the current guideline doesn't quite fit the patient management pathway of RA e.g. monitoring should be done across all stages of disease* *One group felt that toxicity of drugs during pregnancy was a very specialist group, in which treatments were not licensed, and should be an equalities consideration rather than a specific group in the evidence reviews.* *One group suggested that seronegativity/positivity could be subgrouped in review questions.* *One group suggested that cross referral to other guidance might be helpful in the following areas:* • *Lifestyle modification intervention and cardiovascular risks were discussed – a cross-referral to the statins guideline* • *Osteoporosis was also discussed as a co-morbidity requiring management – a cross-referral to the relevant guideline/FRACs tool was suggested* • *A cross-referral to the Depression in Chronic Illness Guideline (CG91) was also proposed*