Present and Future Treatment Strategies in RA

*The Nurse’s Perspective*
Welcome to present and future treatment strategies in Rheumatoid Arthritis, the nurse’s perspective. This activity is accredited by Eastern Kentucky University School of Nursing. Support for this activity has been made possible through an educational grant by UCB Pharma. In order to receive continuing education credit, you must view the entire activity, answer the questions and complete the evaluation.
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Your faculty for this presentation will be rheumatology nurse Victoria Ruffing. Victoria Ruffing has been with the Johns Hopkins Arthritis Center since 2000, dividing her time between the clinical and research arena. Her primary focus is educating patients with inflammatory arthritis. She is also an active volunteer with the Maryland Chapter of the Arthritis Foundation. Ms. Ruffing has been a member of the Association of Rheumatology Health Professionals since 2001. Ms. Ruffing is a founding member of the newly formed Rheumatology Nurses Society. She currently serves as secretary to that organization. She has served this faculty in several continuing education programs and has been an invited speaker at several national meetings, including the American College of Rheumatology, Infusion Nurses Society and the American Society of Pain Educators.
Upon completion of this activity, participants should be able to improve their patient care by being able to assess the epidemiology and pathogenesis of Rheumatoid Arthritis, discuss patient teaching strategies for medication adherence and side-effect management, evaluate current and emerging treatment therapies for RA, identified sources that will keep the nurse abreast of current and emerging therapies in RA.
Hi everybody. Thanks for joining us today. My name is Vicky Ruffing, and I am going to talk about Rheumatoid Arthritis. Let’s go over the epidemiology. First of all, the annual incidence of Rheumatoid Arthritis is about 30 in 100,000. It’s most prevalent in Caucasian. It is somewhat more common in American-Indians and African-Americans. The incidence of women versus men is about 70 to 30. It’s definitely more prevalent in women. Some people would consider it to be a women disease.
Rheumatoid Arthritis

**A systemic inflammatory disease**

- Joint destruction$^1$; 60% to 98% of patients (depending on duration of disease)
- ↓ physical function, ↓ quality of life, disability and underemployment$^2$
- Comorbidities: significant increase in relative risk$^3$
- Affects all age groups from children to the elderly
- Mean age at onset: 40-60 years
- Life expectancy ↓ by 5-15 years$^4$

$^1$Van Der Heijde DM. *Br J Rheumatol.* 1995;34(S2):74-78.  

Rheumatoid Arthritis is considered a systemic inflammatory disease. Joint destruction can occur in 60% to 98% of patients depending on whether or not they have been treated; decreased physical function, decreased quality of life, disability, underemployment and even unemployment or hallmarks of this disease in the untreated population. Comorbidities will increase again depending on if you have been treated or untreated. All age groups will be affected by this disease, and the average onset of the disease is in between the 4th and 6th decade. However, again, you can see this through all age span. Life expectancy can be just decreased by 5 to 15 years and again that would be in an untreated population.
The physical manifestations of RA; a little man in the box will show you which joints are typically affected by RA. What you can see is that this is a symmetric issue if there are joints in the right hand affected, those same joints in the left hand will be affected. Patients experience pain and stiffness. We will talk about the extra-articular manifestations in a little while. The long term consequences, of course, are joint damage, including bone erosion, cartilage loss, patient could end up with deformities which in turn can end up in disability and of course premature death.
Criteria for the Diagnosis of RA*

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Duration</th>
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<tr>
<td>1. Morning stiffness</td>
<td>&gt;1 hour</td>
<td></td>
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<tr>
<td>2. ≥3 joints</td>
<td>Soft-tissue swelling or fluid</td>
<td>≥6 weeks</td>
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<tr>
<td>3. Arthritis of hand joints</td>
<td>Wrist, MCP, or PIP</td>
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<td>4. Symmetric involvement of joints</td>
<td>Simultaneous, bilateral involvement</td>
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<td>5. Rheumatoid nodules</td>
<td>Yes/No</td>
<td></td>
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<td>6. Serum rheumatoid factor</td>
<td>Elevated levels</td>
<td></td>
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<tr>
<td>7. Erosion</td>
<td>Radiographic changes</td>
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* RA diagnosis requires patient to satisfy four of the seven criteria.


The American College of Rheumatology has established criteria to diagnose Rheumatoid Arthritis. This chart shows you the criteria that are needed for this diagnosis. The patient must meet 4 of 7 of the criteria to be diagnosed with Rheumatoid Arthritis. Typically, morning stiffness, joint swelling, the hand involvement and the symmetric involvement are what you often see in early arthritis. You may or may not see rheumatoid nodules in the beginning of a disease, those often come later. The sed rate and CRP are not part of these criteria.
The pathogenesis of RA; the pathogenesis of RA is really a little bit difficult. We do not understand where RA comes from, what triggers it. But it’s often thought that it may be both genetic and environmental. For example, something may turn that on in a person’s body. It could be a dramatic event. It could be an environmental factor such as smoking cigarettes, but something seems to turn on the genetic switch for Rheumatoid Arthritis. What happens is, of course, the inflammation cascade kicks in and joint damage will occur relatively quickly. There are very many molecules, cells and processes involved in this whole cascade of events that happened.
You can see by this complicated slide that all of these different factors start playing off on each other to begin that whole immune response. Up here I would like to say that there was no immunology when we go back in nursing school. And I have to somewhat agree with her, we didn’t understand all of these different cells and all of these different cytokines that were responsible for what happened during Rheumatoid Arthritis. You can see that when an antigen is presented, it kicks off a huge chain of events that will in turn lead to the destruction of cartilage and bone.
Often what we see presented to us in the rheumatology office is perhaps what we would see in picture #1. This particular patient has some swelling across the MCPs and across the PIPs. Now, this swelling is especially noticeable in PIP #3. So this is not uncommon presentation for the early RA patients and likely if we could see both ends, we would see that on the same exact joint, she probably has the same amount of swelling on PIP #3 on the right hand. The middle picture is someone who has probably gone on treated or is in a flair. You can see significant swelling, especially in digit #3 to #4. These are sometimes called sausage digits. You can see the tightness of the skin across those fingers how painful and stiff those must be. Of course, picture #3 is a far advanced stand. What has happened is that you can notice that there is an alner drift which is a deformity that is not uncommon in this disease when left untreated. Actually, she probably had tendon rupture. You can see rheumatoid nodules against the PIPs, you can see huge amounts of synovial swelling across the MCPs. This, of course, is not going to get better. There is nothing we can do when a patient has reached this stage other than continue to try to control the disease but any deformity that a patient is left with is permanent.
Joint erosions occur very early in this disease. Actually, up to 93% of patients with a diagnosis of RA within the first two years will have changes on X-ray showing erosion. It is believed that the disease is even more aggressive in the first six months of those two years. So some X-ray changes can be seen as early as six months.
This is a picture of erosions in Rheumatoid Arthritis. In letter A, you can see the very beginning of bone erosion if you look on the right side of the proximal bone in this joint. If you look at slide B, you can see on the left side of this joint, there is erosion but it's still somewhat smooth. In letter C, it's obvious on the left side there, it looks almost as if some clippers came and just tore a big chunk out of that joint. What you'll also notice is that the joint space between the proximal and this toe bone has totally disappeared. In letter A, you see nice joint space between, you can almost see a dark line in between it proves there are some nice cartilage there. In letter B, it's a little bit disappearing. In letter C, the bone is on the bone. So obviously, this has been an untreated or an undertreated joint because we see a gigantic erosion there and we see that those bones are actually touching. Now, what we must realize is that we cannot fix that. Once that bone is gone, that bone is gone. There is not anything we have on the market right now that would rebuild that bone.
Scenario 1: Disease Education

“What is happening to my body?”

- Establish relationship
- Reassure patient treatment is available
- Explain the disease using simple terms
  - Use visuals when possible
  - Start with the normal immune response
  - Remember reinforcement will be necessary

So, what I have done is intersperse some scenarios throughout this presentation. So if we have a new patient that's coming in and we have an opportunity to spend sometime, what we often hear is the patient say “What is happening to my body?” What we can do is we can start to establish our relationship with the patient at this point. We can reassure patients that there are treatments available and that if one medication doesn’t work, another medication may. It's important to start reviewing what Rheumatoid Arthritis really is with patients. Patients need to start making treatment decisions. They need to assume some responsibility in their disease and their care. So what I like to do is use as many visuals as possible with our patients. I like to show them X-rays, show them what can happen if left untreated, try to explain to the patients that there is not going to be a cure for this disease but we can manage their symptoms very well. It's often difficult to explain to the patient what an immune response is and how to understand what is happening when the immune response kicks in and the inflammatory cascade begins. What I try to do is explain to patients in terms of a chain. I explain that there is a chain and imagine the different links on a chain that are dependent on each other for that chain to stay hold. Now, what happens in the autoimmune disease is a patient’s body will not recognize a foreign body coming into that chain and so, the chain will continue to build and build and build. In a normal immune response, the chain eventually stops and doesn’t keep going because we have conquered that germ that has entered our body, but not so with the autoimmune disease. You will have to explain this to patients many times. This is very complicated and it's very overwhelming.
So how do we manage this patient now that we have a diagnosis? Again, the American College of Rheumatology has established standards. DMARD therapy, which is the Disease-Modifying Anti-Rheumatic Drug, should begin within three months of diagnosis. It will periodically assess the patient if they have an adequate response and decreased disease activity. That's great, you just continue to monitor them. If they have an inadequate response, you are going to either add more medications or switch medications.
This is a complicated slide. However, it's really not hard to understand, it's very much what I just said. But it includes a little bit more of what medications are recommended by the American College of Rheumatology. We are going to institute generally Methotrexate first, titrate that up as high as possible, monitor the patient; and if the patient is not responding, we can either increase the dose of Methotrexate or add another DMARD or add a biologic agent.
Treatment Options: Summary

- **Anti-inflammatory medications:** analgesics, Non-steroidal anti-inflammatory drugs (NSAIDs), steroids
  - Reduce pain, swelling, and inflammation
  - **Do not** stop joint damage or slow down disease progression
- **Disease-Modifying Anti-Rheumatic Drugs (DMARDs)**
  - Improve symptoms; can alter disease progression and produce durable remissions
  - Can be used concomitantly with the newer, biologic DMARDs
- **Biologic DMARDs approved for treatment of RA**
  - Tumor Necrosis Factor (TNF) blockers
  - T-Cell modulators
  - B-Cell blockers

So the anti-inflammatory medications that most patients are going to be offered and often may have been started in their primary care physician’s office are going to be analgesics NSAIDs, and often a primary care doctor may start them on steroids, prednisone primarily. And those work well to reduce pain and swelling and inflammation, but they do not do anything to hold the disease. So if you think about that chain and all the different links of the chain being cytokines and cells, there is nothing in any of the anti-inflammatories that are going to break that chain. They may make the links smaller or bigger, but they do not break the chain. The DMARDs, however, can break the chain. But it's not always clear how they do it, and it's sort of hit or miss. So, again, if we go back to our chain, it might be like throwing a rock at it and just hoping that we get a link broken. Our third group of drugs, biologic DMARDs, they will break the chain and they will target a specific link in the chain, and we will review that.
Methotrexate (MTX)

- Mechanism of action in RA not completely understood
  - May be related to the interruption of adenosine and possible effects on TNF pathways
- Side effects: stomatitis, mild alopecia, GI
  - Rare side effects: hepatic cirrhosis, interstitial pneumonitis, severe myelosuppression
- Dosing begins at 10 to 15 mg per week with a dose escalation up to 25 per week. MTX can be given orally or by injection
- Because of the folic acid antagonistic properties, folic acid is generally prescribed. Folic acid is given at a dose of 1 mg daily. The injectable form may quell complaints of nausea and/or diarrhea

Methotrexate is our most common medication that’s going to be started once the patient has been diagnosed with Rheumatoid Arthritis. It’s not totally clear how Methotrexate works in the body, but it does seem to interrupt the adenosine and TNF pathways. Side-effects of Methotrexate are nausea, vomiting, mild hair loss, some other GI upset, often, sometimes diarrhea. There are very rare side-effects with Methotrexate but they have to be paid attention to; for example, hepatic cirrhosis and Pneumonitis, you may have heard the term Methotrexate lung which is a Pneumonitis that can be a side-effect of Methotrexate. Also, you are going to watch liver enzymes because this can be hepatotoxic. Often, this is dosed at 10 to 15 mgs a week when it is first initiated. It would be escalated up to about 25 mgs per week maximum. It can be given orally or it can be given by injection. Methotrexate does interfere with folic acid in the body, so folic acid is prescribed and generally given at a dose of 1 mgs a day. Patients who have persistent GI complaints and nausea can often still use Methotrexate if they switch to the injectable form.
About 70% of patients do respond to Methotrexate. It has a fairly quick onset of action, about four to six weeks, and many people tolerate Methotrexate for a long period of time. Often you will see patients on Methotrexate for better than five years. Methotrexate is a great drug to use in conjunction with other drugs. Other drugs do not interfere with Methotrexate and Methotrexate does not interfere with those. And actually, what works for you later is that Methotrexate is often recommended with some medication. An important thing to remember about Methotrexate is that it’s known to cause birth defects. Patients need to be counseled that they have a fail-safe form of birth control while on Methotrexate. A period of about three months is required to watch Methotrexate out of the body before attempting conception.
Leflunomide

- Alternative for patients inadequately controlled with MTX
- Can be combined with MTX in patients with no preexisting liver disease
- Dosage: 20 mg/day. 10 mg/day if unable to tolerate higher dose
- Mechanism of action: possibly inhibits tryosine kinase activity and de novo pyrimidine biosynthesis; possibly inhibits mitogen and IL-2 stimulated T cells
- Side effects: elevated liver function tests (LFTs), mild diarrhea, GI upset, alopecia
- Considered a teratogen; women of childbearing potential or men with partners of childbearing potential must practice effective birth control cholestyramine washout if attempting pregnancy

Leflunomide is used for patients who cannot tolerate Methotrexate and also can be used in combination with Methotrexate. Again, you would want to monitor liver function test above on Leflunomide. Leflunomide does cause birth defects. Patients who use Leflunomide, who would like to attempt pregnancy, must have a cholestyramine washout.
Hydroxychloroquine

- Limited effectiveness
  - Sometimes combined with MTX or as a part “triple therapy” with MTX and sulfasalazine
- Dosage: 400 mg/day in either a single dose or divided doses twice per day
- Two to four month response time
  - No response after five - six months should be considered a drug failure
- Side effects: Ocular toxicity while rare, is the most important side effect

Hydrochloroquine is an antimalarial that is often used for patients with a very mild case of Rheumatoid Arthritis or before it is really proven what the diagnosis is. It can be used alone or with triple therapy, which would combine Hydrochloroquine, Methotrexate and Sulfasalazine. It’s dosed at 400 mgs a day. It can be taken in one dose or can be divided. After about four months, if there is no true response to this drug, it is considered a failure. While there are some rare problems with ocular toxicity, it is important that the patient received a full eye exam before beginning this medication.
Sulfasalazine, again it’s a commonly used DMARD, can be used alone or again in triple therapy with Methotrexate and Hydrochloroquine. The dose is usually 1.5 gm a day, it can be divided and it can also be titrated. It takes about six weeks to three months to see any effects from this drug. Allergic reactions are not uncommon, especially in patients who have already had an allergy to sulfa drug.
Scenario 2: Medication Education

“What should I know about my medications?”

- Stress birth control in childbearing women and men using MTX or leflunomide
- Limit alcohol intake with MTX, leflunomide
- Regular monitoring of comprehensive metabolic panel (cmp), complete blood count (cbc), C-reactive protein (crp), erythrocyte sedimentation rate (esr)
  - 1½ - 2 time upper limit for LFT’s requires action
- Remind patient of once weekly dosing for MTX
  - If unable to tolerate side effects of MTX – suggest injectable form

So scenario two medication education; a patient might ask what do I need to know about my medication. One of the most important things to stress the patients is birth control, especially in the presence of Methotrexate or Leflunomide. You want to limits your alcohol intakes to one to two drinks a week if you are on either Methotrexate or Leflunomide. There would be regular monitoring, especially of liver function test, but complete metabolic panel, complete blood count, the C-reactive protein and sed rates are usually going to be done often about every six to eight weeks. This will not only show toxicity but improvement in disease activity. Patients are often confused about Methotrexate only being dosed one time a week rather than everyday.
Biologic DMARDs are newest and latest treatments for Rheumatoid Arthritis and the first group to be approved for the Tumor Necrosis Factor-Alpha inhibitors, TNF inhibitors. And those have come on the market, they have been on the market almost 10 years now. Etanercept, Infliximab and Adalimumab are the three TNF inhibitors that are FDA approved. They are very similar in efficacy and they are very similar in time-to-response. The onset is very quick between one and four weeks. Patients will often know right away whether they are going to respond to this medication. They can be used alone or in combination with Methotrexate. Infliximab is FDA approved to be used with Methotrexate.
The side-effects of the TNF-Alpha inhibitors are all very similar. There is an increased risk for infection, especially respiratory. We have seen a reactivation of Hepatitis B in some of these subjects, and screening for Hepatitis B before beginning in TNF inhibitor is highly recommended. Latent Tuberculosis is another disease that we have seen with patients taking TNF inhibitors. All patients should have a TB screening before beginning. Any patient who has been exposed to TB, however, can take any TNF inhibitor as long as INH is begun it.
One of the newer drugs that has been approved is a T-cell blocker, Abatacept. Abatacept can be used as initial therapy or for patients who have failed a TNF inhibitor. This is given by IV Infusion once a month. There is a loading dose period. The dosing is based on body weight and is approximately 10 mgs per kilogram. There is a response seen typically about three months and that response could continue during the first year. The side-effects of Abatacept are somewhat similar to TNF inhibitors. Infections are increased, especially respiratory infections, and patients with COPD should be monitored with extreme caution. In some cases, COPD has been exacerbated in patients receiving Abatacept. Infusion reactions with this drug are very mild.
**B-Cell Depletion**

**Rituximab**

- Patients who have failed TNF antagonists
- Response time – three months post infusion
  - May last six months to two years following a single course
- **One course = two doses**
  - Each dose, 1000 mg, given two weeks apart
    - Three – four hour infusion
    - Recommended premeds: corticosteroids, diphenhydramine and acetaminophen
  - Side effects

Rituximab is a newer medication approved for the treatment of RA. It is a B-cell depletory and it is for patients who have failed TNF antagonist. The response time is similar to Abatacept about three months after the infusion. The response can last anywhere from six months to two years. It is given in courses. One course of Rituximab equals two doses of 1000 mgs of medication given two weeks apart. The infusions last about three to four hours and there are recommended premedications given before the infusion of steroids diphenhydramine and acetaminophen. The side-effects are similar to any of the other biologics, which is an increased rate of infections, especially respiratory, and infusion reactions have been seen with Rituximab, especially with the first infusion.
Many new biologics are being studied right now and there are quite a few in Phase II and Phase III study phases. There are three that probably will get FDA approval this year. One is Certolizumab Pegol and that is an injectable TNF antagonist. Denosumab is an injectable RANKL inhibitor, and Tocilizumab is an infused IL-6 blocker. And all of these show promise.
Scenario 3: Medication Education

“How do I decide which biologic is right for me?”

• Insurance considerations
• Discuss delivery methods, dosing schedules, time to response, side effects
• Identify lifestyle influences – travel, fulltime employment, child care needs, transportation
• Identify particular fears - self injection, IV’s
• Discuss safety profiles

So scenario 3, a patient may ask you once they have failed Methotrexate or they may need a little boost to what they are currently doing how to decide which biologic is the right biologic. I think the very first thing we then have to do, which is unfortunate in this country, is look at the insurance program that that particular patient has. Insurance may cover an infused product and not an injectable product, or an insurance company may have a preferred injectable. If we have an equal playing field, what I like to do is discuss the different delivery methods whether a patient is interested in something that’s injected or whether they would prefer something infused. I talk about dosing schedules; for example, a drug that’s taken every four weeks by IV versus a drug that’s given every one to two weeks by injection. Side-effects always have to be covered. Identified lifestyle influences; for example, if this is a patient that has the young children and it’s going to be difficult to come into an infusion center periodically, if this is a patient that travels with their job all the time and may not be able to meet a particular type of scheduling. Some patients may have fears of a particular delivery system, self injection or they may have a fear of IVs. The injectable drugs that are on the market right now with FDA approval do have a pen and auto inject type delivery method which is sometimes tolerable to patients. And you need to discuss the safety profile of all these drugs. Patients need to understand that they could have infusion reaction. They shouldn’t be surprised and they should be given very reasonable expectations. We do not want patients to have an unreasonable expectation of how well they will feel in an unreasonable timeframe.
Psychosocial Concerns

Pain and Fatigue impacts entire well being:

• Look for signs/symptoms of depression
• Address activities of daily life (ADL’s) – refer to occupational therapy (OT) for assistive devices, home evaluation
• Discuss patient support systems – family, spouse, co-workers, Arthritis Foundation
• Evaluate sexual history

Important area for nurses to address with patients with Rheumatoid Arthritis are the psychosocial issues. Pain and fatigue are a huge, huge part of this disease and cannot be ignored, especially the fatigue part. Patients don’t understand why they just have no energy to do what they used to do. I think it’s important for us to look for signs and symptoms of depression versus just fatigue. We need to address patient’s activities of daily living. We can refer to occupational therapy, first assistive devices. Occupational therapy can go in and do home evaluations for patients, suggest changes like grab rails, etc. We can discuss with patients how important it is to involve their family. There are a lot of patients who are unwilling to admit that they can’t do what they used to do. But they are encouraging and supporting your patients in being honest with family about how much of a toll this disease has taken is really an important thing that the nurse can do. We can refer patients to the Arthritis Foundation. They may have support groups in your area. The National Arthritis Foundation is a wealth of information for patients. Another part of our psychosocial concerns are intersexual history. This is a difficult thing to bring up to patients, but it’s often a very important part of their relationship with their spouse and should not ever be ignored.
“It is hard to define my role: I am an educator, counselor, IV nurse, and patient advocate in an area of medicine that is changing almost daily?”

- Find credible resources for education – do not rely on sale representative for your education!

So this little scenario was not what a patient may ask but it may be what some nurses feel. They feel it’s very hard to figure out what their role is. If you think back 10 years, there was probably not a great need for nurses in the rheumatology arena. But things have changed so rapidly and we have a hard time exactly finding our place and what we should be doing. So we feel like an educator, a counselor, an IV nurse or a patient advocate. We answer phone calls. We triage. We have incredibly busy and ever changing schedules.
So what do we do as nurses? Well, one thing we need to do is find credible resources to educate ourselves. Unfortunately, a lot of what we have learned is coming from sales representatives, which is not ideal by any means, but they are the ones that understand what these new drugs are. So we need to find somewhere else to go to get objective information. So the resources that I have outlined on this slide can be helpful to people. The Rheumatology Nurses Society, they are working on all of these issues for nurses and for other health care professionals. The Arthritis Foundation is a wealth of information, not only for the nurse to get some really basic information but also to find information to share with their patients. Johns Hopkins University has an exceptional website that is, about 80% dedicated to the professional. So there are lots of places on that website if you search through that you can find updates on disease and treatment. The American College of Rheumatology Health Professionals site has excellent downloadable patient handouts available, and you do not have to be a member to get on to that website to download any of those handouts.
Case Study: Mrs. J

• 26 year-old woman, newly diagnosed with RA
  – Extreme fatigue and pain, swollen and tender metacarpal/tarsal phalangeal (MCPs/MTPs), elevated CRP and ESR

• Treatment options offered by Rheumatologists
  – MTX
  – SSZ + hydroxychloroquine
  – TNGα inhibitor

• You are available to talk with Mrs. J and answer her questions

So, in order to sum up everything we have discussed, we are going to have a case study here. Ms. Jay is a 26-year-old woman, nearly diagnosed with RA, and she has the typical newly-diagnosed symptoms of fatigue and pain, swollen and tender joints of her feet and her hands and an elevated sed rate and CRP. She sees a rheumatologist and she is offered the following drugs; Methotrexate or a combination of Sulfasalazine and Hydroxychloroquine or a TNF inhibitor. So, as the nurses are available to talk with Ms. Jay and answer some of her questions.
“Will I end up in a wheelchair?”

A. “I hope not. Most people don’t end up in wheelchairs.”
B. “It is unlikely. There are many new medications available. We will all work together to develop the right treatment for you.”
C. “It depends on how well you listen to the doctor’s instructions.”
D. “I don’t know, it is always a possibility.”

Here is her first question. Why end up in a wheelchair? What do you think would be the best response?
(a), I hope not, most people don’t end up in wheelchairs anymore;
(b), it is unlikely, there are many new medications available and we will all work together to develop the right treatment for you;
(c), it depends on how well you listen to the doctor’s instructions;
(d), I don’t know, it is always a possibility. So what do you think would be the appropriate answer?
Mrs. J: Question One

- Answer to question one: B – “It is unlikely. There are many new medications available. We will all work together to develop the right treatment for you.”
  - Spend time recognizing influencing factors in the treatment decision. Review each medication and its advantages and disadvantages
- Influencing factors in this case
  - Mrs. J is working full time, insurance coverage is above average, and has a three year old son
- Question Two: “Are any of the medications suggested going to cure me?”
  - HOW DO YOU RESPOND?

The answer to question 1 is going to be (b), it is unlikely, there are many new medications available and we will all work together to develop the right treatment for you. You need to spend time recognizing what the influencing factors are in the treatment decision. This is a good time to be able to review each of the medications, what its advantages and disadvantages are. And how if one medication doesn’t work, there is another one that you can switch to.
Mrs. J: Question Two

“Are any of the medications suggested going to cure me?”

A. “There is currently no cure for RA, but we will aim for clinical remission.”
B. “Yes, we just have to find the right one for you.”
C. “No, the best we can do is manage your pain.”
D. “Maybe, it is too early to tell.”

Let’s move on with Ms. Jay. We are going to try to look at what these different medications are. We have reviewed all the medications with her, and we find out that she is a full-time working mother of a three-year-old, but she has pretty good insurance coverage. So we are not going to have to worry about which medication she would have to take because of her insurance carrier. So question 2, are any of these medications that he is offering going to cure me? Would you say (a), there is currently no cure for RA but we will aim for clinical remission; (b), yes, we just have to find the right one; (c), no, the best we can do is manage your pain; or (d), maybe it’s too early to tell.

What do you think would be the appropriate response?
Mrs. J: Question Two

• Answer to question two: A – “There is currently no cure for RA. We will aim for clinical remission.”
  – Spend time explaining that this is a lifelong disease. Show visuals if possible. Review bone damage cannot be repaired
• Mrs. J reviews options and thinks she has made a decision
• Question Three: “I think I will try methotrexate for now. Once I get pregnant I will stop all medications. I might try something else after I have another baby.”
  – HOW DO YOU RESPOND?

The appropriate response is going to be instructor (a), there is currently no cure for RA but we will aim for clinical remission. This is a good time to spend with the patient explaining that this is a life-long chronic disease. You would want to show visuals if possible. This is where you are going to maybe use the chain analogy. You can discuss bone damage and how that cannot be repaired.
Ms. Jay reviews all of her options and so now, she thinks she has got a decision. And her decision is she wants to try Methotrexate. So her question is I am going to try Methotrexate and then once I get pregnant, I will stop all my medicines and then after I have my baby, I will try something else. What do you think you should respond with?

(a), agreed, I will have the doctor write your prescription;
(b), okay, but I would have chosen something else;
(c), are you sure you have thought this through, why don’t you talk about it with your husband; or (d), Mrs. Jay, Methotrexate is known to cause birth defects, you must have discontinued this medicine for at least three months before trying to get pregnant. If you choose to start Methotrexate, make sure you were using birth control.

What do you think would be the appropriate response to this question?
Mrs. J: Question Three

- Answer to question three: D – “Mrs. J, methotrexate is known to cause birth defects, you must have discontinued this medicine for at least three months before trying to get pregnant. If you choose to start methotrexate, make sure you are using birth control.”

- Chances are you would have already reviewed these side effects of methotrexate with the patient; however, this is a very common scenario as the amount of information given to a patient, especially a new patient, can be overwhelming.

(d), Mrs. Jay, Methotrexate is known to cause birth defects, you must have discontinued this medicine for at least three months before trying to get pregnant, if you choose to start Methotrexate, make sure you were using birth control. Chances are, we have already reviewed the side-effects of Methotrexate, but remember, this is a very common scenario because the amount of information patients receive with this new diagnosis is overwhelming. So, it may not have clicked in but this was one of the medications she could not attempt the pregnancy with.
The rheumatology nurse is a vital member of the health care team. Keeping abreast of current treatments, educating patients on RA and medications, addressing psychosocial concerns, monitoring disease activity, and assisting in treatment decisions are just a few of the roles the nurse can anticipate in this developing medical specialty.

It is exciting time to work in Rheumatology with new treatments offering a promise of hope for those patients with a (until now) devastating diagnosis.

On a final note, I just want to let people know that I think it’s very exciting to be Rheumatology Nurse. I have been doing this for eight years. I have seen new treatments come one after another, and I have seen hope given to patients that had no hope. I really encourage all of you to embrace this wonderful field and continue to work with these great patients.
Thank you so much for joining us today.