

Achieving evidence for the management of arthralgia at risk for RA. Response to: 'The cost of arthralgia 'pretreatment' to prevent rheumatoid arthritis' by Rothschild

We read the letter from Rothschild with interest.¹ We agree that we need more data and better evidence on: (1) how to determine the risk of patients with arthralgia progressing to 'true RA' and on (2) whether or not Disease Modifying AntiRheumatic Drug (DMARD) treatment is better than placebo in this phase. Both points were discussed in our Viewpoint.² Cost-benefit analyses can only be performed afterwards.

Rothschild seems to agree with us not to condone treating patients presenting with arthralgia with DMARDs, pending further evidence. Still, there are different opinions in the field. This is illustrated by a recent study from the UK, in which rheumatologists were asked about their management in clinical practice of arthralgia patients with positive anti-cyclic citrullinated peptide antibodies antibodies and signs of synovitis on power Doppler in at least one joint, but in the absence of clinically apparent arthritis. Seventy-one per cent of consultants said to start DMARD treatment, 16% would treat with glucocorticoids only, 8% considered inclusion in a clinical trial and only 3% replied to wait and see without immediate initiation of DMARD treatment.³

We believe it may be harmful if the rheumatic field gets too comfortable with initiating DMARD treatment already in arthralgia patients with a certain risk of developing true rheumatoid arthritis (RA) without solid proof. Such a behaviour hampers the course of observational studies to properly determine the risk of RA in individual patients. Hindering the natural course of patients in observational studies with DMARD treatment means that we will never be able to know which patients are being overtreated. Importantly, the regular use of DMARDs in this setting may also hinder the inclusion of arthralgia patients in ongoing and future placebo-controlled trials, as this will then be considered increasingly counterintuitive or unethical because physicians in daily clinical practice may increasingly consider DMARD treatment standard of therapy.

Annette van der Helm-van Mil^{1,2} Robert BM Landewé^{3,4}

¹Rheumatology, Leiden University Medical Center, Leiden, The Netherlands

²Rheumatology, Erasmus Medical Center, Rotterdam, The Netherlands

³Amsterdam Rheumatology Center, AMC, Amsterdam, The Netherlands

⁴Rheumatology, Zuyderland MC, Heerlen, The Netherlands

Correspondence to Professor Annette van der Helm-van Mil, Rheumatology, Leiden University Medical Center, 2333 ZA Leiden, The Netherlands; A.H.M.van_der_Helm@lumc.nl

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ORCID iD

Annette van der Helm-van Mil <http://orcid.org/0000-0001-8572-1437>

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