

QUANTITATIVE MEASURES IN A RHEUMATOLOGY PRACTICE IT'S TIME TO USE ONE

We as rheumatologists measure and monitor diseases quite differently than other chronic illnesses like hypertension, diabetes and asthma.

During the past 20 years we have come to understand that there is no perfect gold standard test that monitors disease activity in our diverse group of patients with various rheumatic diseases.

The many old and new laboratory tests are not as sensitive or specific that we would like.

X-rays often lag behind the changes in disease and do not adequately reflect the structural damage that has occurred. Ultrasound and MRI may provide a more precise image. However, their cost and access can be a problem.

What we as clinicians are looking for is a reliable, easy, validated and relatively inexpensive tool that can aid us in monitoring disease activity.

Disease activity measurements fill this role quite well and can also be used to assist in changing and monitoring patient treatment. There have been numerous studies that show excellent correlation between disease activity measurements predicting high and low clinical disease activity.

Today there are many quantitative measurements for us to use in daily practice.

Examples include the Health Assessment Questionnaire (HAQ) or RAPID which are primarily patient driven. The HAQ is now almost 30 years old. There are 20 activities of daily living with four levels of response to describe each activity, without any difficulty (0); with some difficulty (1); with much difficulty (2) and unable to do (3).

These activities are then classified into 8 categories of 2 or 3 each.

The HAQ disability score is the mean of the highest of 0-3 scores in each of the 8 categories. The modified HAQ (MHAQ) developed later and can be scored in much less time and is more patient friendly.

The Disease Activity Score (DAS-28) includes 28 tender and 28 swollen joint count, a sedimentation rate ESR or CRP and a patient global estimate. The scoring, however, does require a calculator based on its formula.

The Clinical Disease Activity Index or CDAI involves 28 tender and swollen joints and a physician global estimate. It is much simpler to calculate than the DAS.

In a report by Dr. Ted Pincus of a large group of practicing rheumatologists when queried about how often they did a formal tender and swollen joint examination almost 45% rarely performed these regularly at patient visits.

We in the rheumatology community need to show our patients and ourselves that we are the primary physicians who understand and examine the musculoskeletal system and evaluate the joint regularly and report these findings with each patient visit. It has been estimated that the average time to perform a HAQ is about five minutes. Compared to scoring, a DAS takes about 2 minutes and a RAPID 3 about 5 seconds.

Numerous studies have validated that each of these quantitative measurement tools is more precise and accurate in evaluating patient disease activity than our current methods, i.e. laboratory or x-ray.

During the past 12 years I have incorporated patient assessment tools into my daily practice and have used the RAPID 3 routinely on all patients. This can be adapted to patients who have osteoporosis and fibromyalgia as well.

We review the results with patients, discuss the findings and compare previous results. These help to direct the examination and enrich the patient interaction. Often issues that might not have been addressed are discussed. The patient also sees that his or her care is better directed to a target with these tools being one of the more important goals of treatment.

The use of quantitative measurement reinforces the physical examination which we perform and improves on our clinical judgment and assessment. The consequences of this practice are a more objective and focused level of patient care that enhances treatment.

As we have all seen in recent years, third party payers are continually reviewing our care of patients. By providing these objective written questionnaires,

along with our progress notes, we can be educating payers about the standard of care that rheumatologists provide to patients with musculoskeletal disease and how this is different and more comprehensive than what is rendered by other health care providers.

In summary, the use of quantitative measures not only offers invaluable information about the patient, it also provides significant prediction regarding outcomes in patients who have inflammatory arthritis regarding functional status, work disability and cost. All of these issues provide important information regarding the status of our patients and help direct and guide towards better patient care.

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