

# VCH Family Practice Rounds - Oct 09, 2024

## Rheumatology – Dr. Kam Shojania

### Key takeaways

- Comorbidities in rheumatoid arthritis (RA) include cardiovascular disease, osteoporosis, infections, and depression
- Exercise is crucial for managing RA and reducing inflammation
- Steroids should be used cautiously due to numerous side effects
- Disease-modifying antirheumatic drugs (DMARDs) and biologics are important treatment options
- Screening for comorbidities and managing lifestyle factors are essential in RA care
- New quaternary clinics and research projects are available at the arthritis center

### Discussed topics

#### Comorbidities in rheumatoid arthritis

Dr. Shojania discussed the main comorbidities associated with RA and similar conditions.

- **Details**
  - Cardiovascular disease, osteoporosis, infections, and depression are the most common and manageable comorbidities
  - Psoriatic arthritis is associated with more metabolic syndrome
  - Lupus has more cardiovascular and osteoporosis association
- **Conclusion**
  - Screening for and managing these comorbidities is crucial in RA care
  - Different autoimmune conditions may have varying comorbidity profiles

#### Treatment approaches for rheumatoid arthritis

Dr. Shojania explained various treatment options and their considerations.

- **Details**
  - Goal is remission, especially for early RA
  - NSAIDs are rarely used due to toxicity concerns
  - Steroids have numerous side effects and should be used cautiously
  - DMARDs and biologics are important treatment options
- **Conclusion**
  - Early aggressive treatment can lead to better outcomes
  - Careful consideration of medication side effects is necessary

#### Lifestyle factors in managing rheumatoid arthritis

The importance of lifestyle modifications in RA management was discussed.

- **Details**
  - Exercise, including strengthening and cardio, reduces inflammation
  - Smoking cessation, weight management, and a healthy diet are crucial
- **Conclusion**
  - Lifestyle changes can significantly impact RA management
  - Doctors should regularly discuss and encourage these modifications with patients

## **Cardiovascular risk in rheumatoid arthritis**

Dr. Shojania explained the increased cardiovascular risk in RA patients.

- **Details**
  - RA patients have a 1.5 times higher cardiovascular risk compared to the general population
  - This risk is similar to that of diabetes
- **Conclusion**
  - Regular monitoring of cardiovascular risk factors is essential in RA patients
  - Management should include addressing modifiable risk factors

## **Osteoporosis in rheumatoid arthritis**

The increased risk of osteoporosis in RA patients was discussed.

- **Details**
  - RA and steroid use increase the risk of osteoporotic fractures
  - FRAX tool can be used to assess fracture risk
- **Conclusion**
  - Regular assessment of bone health is important in RA patients
  - Treatment decisions should consider individual risk factors

## **Infection risk in rheumatoid arthritis**

Dr. Shojania addressed the increased infection risk in RA patients, especially those on certain medications.

- **Details**
  - Patients on biologics have increased risk of various infections
  - Screening for latent TB and hepatitis is important before starting biologics
- **Conclusion**
  - Regular monitoring for infections is crucial in RA patients
  - Vaccination and infection prevention strategies should be implemented

## **Depression screening in rheumatoid arthritis**

The importance of screening for depression in RA patients was discussed.

- **Details**
  - PHQ-2 and PHQ-9 can be used for depression screening
- **Conclusion**
  - Regular depression screening should be part of RA care
  - Early identification and management of depression can improve overall outcomes

## **Management of long-term steroid use**

Dr. Shojania addressed the issue of patients on long-term steroid therapy.

- **Details**
  - Shared decision-making with patients is important
  - Tapering strategies should be individualized based on patient factors
- **Conclusion**
  - Long-term steroid use should be minimized when possible
  - Careful tapering and monitoring are necessary when reducing steroid doses

## **Autoimmune disease overlap**

The overlap between various autoimmune conditions was discussed.

- **Details**
  - Certain autoimmune conditions tend to cluster together
  - Patients with one autoimmune condition may be at risk for developing others
- **Conclusion**
  - Clinicians should be aware of potential overlaps between autoimmune conditions
  - Regular monitoring for signs of other autoimmune diseases is important

## **Rheumatological conditions in Indigenous populations**

Dr. Shojania addressed considerations for managing rheumatological conditions in Indigenous populations.

- **Details**
  - Traveling clinics are available for remote communities
  - Arthritis wellness programs have been developed for Indigenous communities
- **Conclusion**
  - Culturally sensitive approaches are important in managing rheumatological conditions in Indigenous populations
  - Community-based programs can improve access to care and education

## **New developments at the arthritis center**

Dr. Shojania shared information about new clinics and research projects.

- **Details**
  - New quaternary clinics for complex conditions like lupus and vasculitis
  - Fast-track giant cell arteritis clinic has been established
- **Conclusion**
  - Specialized clinics can improve management of complex rheumatological conditions
  - New initiatives aim to reduce hospital stays and improve patient outcomes

## **Q & A summary**

### **Steroid management in long-term patients**

**Q:** How do you approach managing patients who have been on steroids for a long time (5-10 years) as part of their therapy?

**A:** I use shared decision-making with the patient. For younger patients (e.g., 50 years old), I strongly encourage tapering off steroids. For older patients (e.g., 80 years old), I discuss the risks and give them options. I explain the tapering process, potential discomfort, and the importance of adrenal gland function. I tailor the approach based on the patient's age and preferences.

### **Autoimmune disease correlations**

**Q:** Is there any correlation between rheumatoid arthritis and other autoimmune diseases like thyroid disease, diabetes, or IBD?

**A:** Yes, there are correlations. I use a "4 circles" concept to explain overlaps. Psoriatic arthritis, ankylosing spondylitis, inflammatory bowel disease, and reactive arthritis often overlap. Another

group includes lupus, scleroderma, Sjögren's syndrome, and dermatomyositis. These high-antibody diseases often coexist with autoimmune thyroid disease, alopecia areata, vitiligo, and autoimmune hepatitis. Psoriatic arthritis is less associated with these antibody-mediated conditions.

### **Pulmonary involvement in autoimmune conditions**

**Q:** What about the overlap of autoimmune conditions with pulmonary fibrosis or sarcoidosis?

**A:** Most rheumatic diseases have some pulmonary involvement, including interstitial lung disease, airway disease, and pulmonary artery system involvement. This is common in rheumatoid arthritis, lupus, and dermatomyositis. Sarcoidosis has less overlap but can present with autoimmune rheumatic diseases. We are working closely with respiratory colleagues and planning to open a combined rheumatology-respiratory clinic.

### **Stopping medications during hospitalization**

**Q:** Why do you recommend stopping DMARDs and biologics when patients are hospitalized?

**A:** I recommend stopping these medications due to potential drug interactions, difficulty in administering biologics in the hospital, and to simplify management during hospitalization. The exception is steroids, which may need adjustment. I restart the medications once the patient is stable and safe.

### **Steroid dosing during illness**

**Q:** How much steroid does a patient need to be on for you to worry about increasing the dose when they're sick, and what kind of sickness warrants an increase?

**A:** I suspect we often overtreat with steroids. I only increase the dose if the patient is septic, very sick, or unstable (e.g., in step-down or ICU). For cardiovascularly unstable patients, I increase the dose to avoid potential Addisonian crisis. Any dose of prednisone (even 5mg) can lead to adrenal insufficiency when sick, so stress dosing (e.g., 100mg hydrocortisone IV twice daily or increasing prednisone to 20mg daily) may be necessary.

### **Management of Indigenous patients with rheumatic diseases**

**Q:** Any pearls regarding conditions and management for Indigenous patients? Should we screen all Indigenous patients for HLA-B27, even if asymptomatic?

**A:** We have traveling clinics to about 35 towns and villages in BC, many of them First Nations communities. I recommend referring Indigenous patients to the nearest Mary Pack clinic for screening. I wouldn't screen everyone for HLA-B27 if asymptomatic, but maintain a high suspicion and thorough examination. We've developed an arthritis wellness program with First Nations communities, involving weekly meals and health discussions. This program is expanding to more communities to provide safe and relaxing assessment and information sharing.

### **Vaping vs. smoking in autoimmune diseases**

**Q:** Can you comment on the impact of vaping versus smoking on autoimmune diseases?

**A:** We don't have enough data yet, but it appears that vaping is not as bad as smoking for triggering antigens in the lungs and autoimmune disease. Vaping is probably better than smoking in terms of autoimmune diseases, but more research is needed.