



ASK DR. BOB . . .

with Dr. Bob Frank

RHEUMATOID ARTHRITIS

I have heard an agent ask, "Why is this person who has rheumatoid arthritis, but otherwise healthy, being rated"? This is a fair question, so I thought it would be good to discuss rheumatoid arthritis, especially since there have been new medications developed in the last several years that can have a profound impact on the disease. Rheumatoid arthritis is a somewhat common disease with a prevalence of 1% in adults. The majority are females, with the usual onset between 25 - 45 years of age, but the incidence does increase the older one becomes. It usually is a chronic progressive disease, often leading to disability. The cause is unknown, but there is a strong genetic influence along with some type of environmental influences, which so far are not clearly identified. Overall, 15-20% have mild stable disease, 70-75% have chronic disease with intermittent flairs, and a small 10% have progressive disease leading to significant disability within a few years.

In the past, many people thought to have rheumatoid arthritis probably suffered from some other type of rheumatic disorder. The American Rheumatism

Association has seven specific criteria, which clinicians can use to arrive at a more precise diagnosis. These criteria include morning stiffness, arthritis of three or more joint areas, arthritis of the hand joints, symmetrical arthritis, the presence of rheumatoid nodules, the presence of rheumatoid factor on blood testing, and radiographic changes of the joints. Other diseases that can be confused with RA include lupus, gout, acute infectious arthritis, reactive arthritis, and a host of other uncommon diseases. In RA, the rheumatoid factor (immunoglobulins that react with other immunoglobulins) causes a cascade of inflammation to develop that involves the synovium of joints, later leading to damage of the bone and cartilage. There can be manifestations of RA outside of the joints, including enlarged lymph nodes, eye irritation and dry eyes, lung disease, inflammation of the heart, and inflammation of the vessels referred to as vasculitis. These extra articular manifestations usually mean more serious disease with a worse prognosis.

In the past, there has been a lack of good drugs for treatment of this disease. Steroids could relieve the symptoms, but had serious long-term side effects and did nothing to alter the long-term progression of the disease. The mainstay of therapy, the non-steroidal anti-inflammatory drugs such as aspirin and ibuprofen, are still used. In mild cases, no other type of treatment is often necessary. In the majority of individuals, a second line of therapy is necessary. Second line drugs in the past often provided only mild to moderate efficacy. The new concept regarding treatment of RA is the use of disease modifying drugs. By this it is meant drugs that actually prevent progression of the disease and the progressive joint destruction, where treatment in the past simply alleviated the symptoms. The current mainstay of the disease modifying drugs is methotrexate, which has been used for many years in chemotherapy of cancers. Approximately 30% of individuals treated with methotrexate have a marked beneficial response. In the remaining 70%, third line drugs are often necessary. There are now three newer

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disease modifying drugs that have even more benefit than methotrexate. The drugs are all referred to as tumor necrosis factor inhibitors, and actually block the chemical mediators of inflammation. They include Kineret, Enbrel, and Remicade. The drawback is that they have to be given either intravenously or by injection, may have serious side effects, and are quite expensive. As more rheumatologists treat an increasing number of their rheumatoid patients with disease modifying drugs, we may see better results in the future.

The actual mortality implications of rheumatoid arthritis in the past was not fully recognized. More recent studies have suggested that overall there is a twofold increase in the mortality ratio, and that lifespan is decreased anywhere from 3-18 years in various studies. One reason the increased mortality was not recognized is that rheumatoid arthritis patients die of the same diseases as everyone else, but they do so at an earlier age. The main cause of death in these individuals is cardiovascular disease, with 15% dying of cancer and 10% of infection. Interestingly, we now know that cardiovascular disease is an inflammatory process (as discussed in previous FYI articles) and it

seems that the overall increased inflammation of the body in rheumatoid arthritis leads to increased inflammation in our hearts and arteries.

A worse prognosis is seen in individuals with a high titer of rheumatoid factor, the presence of rheumatoid nodules, multiple joint involvement and extra articular manifestations. All of this means an increased burden of inflammation. An underwriter needs to look at an individual's cardiovascular profile when underwriting rheumatoid arthritis, since this is the number one cause of death. There is an increased incidence of silent myocardial infarctions in rheumatoid patients. Complete responders to methotrexate may have a better long-term prognosis. Obviously, rheumatoid arthritis individuals are usually not insurable for disability. For life insurance, some may be insurable at standard rates if they have mild stable disease, while the majority will require a small rating.

I would be happy to discuss this topic or any other topic with anyone who has questions, and can be reached at ext. 2641.