LETTERS

Potential effects of a national consensus statement on optimal treatment of early rheumatoid arthritis in Ontario

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The Ontario Biologics Research Initiative (OBRI) represents a collaboration of stakeholders (rheumatologists, patients, and researchers) aiming to improve rheumatoid arthritis (RA) management. Goals include the provision of real-world surveillance and evaluation, through administrative database linkages.

Earlier population-based assessments have demonstrated that many Canadians are not provided optimal RA therapy (1, 2), especially older persons with RA (3). In 2004, the Canadian Rheumatology Association (CRA) convened an expert panel regarding optimal therapy in early RA. This led to the development and dissemination of a consensus statement; this reinforced the importance of early RA treatment, with methotrexate as the cornerstone. Our group recently examined Ontario provincial administrative data to determine whether appropriate drug therapy for older individuals with RA has improved since the CRA consensus statement was established. In light of the recent article by Carli et al (4), we thought it might be useful to report our findings, as they may shed additional light on the issues and questions at hand.

We assembled an incident RA cohort aged $\geq$65 years, using the administrative medical databases of the Ontario Health Insurance Plan (OHIP) for April 1998 to March 2007. In the province of Ontario, coverage for health services is universal. The OHIP physician billing database maintains information for physician services provided to all provincial beneficiaries, including physician diagnosis codes, provided as International Classification of Diseases (ICD) codes. Medication exposures were determined by the pharmacy claims database of the OHIP, which is limited to provincial residents aged 65 years or older. We relied on a standard algorithm (5) to identify RA patients within the OHIP billing data, based on at least two billing code diagnoses of RA (ICD code 714), $\geq$60 days apart but within 5 years. We further required the subjects to have had at least one prescription for an oral glucocorticoid, disease-modifying anti-rheumatic drug (DMARD), or biologic drug, in an effort to optimize our case definition specificity (6).

The cohort was stratified into three subcohorts, according to calendar year of RA diagnosis: 1997–2000, 2001–2003, and 2004–2006. We followed subjects for 1 year, and assessed whether a subject had been exposed to methotrexate (defined as $\geq$2 prescriptions). We then compared the percentage of early RA patients exposed to methotrexate over 2001–2003, vs. 2004–2006, calculating the difference, with 95% confidence intervals (CIs). However, to assess prescription trends that may have been unrelated to the consensus statement, we also looked for changes in 1997–2000 vs. 2001–2003.

The results suggested a significant increase in methotrexate use over 2004–2006, vs. 2001–2003. The percentage of early RA patients exposed to methotrexate in 2001–2003 was 16.8% (95% CI 15.4–18.3) compared to 28.4% (26.5–30.3) in 2004–2006. This substantial increase was statistically significant (11.5%, 95% CI 9.2–13.9). However, when we looked at early periods, the percentage of early RA patients exposed to methotrexate in 1997–2000 was 9.9% (95% CI 9.1–10.9), indicating a very slight increase during 1997–2000 vs. 2001–2003 (6.8%, 95% CI 5.2%–8.5%), even before implementation of the CRA consensus statement.

Carli et al (4) showed an upward trend in the prescription of DMARDs in Sweden since the implementation of national guidelines in 1998. Like them, we believe that a national guideline may lead to some improvements in RA care. However, we want to point out that, given the slight increase in use of methotrexate in our sample, which was evident even prior to the 2004 CRA guideline, other factors might explain some of our results. This possibility might be

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interesting to explore in the Swedish Rheumatoid Arthritis Register as well.

A final observation in our data is that most persons aged $\geq$65 years identified with early RA apparently still do not receive optimal care in Ontario. This problem has been noted in other Canadian provinces, including British Columbia (2) and Quebec (3), despite universal h\ealthcare access. This definitely calls for further efforts towards improving care in RA, especially for vulnerable populations such as older patients.

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Functional bowel symptoms and GnRH antibodies: common findings in patients with primary Sjögren's syndrome but not in systemic sclerosis

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Recently, we described the expression of gonadotrophin-releasing hormone (GnRH) in the gastrointestinal bowel wall, and showed how treatment with the GnRH analogue buserelin gave rise to antibodies against GnRH with destruction of GnRH-containing enteric nerves and gastrointestinal dysmotility (1). Primary Sjögren's syndrome (pSS) and systemic sclerosis (SSc) are characterized by the expression of various autoantibodies, and gastrointestinal complaints occur in up to 90% of SSc patients (2). Therefore, the aims of the present study were: (i) to examine the presence of autoantibodies against GnRH in patients with rheumatological diseases, and (ii) to relate the presence of such antibodies to gastrointestinal complaints. The study was approved by the ethical committee of Lund University.

Forty-six consecutive patients (43 women, mean age 49 $\pm$ 10 years, range 25–60 years) with a diagnosis of pSS (3) were included in the study. The duration of the disease was 14 $\pm$ 11 years (range 1–49 years). Forty-six age- and gender-matched healthy subjects were randomly selected from the Swedish general population registry to serve as controls for gastrointestinal complaints. The patients and controls had to complete a validated questionnaire, the Autonomic Symptom Profile, on autonomic nervous symptoms, including various gastrointestinal complaints (4). Irritable bowel syndrome (IBS) and functional dyspepsia (FD) were diagnosed in pSS patients and controls if the subjects fulfilled the Rome III criteria (5).

Fifty-five consecutive patients (45 women, mean age 58 $\pm$ 13 years, range 23–83 years) with a diagnosis of SSc (6) were included in the study. The mean duration of the disease, defined from the onset of skin involvement and of Raynaud's phenomenon, was 6 $\pm$ 7 years (range 0–32 years) and 8 $\pm$ 9 years (range 0–34 years), respectively. All patients were examined by cinefluorography and the existence of gastrointestinal symptoms, as well as comorbidities, was registered.