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**FOR IMMEDIATE RELEASE**

### **WHEN LESS IS MORE IN TREATING RHEUMATIC DISEASES**

**ATLANTA** – The American College of Rheumatology today announced a list of five tests and treatments commonly used in rheumatology whose use should be questioned and discussed between rheumatologists and their patients.

The list is currently published in the ACR's journal, *Arthritis Care & Research*, and was created as part of the ACR's participation in the American Board of Internal Medicine Foundation's *Choosing Wisely* campaign.

"The American College of Rheumatology and its members are committed to promoting dialogue between rheumatologists and their patients about appropriate care in rheumatology," explains ACR President, Audrey Uknis, MD. By joining 25 other medical societies, the ABIM Foundation, and *Consumer Reports* in this campaign, the ACR is continuing to define high-quality, high-value care for people with rheumatic diseases."

#### **Rheumatology's Top Five Things**

The ACR's Top Five list includes diagnostic tests and treatments that are commonly ordered/provided by rheumatologists, are among the most expensive services provided in rheumatology, and have been shown by the currently-available research not to provide any meaningful benefit to at least *some* major categories of patients for whom these are ordered without careful consideration.

The list includes the following:

#### **Don't test ANA sub-serologies without a positive ANA and clinical suspicion of immune-mediated disease.**

Tests for anti-nuclear antibody (ANA) sub-serologies (including antibodies to double-stranded DNA, Smith, RNP, SSA, SSB, Scl-70, centromere) are usually negative if the ANA is negative. Exceptions include anti-Jo1, which can be positive in some forms of myositis, or occasionally, anti-SSA, in the setting of lupus or Sjögren's syndrome. Broad testing of autoantibodies should be avoided; instead the choice of autoantibodies should be guided by the specific disease under consideration.

#### **Don't test for Lyme disease as a cause of musculoskeletal symptoms without an exposure history and appropriate exam findings.**

The musculoskeletal manifestations of Lyme disease include brief attacks of arthralgia or intermittent or persistent episodes of arthritis in one or a few large joints at a time, especially the knee. Lyme testing in the absence of these features increases the likelihood of false positive results and may lead to unnecessary follow-up and therapy. Diffuse arthralgias, myalgias or fibromyalgia alone are not criteria for musculoskeletal Lyme disease.

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### **Don't perform MRI of the peripheral joints to routinely monitor inflammatory arthritis.**

Data evaluating MRI for the diagnosis and prognosis of rheumatoid arthritis are currently inadequate to justify widespread use of this technology for these purposes in clinical practice. Although bone edema assessed by MRI on a single occasion may be predictive of progression in certain RA populations, using MRI routinely is not cost-effective compared with the current standard of care, which includes clinical disease activity assessments and plain film radiography.

### **Don't prescribe biologics for rheumatoid arthritis before a trial of methotrexate (or other conventional non-biologic DMARDs).**

High quality evidence suggests that methotrexate and other conventional non-biologic disease modifying antirheumatic drugs (DMARD) are effective in many patients with rheumatoid arthritis (RA). Initial therapy for RA should be a conventional non-biologic DMARDs unless these are contraindicated. If a patient has had an inadequate response to methotrexate with or without other non-biologic DMARDs during an initial 3-month trial, then biologic therapy can be considered. Exceptions include patients with high disease activity and poor prognostic features (functional limitations, disease outside the joints, seropositivity or bony damage), where biologic therapy may be appropriate first-line treatment.

### **Don't routinely repeat DXA scans more often than once every two years.**

Initial screening for osteoporosis should be performed according to National Osteoporosis Foundation recommendations. The optimal interval for repeating Dual-energy X-ray Absorptiometry (DXA) scans is uncertain, but because changes in bone density over short intervals are often smaller than the measurement error of most DXA scanners, frequent testing (e.g., <2 years) is unnecessary in most patients. Even in high-risk patients receiving drug therapy for osteoporosis, DXA changes do not always correlate with probability of fracture. Therefore, DXAs should only be repeated if the result will influence clinical management or if rapid changes in bone density are expected. Recent evidence also suggests that healthy women age 67 and older with normal bone mass may not need additional DXA testing for up to ten years provided osteoporosis risk factors do not significantly change.

“Rheumatologists care for patients with some of the most complex and poorly-understood diseases affecting human beings,” explains Rheumatologist Jinoos Yazdany, MD, who – along with Rheumatologist Charles King, MD – is the co-chair of the ACR’s ‘Top Five’ Task Force. “We were encouraged by the number of ACR members who participated in the process to create this list. Their willingness to share their breadth of knowledge gave the ACR an opportunity to create a list that will help to better define high quality, cost-effective care for people with rheumatic diseases.”

### **The Beginning of Conversations and Joint Decision Making**

Over 50 million Americans — including nearly 300,000 children — suffer from the painful, disabling and sometimes fatal effects of arthritis and rheumatic diseases. As care leaders, rheumatologists and rheumatology health professionals play a uniquely vital role in guiding these individuals toward the most effective care. The ACR’s Top Five list offers a strong starting point for evaluation and conversation.

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Rather than being a prescriptive set of rules, the list is meant to leave room for clinical judgment. “This list will help the rheumatology community — patients, rheumatologists and rheumatology health professionals — have open conversations and identify the best, and most cost-effective, care for each individual,” says Dr. King. “However, it is important to note clinical autonomy is paramount; ultimately, the choice of treatment is between the rheumatologist and his or her patients – based on each patient’s clinical needs, values and preferences.”

### **Next Steps**

As the ACR’s Top Five lists becomes a reference tool for the rheumatology community, the ACR will discuss strategies to help the rheumatology community implement the items on the list.

“The ACR brings valuable expertise and focus on rheumatic disease care to the *Choosing Wisely* campaign, and is providing this list to its members and their patients, other medical professionals, and the public as a way to guide conversations about high-quality, cost-effective care for people with rheumatic diseases,” says Dr. Uknis. “We look forward to continuing our work with the ABIM Foundation and *Consumer Reports* in the coming months as we continue to disseminate this list and begin to develop another Top Five list specific to pediatric rheumatology – to be released later this year.”

To view the ACR’s list and its accompanying article in the ACR’s journal, *Arthritis Care & Research*, visit [www.rheumatology.org/fivethings](http://www.rheumatology.org/fivethings). To learn more about the *Choosing Wisely* campaign, visit [www.ChoosingWisely.org](http://www.ChoosingWisely.org).

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Headquartered in Atlanta, Ga., the American College of Rheumatology is an international professional medical society that represents more than 9,000 rheumatologists and rheumatology health professionals. Rheumatologists are internists or pediatricians who are qualified by training and experience in the diagnosis and treatment of arthritis and other diseases of the joints, muscles and bones. Over 50 million Americans — including nearly 300,000 children — suffer from the painful, disabling and sometimes fatal effects of arthritis and rheumatic diseases. The ACR’s mission is to advance rheumatology. Learn more by visiting [www.rheumatology.org](http://www.rheumatology.org) or follow ACR on Twitter at [twitter.com/acrheum](https://twitter.com/acrheum).

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policy makers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice. To learn more about the ABIM Foundation, visit [www.abimfoundation.org](http://www.abimfoundation.org), read our blog [blog.abimfoundation.org](http://blog.abimfoundation.org), connect with us on [Facebook](https://www.facebook.com/abimfoundation) or follow us on [Twitter](https://twitter.com/abimfoundation).

First announced in December 2011, Choosing Wisely is part of a multi-year effort led by the ABIM Foundation to support and engage physicians in being better stewards of finite health care resources. Participating specialty societies are working with the ABIM Foundation and Consumer Reports to share the lists widely with their members and convene discussions about the physician’s role in helping patients make wise choices. Learn more at [www.ChoosingWisely.org](http://www.ChoosingWisely.org).