A Narrow Window of Opportunity: Diagnosis and Management of Rheumatoid Arthritis in Underserved Populations

Podcast 3 | Run Time: 27.2 minutes

D Kaminski: [00:00:00]
Hello. Welcome back to the second half, I'd like to introduce myself. I'm Donna Kaminski. I am a family medicine physician with Robert Wood Johnson, University Hospital here in New Jersey. And I'm very excited to have to have with me a rheumatologist, Dr. Prabhakaran. Dr. Prabhakaran I'm going to let you introduce yourself to us.

S Prabhakaran: [00:00:23]
Hi everybody. I'm Sajina Prabhakaran. I'm a rheumatologist at Capitol Health's Rheumatology Specialist, working primarily out of Hopewell New Jersey and I'm excited to be here during the second half of our talk on RA.

D Kaminski: [00:00:38]
Thank you, Dr. Prabhakar, and so, just to continue onwards, so you and Dr. Friedman had talked about and given us the sort of a case presentation that we're talking through. And I really wanted to ask you... If you would take a minute to kind of go through treatment. You really did a great job talking us through what to order, how to diagnose, what to be looking for... but then the next step is a really hard step for us as family physicians and Primary Care Providers which is treatment. So, there's such a just feels to me like there's such a wide myriad of treatment options that can feel really hard to navigate through. Can you talk us through basically what the different treatment options are, when you feel which are appropriate as first steps… So, that again, this is something we can all we can navigate as primary care physicians, but also help our patients with.

S Prabhakaran: [00:01:38]
Absolutely. So, when we see our patients with rheumatoid arthritis that we have diagnosed as having RA, one of the things we do for me doing the diagnostic process is looking at the presence of antibodies, and typically when you have somebody who seropositive with a positive rheumatoid factor and more so with the high titer positive anti-CCP antibody, you're looking at more aggressive disease. You have patients with elevated markers of inflammation with significant swelling or synovitis on examination… again, you're looking at somebody with more aggressive disease. If you have somebody with already extra-articular involvement, for example, if they have pulmonary involvement, or they have vasculitis, or they have eye involvement, inflammatory eye disease, you're again looking at more aggressive disease. So, your approach would be in the direction of how significant or how severe is the disease process in a patient. And when we approach treatment of a patient with rheumatoid arthritis, the dictum is to treat to target and target here would be a low disease activity or to put the patient into remission. So, disease activity is, is a method by which we can score the severity of the disease. We're looking at certain calculations which include the number of swollen joints…tender joints…markers of inflammation, and overall patient's, or provider's estimate of the quality of life. So, the different scores available to doctors… and not all rheumatologist physicians use them… most of us do. And we are using them as an objective method to classify our patients. So, depending on, so when we have somebody with high disease activity, you want to be more aggressive and the approach to treatment for rheumatoid arthritis frequently involves the drug methotrexate. So, the medications that we use in the treatment of RA… they're called disease-modifying agents or what's also referred to as DMARDs. So, then we have the oral DMARDs. Then we have the synthetic DMARDS, and then we have the targeted DMARDS. So, the

common old ones that are frequently the first line of therapy include methotrexate, there's hydroxychloroquine, there's leflunomide, there's sulfasalazine. They're all disease-modifying agents, orally administered, which require very strict monitoring of patients' blood counts and patients' hepatorenal function. The most common one is methotrexate which is frequently the first line of therapy, and I'm just going to give you a two-line on that one because it's one of the most commonly used medications in rheumatoid arthritis and one of the medicines which have has been shown to improve mortality in patients with RA. And it's, you know, it's a chemotherapy agent. However, just like everything else, different doses have different interactions with drugs. So, at lower doses, which is what we use in RA, it acts as an immunomodulator through the release of adenosine. But in these patients, we still have to watch for hepatorenal dysfunction… they cannot be consuming alcohol… if it's a woman, she needs to understand that she has to be on a contraceptive pill. If it's a man, again, we recommend the same in these patients. And we also have to make sure we give them folic acid to cover for any deficiency of folic acid that can occur as a result of methotrexate use. So, in patients with lower disease activity, we tend to use hydroxychloroquine, and there's sulfasalazine, there's leflunomide, and so on and so forth. If you have somebody who's got more aggressive disease or not completely controlled with these medications or if they have contraindications or side effects with these medicines, then we move on to our biologics. So, these are the small molecules. For example, you have TNF blockers, tumor necrosis factor alpha blockers, which were the first drugs in this family of the biologics. You have other specific blockers too, we have IL6 blockers, we have medications that work on the T lymphocytes like abatacept … we have rituximab with works on CD20. So, depending upon the severity of the disease, depending upon the tolerance of the patient, we can switch between medicines, but typically…most commonly, we start off with a TNF blocker… if I have somebody who has already gone through an oral DMARD there is an approach called triple therapy where you can use three…two or three oral agents in combination in these patients as well, and that's an approach which has shown to be effective in treatment of rheumatoid arthritis too. So, for patients with low disease activity, we try to go through, go to hydroxychloroquine or leflunomide…they're both very reasonable options for treatment of RA. If I have somebody who wants to get pregnant and who happens to have mild RA I could very well go with hydroxychloroquine because it is safe in pregnancy. So, each medication will have its own role and we kind of go through them depending upon what the patient's objectives are, what their current situation is, and what they're comfortable with. So that would be our approach and, typically, I give patients about 6 weeks… 6 to 12 weeks at the most, to know how their response is. If I don't see a response by that time, we're looking to switch or we're looking to add depending upon the situation to a different medication.

D Kaminski: [00:07:21]
Hey, that's great. That was, that's, that was a really great walkthrough and it kind of also highlights the complexity. Right? So, you talked about different levels of severity. For us, as primary care providers, what do you see as our role in a case such as this one that we just described and talked through? I'm sort of thinking about like, you know, for me as this patient walks through, what is it that I should order versus when to…when do I come to you or when do I send the patient to you? So, I'm trying to sift through my role as a primary care provider versus this great level of expertise that you have in Rheumatology for my patient.

S Prabhakaran: [00:08:21]
That's an excellent question because we as a rheumatologist, we do depend significantly… overwhelmingly on our primary care physicians for their support and their help in taking care of these patients because you probably see the patients a lot more frequently than we do. So, one of the first things is early recognition. So, the patient is invariably coming to you with complaints of joint pain…or

stiffness…or swelling. So, to be able to recognize that this is a potential rheumatological condition in inflammatory joint pain, a story of inflammatory joint pain, concerning for inflammatory arthritis, and then ordering the appropriate lab tests and workup that will be needed and necessary to make a diagnosis. And, if you have these results and they are consistent with rheumatoid arthritis…if you're comfortable…you can please go ahead and start treatment. Like I said, typically methotrexate is a good go-to drug as long as we are communicating with the patient as to the side effects and they have a good understanding of what they are taking and what to expect, and what is expected of them in order to reduce any adverse reactions from the medications as well. So that would be a perfectly good start from a primary care provider's perspective…till such time that the patient can get to a rheumatologist if they need to. And, and also to ensure that the patient understands that they require monitoring of the medication to rule out side effects or any adverse reactions. The other important thing from a primary care provider's perspective is rheumatoid arthritis…the target is to put the patient into remission. Unfortunately, that doesn't happen sometimes, you know… they can have flare-ups, or they can have severe adverse reactions to a medication or they can have other complications of RA, and being aware of these possibilities and recognizing them, and then having the patient refer to the appropriate specialist to address these problems would be something that would be very helpful if a primary care provider could do that so we could Institute of therapy at the earliest….so just like everything else in RA there's what we call a honeymoon period which is about approximately three months after diagnosis. So early diagnosis and early institution of treatment increase the odds that a patient is going to go into remission, or we can achieve a low disease activity. So certainly, that aggressiveness in the approach for diagnosis would be extremely valuable for our patients.

D Kaminski: [00:10:59]
That's really, really helpful. So, for me, if I charge myself with increasingly diagnosing my patients and starting treatment certainly, until they're…until they come to see you. It also means being really cognizant about what type of conversation I have. I'm just, I'm just diagnosing, and I'm just telling my patient that they have a condition that they're going to have for the rest of their life, right? So, I have to be very cognizant about how I talk to my patients about rheumatoid arthritis. Do you have any advice for me as a primary care provider as to… as to how to talk to my patients as they're newly diagnosed with rheumatoid arthritis? What's …what's important for me to say?

S Prabhakaran: [00:11:51]
That's an excellent question, because usually when people need to tell somebody "You have rheumatoid arthritis" there is this, this, this fear on their face as soon as you give someone the diagnosis because the picture is immediately of somebody in a wheelchair… disabled, you know…chronically for life. So that… that's what the patient is expecting to be their future life. So, one of the things that we want to approach as physicians…our approach should be to provide education, right? So, when we talk to a patient and you tell them "Hey, this is what we are suspecting that you have… is rheumatoid arthritis" you want to go into…and being very open and frank as well…the patient understands this is a chronic illness…this is not something that they're going to be cured off… that this is something that we can treat and control…and, that there is certainly a myriad of options to treat the patient such that they can lead as close to a normal life as possible. It may not be exactly what was before they were diagnosed, but that patient, if they can follow through with treatment…and I mean, you know, be compliant with their treatment…communicate openly with their physicians…. that it is possible that the patient can lead a normal life at least to the extent possible. And I think that is very, very important because it's very depressing when you get a diagnosis like… such as RA when you're thinking that this is the end of their life as they know it, which in turn, we know, leads to non-compliance, which in turn is not going to help the patient at all to get anywhere. So, I think the time of diagnosis trying to have them understand the

weight of the diagnosis, but at the same time assuring them that it's possible to get over it…and that also that they have the support of the physicians… of the providers…the whole time to help them navigate this disease and navigate the treatments and so on and so forth. So that's very, very important…to reinforce that concept with the patients from the primary care provider's point of view. And the other thing is also, the patient understands that it's important that they work on improving their diet, improving exercise…it's important that they do all of that because all of that has a role also, to improve the effectiveness of the medication, as well as the, in terms of disease, control and improving the quality of life….and avoiding other complications down the line. So, all of these things, a lot of this is a lot of counseling that we as physicians can provide to our patients which we have to do repeatedly, unfortunately, because it's just constantly repeating it to reinforce the idea… so that would be very helpful.

D Kaminski: [00:14:48]
…You just mentioned diet and exercise, and I feel like increasingly with my patients…they are very interested in integrating alternative treatments into their regimen, right? So, they'd love to know what… …what vitamins, what nutrients, what supplements might be helpful? Are there any that you can recommend that we can… you know, pass on to our patients as being helpful with rheumatoid arthritis?

S Prabhakaran: [00:15:28]
So, the one thing I will tell you at the outset is that patients should understand supplements are just that… they are supplementing…they are not the treatment. So, patients should not assume that they are going to take the supplements and that's going to lead to disease control. I would not recommend… a lot of these have not been studied… they have not been proven so; do they help? Certainly. So, a couple of things I always tell patients to do is to follow a relatively clean diet, which mainly means avoiding processed foods…red meat… trying to move to a more plant-based diet…plenty of water…. If somebody is overweight…trying to reduce their carb intake…. all of these are going to ultimately help in reducing the overall inflammation to a certain extent. The only other supplement, per se, that I would have recommended to my patients would be turmeric, which has been proven to be an anti-inflammatory. So turmeric, over-the-counter, 1000 mg mixed with black pepper, which is how it's now available, certainly has been proven to help patients, but…they should understand that this is not the treatment. It's only supplementing the treatment. You don't want to overdo it because again, too much turmeric can cause kidney stones…and…and it has other complications with anticoagulation and so forth. So, I do not recommend high doses. Besides this, the other question I get is about fish oil which has some anti-inflammatory role but again, it has other problems too…. again, in terms of acting as a blood thinner and so forth. So, I don't really recommend all of these, unless a patient's already taking it for some other reason…I'm not going to tell them to stop taking it. A frequent question I get is about joint collagen supplements, like chondroitin, glucosamine…things like that…which we do know does not help in cartilage regeneration. However, studies have shown that these drugs…these supplements can help in reducing pain. So, my advice to patients is you can take it…it is just like any other protein, it gets digested in your stomach, however, if after one month, if you notice a benefit, you can take it. But if it doesn't help you, you can stop it. But that is more so in patients with osteoarthritis than in rheumatoid arthritis. So, in RA, if anything, I would recommend…I would recommend turmeric. I do not recommend a lot of the other supplements only because they have not been studied or proven to be beneficial.

D Kaminski: [00:17:57]
And what if…let's say, we have somebody in the honeymoon period that you described, that says, "Oh, I don't really want to start medication yet," so they decline the methotrexate option that…you recommend, and they say they want to just do to turmeric instead…how do you respond to that?

S Prabhakaran: [00:18:16]
Yeah, that's a tough one. But …you know, my job…our job is to provide the information to the patient and counsel them and say, “Hey, we do this, we're going to be… going to be able to get you feeling better a lot quicker. The more you wait, there's damage incurred on your joints…the more we have to work, and the longer it’s going to take for us to get you to where you are going to be symptom-free” … as long as the patient understands that concept…and sometimes we have to go with what the patient wants to do. Sometimes, I might approach it differently with using different medications, so methotrexate definitely sounds like a scary medicine when you enumerate the side effects that when you use the word, chemo agent, a lot of patients get very nervous to go on that medication. So, if that's the case I might approach it differently saying, can we do hydroxychloroquine instead or something else? And have the patient come back relatively quickly in about four to five weeks and if they're not feeling any better, then reintroduce the idea of using something stronger such as methotrexate or something different if need be. So, I try to… sometimes it takes a couple of visits you know, to introduce the idea for the patient to feel comfortable with the whole concept, but I would encourage patients as much as I can to follow the guidelines for treatment, only because it's for their own good. But it's as long as they understand that and they still insist, which we do have patients, who, you know, who prefer not to do it, then I just have them come back a little sooner because they're usually very compliant, that’s usually not the problem. These patients are very complaint, they’re just nervous and they just need a little bit of encouragement, and that usually works.

D Kaminski: [00:19:59]
Wonderful….my last question. So, I feel like, I feel like… our conversation with you… really, for me, empowers me to prescribe more and to really manage more, more of my patients who are newly diagnosed with rheumatoid arthritis, which is, which is great, I guess one of my questions is what would you say the cornerstone should be for me as a primary care provider to refer to you…. at what point, you know, at what point should I be sending my patient to you for management as compared to trying to manage them on my own?

S Prabhakaran: [00:20:42]
So that's a good question. So, say you have somebody with…. rheumatoid arthritis, like the patient that we have. You start on the methotrexate, and you have patients tolerating it well and you ramp up the dose… and I usually don't go past 20 or 25 milligrams a week because after that you are really looking at more toxicity than benefit… and you do that and the patient has no response, right, and they are continuing to get worse and then you try to add another DMARD like hydroxychloroquine, and again, you have zero response, but that doesn't quite fit? Doesn't make sense. So, then the question comes, well, do we have the right diagnosis? That's the first thing, right? Or if you have the right diagnosis, should we escalate therapy? So, if you're comfortable moving onto a TNF blocker, please go ahead. Your patient… the story is there, it fits…you have high markers of inflammation and everything…then you can go ahead if you're comfortable, but otherwise, that would be a time when you're not quite sure if you have the right diagnosis, when you've tried multiple treatments that you would normally do for a RA patient and they've had no relief, then that would be a time to reach out to a rheumatologist and say, “Hey, what do you think about this?” You can always order tests as well. You can get an MRI of the hand, to… you know…confirm your diagnosis, just on a side note at that point in time. Similarly, if you have somebody with RA who’s got extra-articular involvement, like the eye, or if it's looking like its involving the lungs or, you know, if they have scleritis which is not getting any better with steroid drops and, you know, they need to be on DMARD and they want them on a TNF blocker and not getting any better on that either or if they have interstitial lung disease and you have a biopsy of the lung done and it's showing active

disease, active inflammatory disease, and you need something…some help there. I think that would be another reason to have a rheumatologist involved…to treat the patient… to help manage the patient to see if we can control the disease. So, I mean those all would be reasons… or if you have somebody who is not able to tolerate any of the standard medications… you've tried methotrexate… hydroxychloroquine… they have side effects. Well, then what do we do? I mean these are all instances where I think we can be of help to the primary care physician as well.

D Kaminski: [00:22:51]
Thank you so much. This has been amazing. Thank you so much, Dr. Prabhakaran, and I really feel like… I really feel like this aids me tremendously. I do have one more question. I know I said that the last one would be my last one, but this is one more, you know, as we talked about diet, we talked about the plant-based diet, we talked about turmeric as a supplement, but, you know, one other piece, I'm just sort of thinking about now, that I know my patients are going to ask…. especially when they're newly diagnosed…is to say, "Physical Therapy! Can I try Physical Therapy?" Can you talk a little bit about the role of physical therapy, especially in our newly diagnosed and maybe not even only our newly diagnosed, but our patients with more severe rheumatoid arthritis…. What type of an impact have you seen and what type of role do you see in your patients?

S Prabhakaran: [00:23:53]
That's a very good question. So… therapy… Physical Therapy has… and occupational therapy, I should say, have got very, very important roles in our patients with chronic inflammatory disease…especially with RA… talking about RA…when we have somebody with chronic inflammation. One of the things that we see in these patients is ligament laxity with subsequent subluxation of the metacarpophalangeal joints in the PIPs. And thereby, the next result is a loss of dexterity in these patients, right? So…which can be very impactful on the day-to-day life, to carry out their ADLs or their job or whatever it is that they're doing. So, in those instances, PT can be very helpful, obviously, you want to start it before they get to that point. So, once we have inflammation controlled, they should be able to get into a therapy program for them to be assessed, to learn exercises that they can continue going forward. It's not a one-time thing. It's not a six-week program that it's done and then you go back home and never do this exercise again. It's one of those things which we have to keep up with and encourage our patients to do that. Similarly physical therapy… if it's the knees…or the of the feet… wearing appropriate footwear…talking about therapy appropriate footwear. If they have, you know, if they need to be in with orthotics or inserts, or what have you, to provide proper support to the feet in order to avoid subsequent and a secondary OA of their feet or their knees or the hips. So, all of that has got a significant role. The only point…the only caveat that I would put in there….is that if you have somebody with an inflamed joint you do not recommend that they go and start exercising on that joint because they have a high risk for injury. So now you can have…you have a high risk of tendon rupture, or you have a higher risk for accelerating the arthritis and, and it's also very painful. So, you don't really want to do that at that time. But if you have somebody who's got chronic RA, like your patient knows had seven years of rheumatoid arthritis and a good control, and now they're telling, "You know what, my hands don't feel as strong as they used to be." Certainly, sending them to occupational therapy for them to work on their dexterity…work on the intrinsic muscles of the hand…all of that will be very, very advantageous to our patients, as long as you can control the disease. And then we also have, you know, devices to hold the patient's fingers in plane, especially in those patients with chronic deformities, and into these can be introduced…now, they're all available online…so we can introduce them to… to these patients on Amazon, for example, from Amazon. But even occupational therapists can custom-build these…you know, devices… assistive devices for the patients to hold their fingers up, to support their digits so that they can write and read and pick

up things or what have you or to even reduce the deformities by using these devices overnight. So, there are a lot of options available for our patients to improve their quality of life that is not just medication-related, but even other…other modalities.

D Kaminski: [00:26:45]
This has been…so, I can't even tell you how helpful this has been…really truly, I mean, it really feels like you've really helped me enhance my skill set and tool set, to be able to respond to my patients with rheumatoid arthritis.

S Prabhakaran: [00:27:01]
Thank you. Happy to help.

D Kaminski: [00:27:02]
Thank you so much, Dr. Prabhakaran, and thank you. Thank you. And thank you to our listeners. Thank you.