ChoosingWisely UK

British Society for Rheumatology

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#choosingwisely @UKchoosewisely @RheumatologyUK

- What is Choosing Wisely?
- What is shared decision making?
- How did we develop the BSR's recommendations?
- What are the recommendations?
  - Rheumatoid factor/CCP - Vitamin D
  - Bisphosphonates - Steroid injections
  - ANA - Complement/dsDNA
- How can we implement them?

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What is Choosing Wisely?

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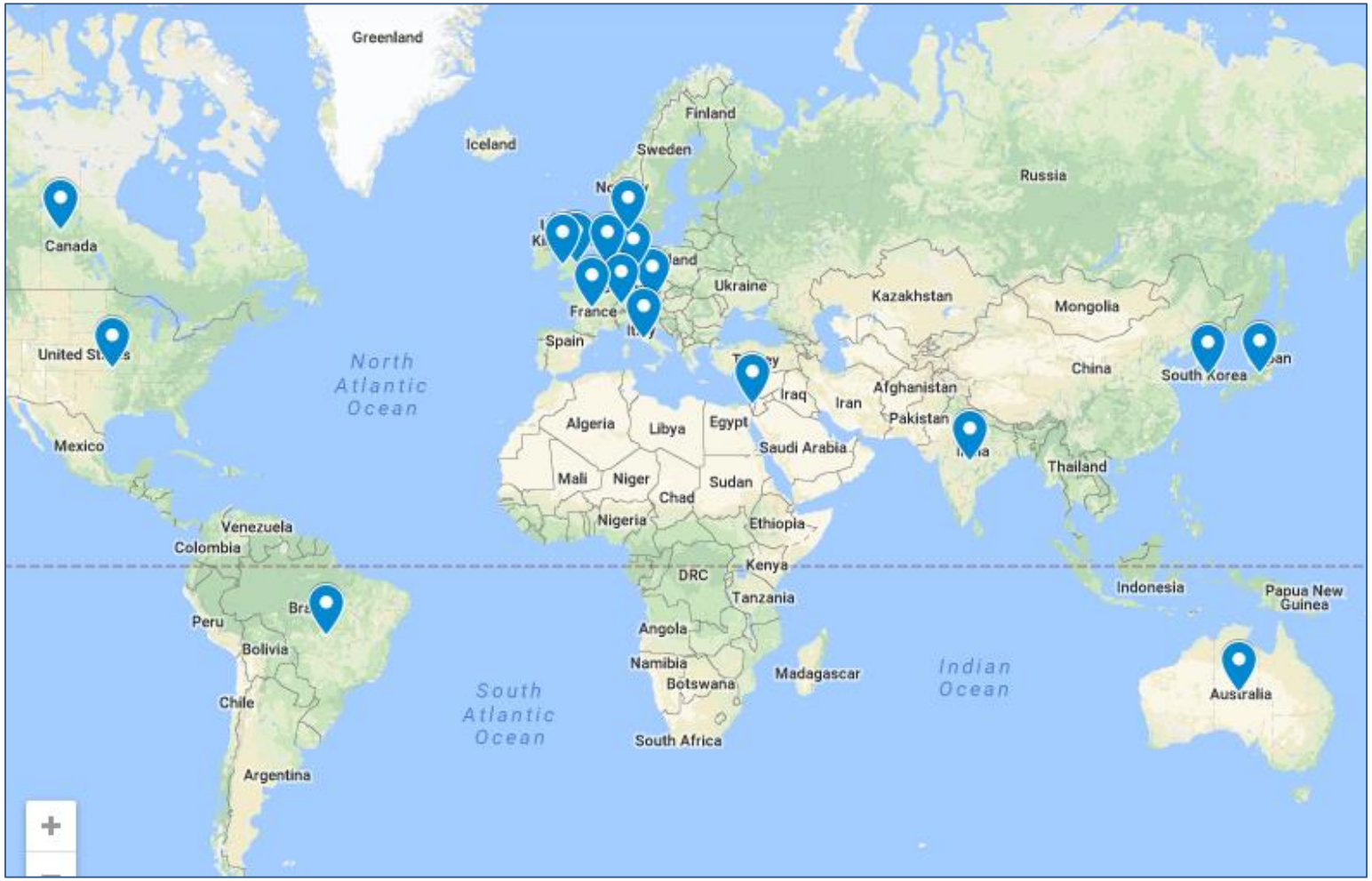

http://buzz.bournemouth.ac.uk/2017/01/the-18-countries-that-have-implemented-choosing-wisely/ [Accessed 09/07/2018]

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- Aim to **reduce unnecessary interventions**

- Promote **shared-decision making** conversations between clinicians and patients, to choose care that
  - is supported by evidence
  - not duplicative
  - free from harm
  - truly necessary
  - consistent with patients' values

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Local Campaigns

Start a Local Campaign or Implementation Project

Take leadership on reducing unnecessary care by launching a local Choosing Wisely campaign or implementation project

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What is shared decision making?

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Four questions to ask my doctor or nurse to make better decisions together:

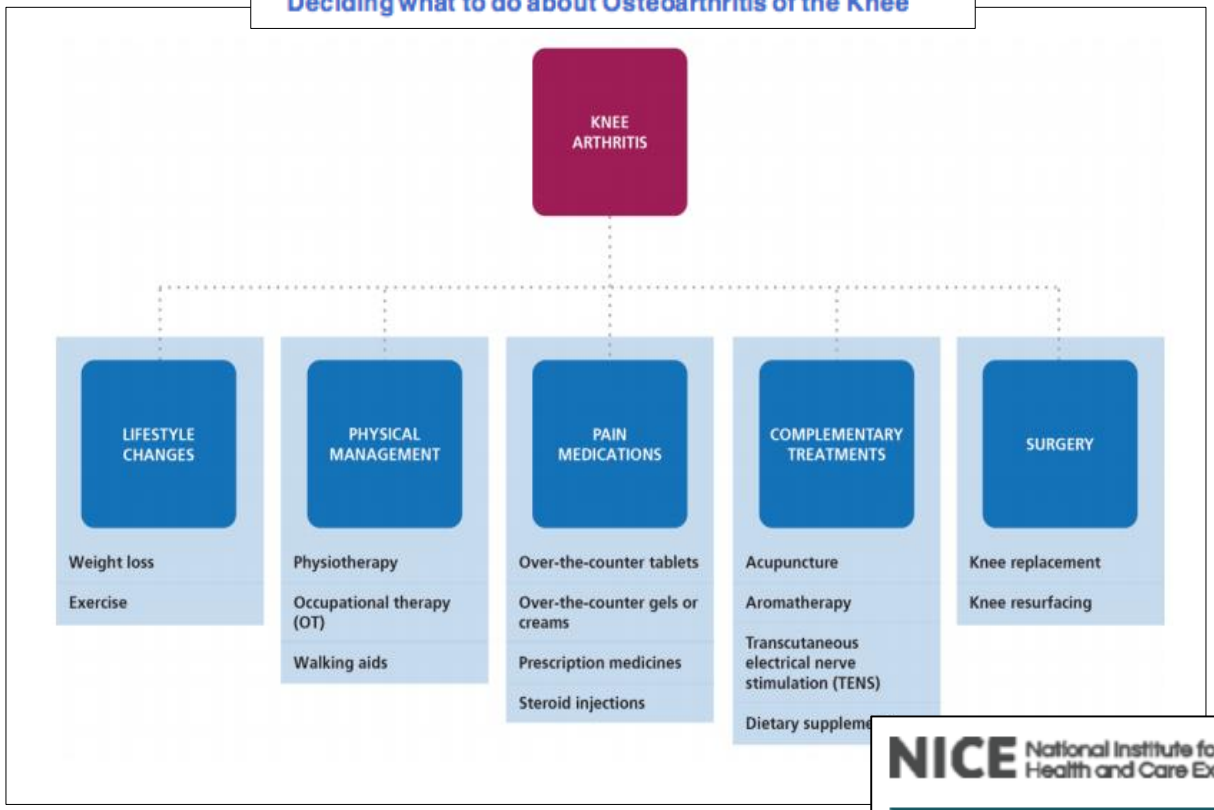
What are the **B**enefits?
What are the **R**isks?
What are the **A**lternatives?
What if I do **N**othing?

www.choosingwisely.co.uk

Shared Decision Making – osteoarthritis of the knee

Next clinical review date March 2018

Deciding what to do about Osteoarthritis of the Knee



NICE National Institute for Health and Care Excellence

Decision support from NICE

Bisphosphonates for treating osteoporosis

Information to help people with osteoporosis and their health professionals discuss the options

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How did we develop the BSR's recommendations?

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- Patients not sufficiently involved in developing the list recommendations (Ross et al., 2018)
- The emphasis in the briefing documents for the latest development round was upon
  - ensuring a thorough and inclusive process
  - importance of including patients and the membership in recommendation development (Reid, 2017)

REID, J. 2017. *Choosing Wisely UK Recommendations – Round II: Guidance and template for participating Colleges and Specialist Societies*.

ROSS, J., SANTHIRAPALA, R., MACEWEN, C. & COULTER, A. 2018. Helping patients choose wisely. *BMJ,* 361.

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Bisphosphonates

Immunoglobulins

Anti-neuropathic agents

B-cell testing post RTX

Outcome measures

Steroid injections vs physio

DAS28 ESR vs CRP

Vitamin D testing

ANA + ENA

Spinal imaging

C3, C4, dsDNA

RF, CCP

Steroid therapy in unconfirmed diagnoses

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Bisphosphonates

Vitamin D testing

ANA + ENA

C3, C4, dsDNA

RF, CCP

Steroid injections
vs physio

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Wording subgroup

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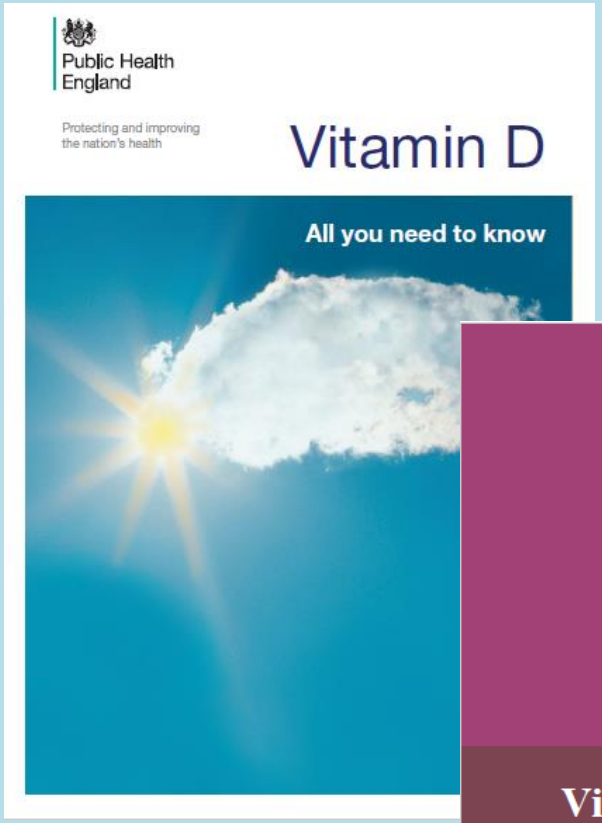

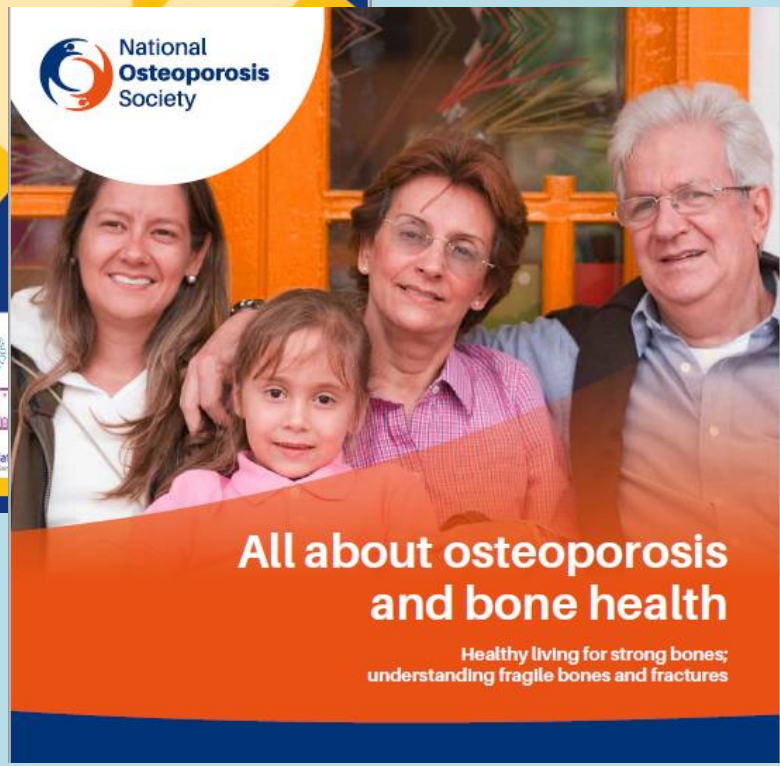

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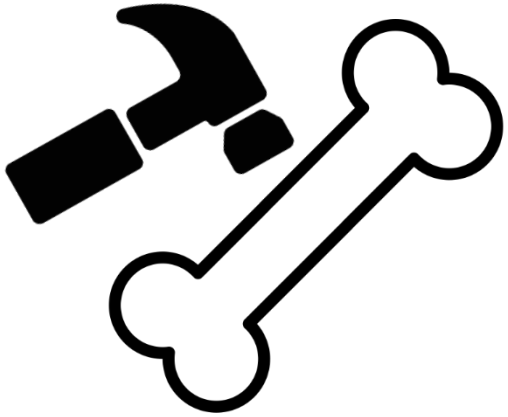
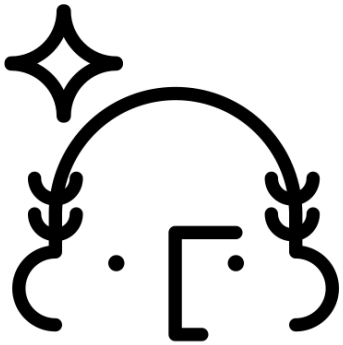
Royal College of General Practitioners





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Any questions?

What are the recommendations?

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Rheumatoid factor / anti-CCP

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POLL

There is a single blood test to determine if someone has rheumatoid arthritis.

a) TRUE

b) FALSE

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Rheumatoid Arthritis

- Window of opportunity – 3 months of onset

- NICE Guidelines (NG 100) advise when to refer
  - Involvement hands & feet
  - Involvement more than one joint
  - Refer within 3 working days of presentation

- Rheumatoid Arthritis is a **Clinical** diagnosis

- Antibodies *may* help

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Rheumatoid factor / anti-CCP antibody

- Antibodies often cause confusion

  Positive test **does not** mean a patient has RA
  Negative test **does not** exclude RA

- Can delay patient being referred/diagnosed

- NICE Guidelines (NG100) highlight
  - refer if acute phase response normal (ESR/CRP)
  - negative rheumatoid factor

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Rheumatoid factor / anti-CCP antibody

Clinician:

Patients with suspected inflammatory arthritis should be referred to Rheumatology without delay. Rheumatoid factor and CCP/ACPA are important, but should be avoided as screening tests. A negative result does not exclude rheumatoid arthritis, nor does a positive result equate to a diagnosis of rheumatoid arthritis. Repeat testing is not normally indicated.

Patient:

If a doctor suspects that you have rheumatoid arthritis, it is recommended that you are referred to rheumatology without delay, even before any tests are done. There is no single blood test which can determine whether someone does or does not have rheumatoid arthritis.

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Vitamin D

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POLL

Do you take vitamin D supplementation during winter?

a) YES

b) NO

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Vitamin D

- ~1/4 UK population have low vitamin D
- Worse in winter

https://steemkr.com/food/@talha96/eat-healthy-live-healthy-or-foods-enriched-of-vitamin-d

- Cost of vitamin D test ~£25 + patient burden + clinician burden
- Increasing use in patients with generalised aches and pain
- Supplementation is cheap and safe
- Repeat testing is often unnecessary
- Reserve testing for patients at high risk of complications e.g. osteomalacia, osteoporosis

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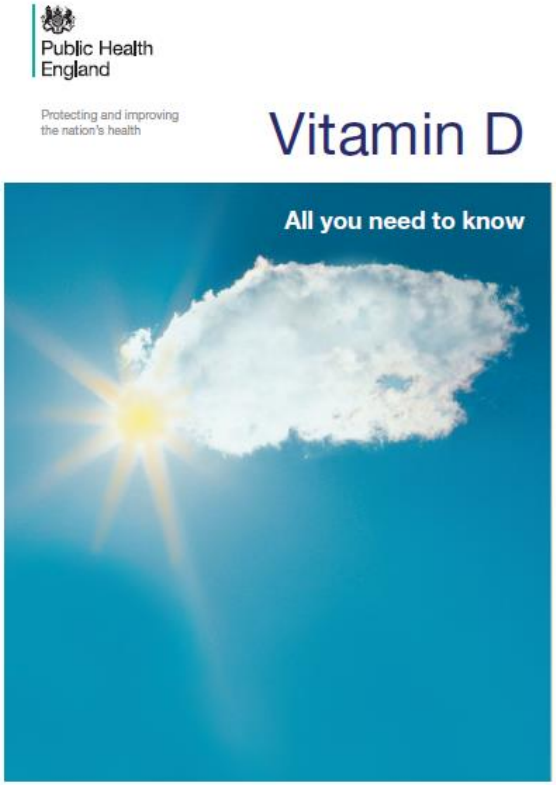

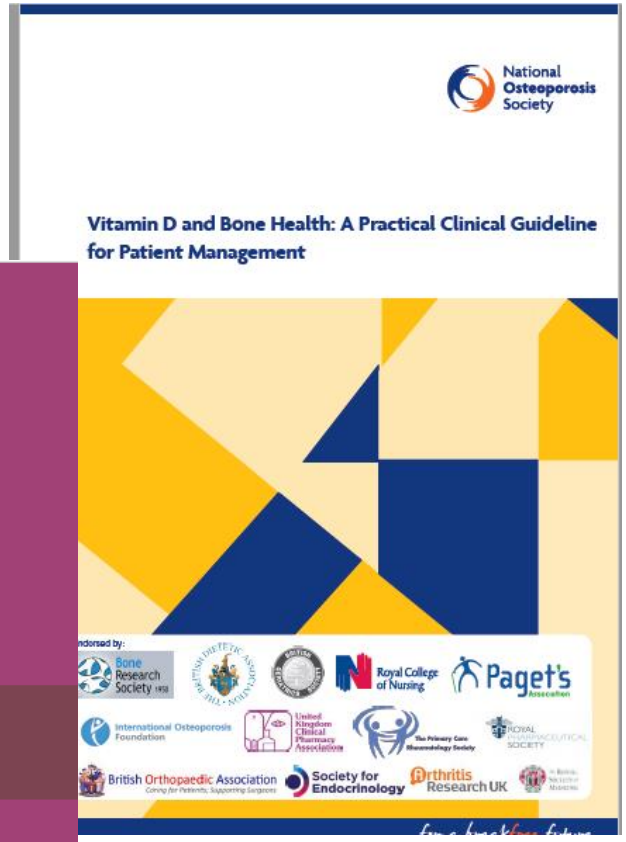

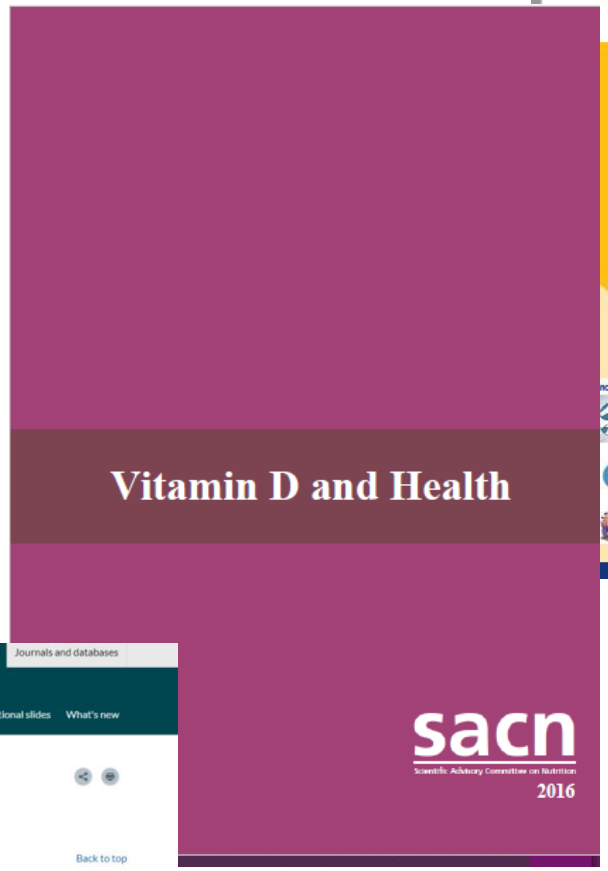

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Vitamin D

Clinician

Everyone should consider Vitamin D supplementation during winter. People who have restricted access to sunlight (e.g. those living in institutions or who cover their skin), or have dark skin, should consider supplementation all year round. Vitamin D testing should be reserved for people at high risk from deficiency and avoided as part of routine investigation of widespread pain alone. Repeat testing is not normally indicated in those taking supplements.

Patient:

It is important for everyone to take Vitamin D supplements during winter. If you have restricted access to sunlight (e.g. if you live in a care home or cover your skin), or have dark skin, it is recommended that you take a supplement all year round. Vitamin D testing is unlikely to be useful or necessary in most people and future testing is not normally needed for those taking supplements.

Bisphosphonates

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POLL

Bisphosphonate treatment should be reviewed:

a) After 1 year

b) After 3-5 years

c) After 10 years

d) It's a lifelong treatment

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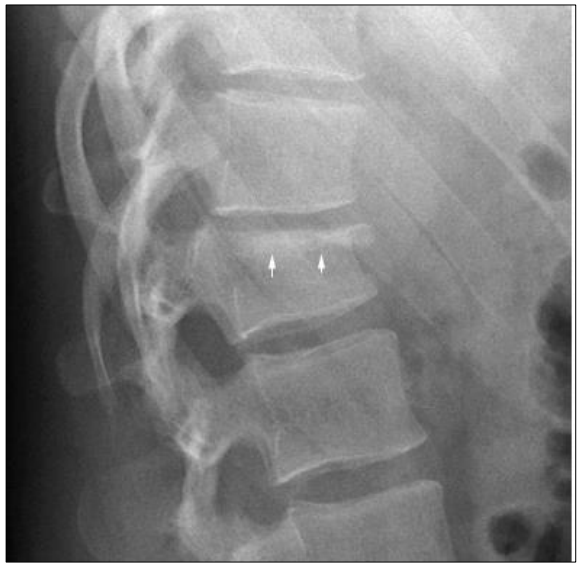
Bisphosphonates

Alendronic acid (Fosamax)
Risedronate (Actonel)
Zoledronic acid (Zometa)

- Primary prevention Vs Secondary prevention
- Evidence limited beyond 3-5 years
- Absorbed into bone – effects continue even after stopping drug
- Risk of adynamic bone
- Risk of atypical fractures



http://www.wikiradiography.net/page/Imaging+Vertebral+Body+Wedge+Fractures

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Bisphosphonates

Clinician:

Bisphosphonate therapy should be reviewed with every patient after 3-5 years, and a treatment holiday considered. This should follow a shared-decision making conversation which includes the risks and benefits of continued treatment.

Patient:

Bisphosphonates are drugs that help reduce fracture risk due to bone thinning (osteoporosis). People who take bisphosphonate treatment should discuss this with their healthcare professional every 3-5 years because it may be advisable for some to have a break in treatment.

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Steroid injections for non-inflammatory musculoskeletal conditions

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Steroid injections

https://www.medicinenet.com/cortisone_injection/article.htm#for_what_conditions_are_cortisone_injections_used

- Non-inflammatory conditions
- Often long-term: repeated injections
- Reasonable evidence for short term benefit: not for long term
- Minor side effects common
- Longer term safety profile unclear; obvious concern regarding cumulative steroid dose
- Exercise therapy may be equally efficacious, without side effects
- Emphasis on informed consent regarding short AND long term implications

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Steroid injections

Clinician:

The use of intra-articular and soft-tissue steroid injections for non-inflammatory musculoskeletal conditions should be preceded by consideration of non-invasive alternatives such as exercise and physical therapy. Consent to any invasive procedure such as this must arise from a shared-decision making conversation with every patient, which includes assessment of the risks and benefits.

Patient:

It is recommended that you have a conversation with your healthcare professional before accepting steroid injections for non-inflammatory musculoskeletal conditions. So that you can make an informed decision, this discussion should include the risks, benefits, and alternatives such as exercise and physical activity. Although some people may experience short term benefit, there are potential long-term risks with repeated injections.

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ANA + ENAs

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A case to reflect on……..

- 35 yr old female
- Presented with fatigue & muscle aches to GP
- Bloods revealed a positive ANA which then prompted further antibody checks to be done (reflex testing)
- GP raised concern about Lupus, referred to rheumatology

- Patient read about condition
- Seen in rheumatology clinic by which time very anxious

- Transpires patients was known to have underactive thyroid and TPO antibodies
- Patient was reassured did not have Lupus

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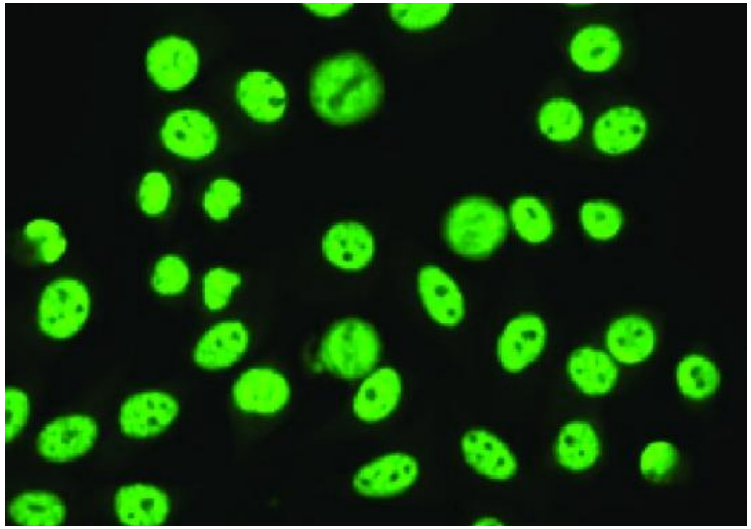
ANA + ENAs

- Antibodies do not equate to a diagnosis of a CTD
- Avoid testing in widespread pain or fatigue alone
- Only request tests if the implications are fully understood
- Antibody picture unlikely to change



https://www.hindawi.com/journals/jir/2012/494356/fig1/

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ANA + ENAs

Clinician:
Testing ANA and ENAs should be reserved for patients suspected to have a diagnosis of a connective tissue disease, e.g. lupus. Testing ANA and ENAs should be avoided in the investigation of widespread pain or fatigue alone. Repeat testing is not normally indicated unless the clinical picture changes significantly.

Complement C3, C4 + dsDNA

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Complement C3/C4 + dsDNA

Clinician:

C3, C4 and dsDNA are important tests to help in the diagnosis and assessment of disease activity in lupus. They should be reserved for specialist monitoring of disease activity and should be avoided as screening tests.

How can we implement them?

How to implement

- Raise awareness through championing – tell your patients and your clinicians!
- Twitter / other social media platforms
- Local implementation through collaboration with e.g.
  - Primary care: education sessions
  - Pathology: changing requesting panels / including reminders on requesting system or results
  - Trainees: as basis for quality improvement projects
- Lead by example

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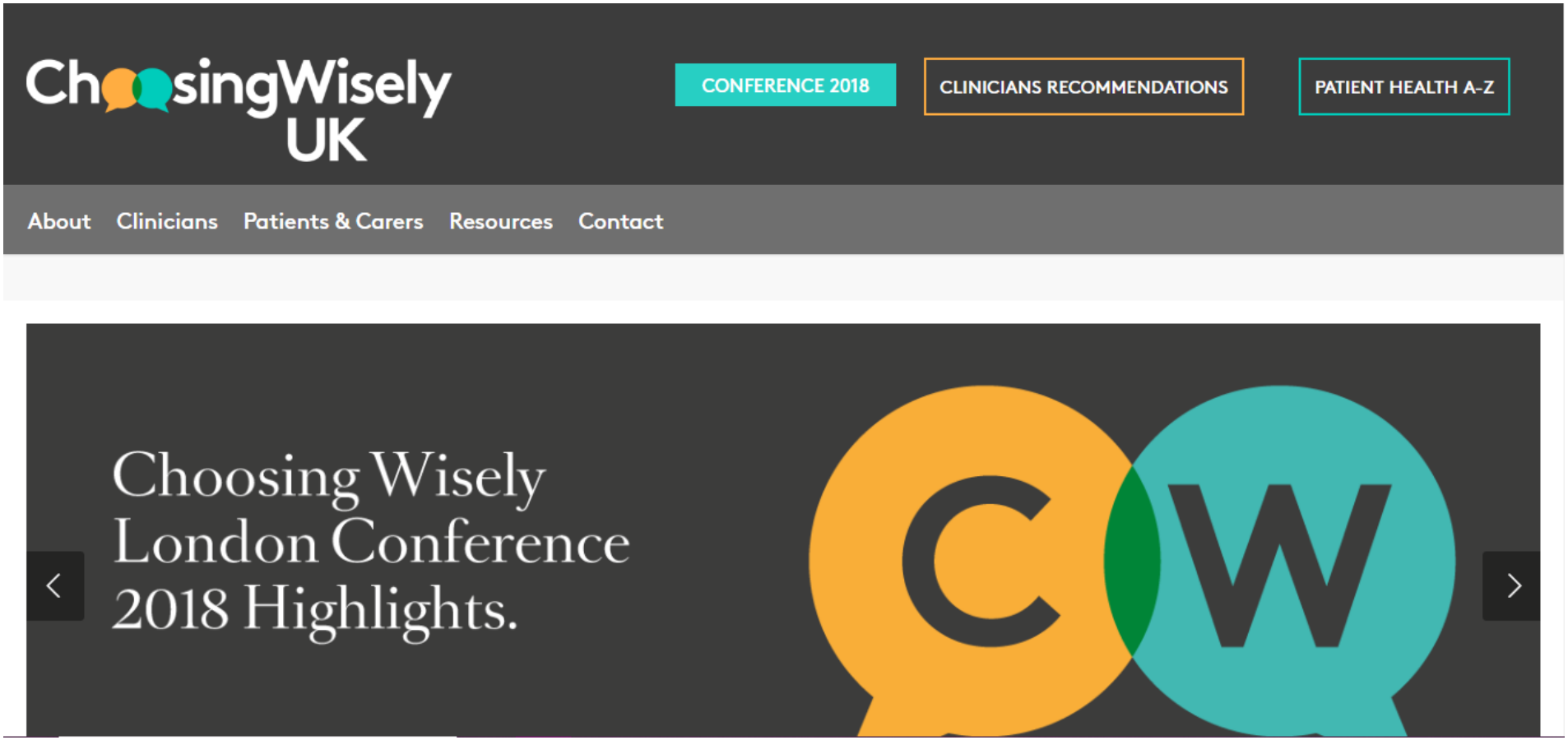

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Summary

- Choosing Wisely
- Shared-decision making
- Development of the BSR's recommendations
- The recommendations
  - Rheumatoid factor/CCP - Vitamin D
  - Bisphosphonates - Steroid injections
  - ANA - Complement/dsDNA
- How to implement them

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Thank you….
… and thanks to our working group

Ian Bruce	Consultant Rheumatologist
Benjamin Ellis	Consultant rheumatologist, senior clinical policy advisor Versus Arthritis
Shuayb Elkhalifa	Immunology trainee
Jill Firth	Consultant nurse in rheumatology, past President BHPR
Joyce Fox	Patient contributor
James Galloway	Consultant rheumatologist
Ben Mulhearn	Rheumatology trainee
Chetan Mukhtyar	Consultant rheumatologist, Secretary BSR
Danny Murphy	GP, staff grade rheumatologist
Anthony Rowbottom	Consultant immunologist
Neil Snowden	Consultant rheumatologist
Karen Staniland	Patient contributor

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Any questions?

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References

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- Bisphosphonates decision support:
- https://www.nice.org.uk/guidance/ta464/resources/decision-support-from-nice-information-to-help-people-with-osteoporosis-and-their-health-professionalsdiscuss-the-options-pdf-4608867565
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