

Rheumatology

Eleven Things Physicians and Patients Should Question

by
Canadian Rheumatology Association

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1 **Don't order ANA as a screening test in patients without specific signs or symptoms of systemic lupus erythematosus (SLE) or another connective tissue disease (CTD).**

ANA testing should not be used to screen subjects without specific symptoms (e.g., photosensitivity, malar rash, symmetrical polyarthritis, etc.) or without a clinical evaluation that may lead to a presumptive diagnosis of SLE or other CTD, since ANA reactivity is present in many non-rheumatic conditions and even in "healthy" control subjects (up to 20%). In a patient with low pre-test probability for ANA-associated rheumatic disease, positive ANA results can be misleading and may precipitate further unnecessary testing, erroneous diagnosis or even inappropriate therapy.

2 **Don't order an HLA-B27 unless spondyloarthritis is suspected based on specific signs or symptoms.**

HLA-B27 testing is not useful as a single diagnostic test in a patient with low back pain without further spondyloarthropathy (SpA) signs or symptoms (e.g., inflammatory back pain ≥ 3 months duration with age of onset < 45 years, peripheral synovitis, enthesitis, dactylitis, psoriasis or uveitis) because the diagnosis of spondyloarthropathy in these patients is of low probability. If HLA-B27 is used, at least two SpA signs or symptoms, or the presence of positive imaging findings, need to be present to classify a patient as having axial SpA. There is no clinical utility to ordering an HLA-B27 in the absence of positive imaging or the minimally required SpA signs or symptoms.

3 **Don't repeat dual energy X-ray absorptiometry (DEXA) scans more often than every 2 years.**

The use of repeat DEXA scans at intervals of every 2 years is appropriate in most clinical settings, and is supported by several current osteoporosis guidelines. Because of limitations in the precision of testing, a minimum of 2 years may be needed to reliably measure a change in BMD. If bone mineral densities are stable and/or individuals are at low risk of fracture, then less frequent monitoring up to an interval of 5-10 years can be considered. Shorter or longer intervals between repeat DEXA scans may be appropriate based on expected rate of change in bone mineral density and fracture risk.

4 **Don't prescribe bisphosphonates for patients at low risk of fracture.**

There is no convincing evidence that anti-osteoporotic therapy in patients with osteopenia alone reduces fracture risk. The 2008 Cochrane Reviews for three bisphosphonates (Alendronate, Etidronate, Risedronate) found no statistically significant reductions for primary prevention of fracture in postmenopausal women. Fracture risk is determined using either the Canadian Association of Radiologists and Osteoporosis Canada risk assessment tool (CAROC) or FRAX[®], a World Health Organization fracture risk assessment tool. Both are available as online calculators of fracture risk. Given the lack of proven efficacy, widespread use of bisphosphonates in patients at low risk of fracture is not currently recommended.

5 **Don't perform whole body bone scans (e.g., scintigraphy) for diagnostic screening for peripheral and axial arthritis in adults.**

The diagnosis of peripheral and axial inflammatory arthritis can usually be made on the basis of an appropriate history, physical exam and basic investigations. Whole body bone scans, such as the Tc-99m MDP scintigraphy, lack specificity to diagnose inflammatory polyarthritis or spondyloarthritis and have limited clinical utility. This approach is cost-effective and reduces radiation exposure.

6 Don't prescribe opioids for management of chronic rheumatic disease before optimizing the use of non-opioid approaches to pain management.

Opioids in chronic non-cancer pain are associated with substantial risks. Optimize non-opioid pharmacotherapy and non-pharmacologic therapy. Opioids are not superior to non-opioid medications for pain-related function over 12 months in moderate to severe hip or knee osteoarthritis, or mechanical back pain. Opioids should only be prescribed by physicians skilled in their use.

7 Don't delay or avoid palliative symptom management and advance care planning for a patient with life-limiting rheumatic disease because they are pursuing disease-directed treatment.

A palliative approach to care alongside disease-specific treatment should be part of the continuum of care for patients with advanced rheumatic disease toward the end of life. This approach aims to improve quality of life for patients with life-limiting illnesses, through the prevention and relief of suffering, the control of symptoms, and the management of physical, psychosocial and spiritual distress. Such an approach is supported by a growing body of evidence that demonstrates improved patient satisfaction with care, decreased symptom burden and, in some cases, better survival, when a palliative approach to care is integrated early in a patient's disease trajectory.

8 Do not order labs for drug toxicity monitoring (i.e., CBC, liver enzymes, creatinine) more often than every 8-12 weeks for patients on a stable dose of non-biologic disease monitoring anti-rheumatic drugs (DMARDs), in patients without comorbidities or lab abnormalities.

Patients on stable doses of non-biologic DMARDs (e.g., methotrexate, sulfasalazine) without specific comorbidities (e.g., obesity, diabetes mellitus, renal disease, liver disease, alcohol use, concomitant use of hepatotoxic or myelosuppressive medications) are at a low overall risk of toxicity. More frequent blood draws pose an unnecessary burden to patients. Patients new to treatment, on escalating doses, or with abnormal baseline labs typically require more frequent monitoring.

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Avoid ordering these autoantibodies in patients with arthralgia (joint pain) but who do not meet the CSA criteria or have arthritis (>one swollen joint) on physical exam. EULAR defines CSA at risk for developing Rheumatoid Arthritis (RA) as having 3 or more parameters including new joint symptoms <1 year, symptoms located in metacarpophalangeal (MCP) joints, morning stiffness >60 min, most severe symptoms in the morning, 1st degree relative with RA, and difficulty making a fist and positive MCP squeeze test on physical exam. Even in CSA with positive RF and ACPA, more than 30%-60% of patients will not develop RA over the next two years. Most musculoskeletal pain causing global disability is not related to rheumatoid arthritis. Inappropriate testing of RF serology in patients with low likelihood of RA is associated with low positive predictive value (PPV) and increased cost.

10 Don't perform serological, imaging, or genetic tests without checking for and considering past available results.

In addition to increasing healthcare costs and blood draws from patients, redundant diagnostic testing for rheumatic disease adds carbon emissions through sample procurement, equipment, and processing. Beyond the tests themselves, patient transport to/from facilities and sample transport (including, for some tests, across institutions, provinces, or countries) adds to the carbon footprint. Ordering providers need to consider the reliability and validity of prior results, as well as the patients' clinical evolution, when deciding whether repeat testing could be justified.

Because repeat testing may occur if test results performed elsewhere are not readily available, integrating electronic medical records across systems to facilitate rapid retrieval of external test results may curb redundant testing without contributing to providers' administrative burden. Within a single health system, testing algorithms could prevent inadvertent repeat testing.

11 Don't dispose of regular waste in a biohazardous waste container when performing joint aspirations or injections.

Joint aspirations and injections create biohazardous and non-biohazardous waste. Since biohazardous waste is incinerated before going to the landfill, it generates higher greenhouse gas emissions than other types of waste disposal. Avoid placing regular, non-biohazardous waste in biohazard/sharps containers to reduce unnecessary incineration and associated emissions.

How the list was created

Recommendations 1 – 5

The Canadian Rheumatology Association (CRA) established its Choosing Wisely Canada Top 5 recommendations using a multistage process combining consensus methodology and literature reviews. A steering committee solicited a group of practicing rheumatologists from across the country from diverse clinical settings and an allied health professional to form the CRA Choosing Wisely Canada committee. This group generated candidate recommendations using the Delphi method. Recommendations with high content agreement and perceived prevalence advanced to a survey of CRA members. CRA members ranked these top items based on content agreement, impact and item ranking. A methodology subcommittee discussed the items in light of their relevance to rheumatology, potential impact on patients and the member survey results. The Top 5 candidate items were selected to advance for literature review. The list was approved by the CRA Board of Directors and has been reviewed by a group of patient collaborators with rheumatic diseases. Patient collaborators also worked with the CRA to ensure the CRA Choosing Wisely Canada statements were translated into lay-language and made accessible to patients and the public.

Recommendations 6 & 7

Recommendation 6 was approved by the CRA board in September, 2019. The statement was created by the CRA Choosing Wisely subcommittee and was selected for having good evidence and for being frequently encountered by rheumatologists. The statement was then adjudicated by the CRA Guidelines committee and the CRA Board, and the statement was further modified for language by the group.

Recommendation 7 was approved by the CRA board in February, 2021. This statement was created by the CRA Choosing Wisely subcommittee in response to the Choosing Wisely Canada campaign about serious illness conversations entitled "Time to Talk." The subcommittee liaised with a palliative care doctor on the wording of the statement, given the scarcity of evidence in this area to date in rheumatology.

Recommendations 8 & 9

Recommendations 8 and 9 were approved by the CRA board in June, 2022. These items were identified from the paediatric rheumatology Choosing Wisely list as being frequently encountered problems by adult rheumatologists. A working group of the CRA Choosing Wisely subcommittee was formed, and they completed an updated literature review of the topic and developed their own statement. The statement was then adjudicated by the CRA Choosing Wisely subcommittee, the CRA Quality Care committee, and then the CRA Board of Directors. Modifications were made as needed.

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About The Canadian Rheumatology Association

The Canadian Rheumatology Association (CRA) is a proud partner of the Choosing Wisely Canada campaign. Made up of over 500 members, including just over 400 rheumatologists, the mission of the CRA is to promote the pursuit of excellence in arthritis care, education and research. The CRA strives to provide the best services and support to its membership to provide the best quality of care possible to patients. This includes an amazing lineup of topics and speakers for the Annual Scientific Meeting, a website full of information, programs to attract more medical students into rheumatology, awards to recognize its members, guidelines development, research funding opportunities and excellent working partnerships with other organizations.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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