EDITORS

Rheumatoid arthritis prevention: any takers?

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To have clinical impact, therapeutic approaches identified as being effective in reducing the risk of RA need to be acceptable to those at risk. Previous qualitative research has identified that individuals at risk of RA have concerns about taking ‘preventive’ medicines.11 In this issue of RMD Open, van Boheemen et al.8 report on the perspectives of individuals who had declined participation in, and also who had participated in, one of the two RA prevention trials: the STAmins to Prevent Rheumatoid Arthritis trial (RMD open to insert Ref) and the Arthritis Prevention In the Pre-clinical Phase of RA with Abatacept trial.8 Challenges to participant recruitment in trials of patients with seropositive arthralgia raise some important issues for the rheumatology research community to consider and reflect the importance of understanding the preferences of at-risk individuals about benefits and risks of interventions in relation to the disease they are at risk of.12

Direct perceptions about RA are often inaccurate: many do not perceive RA to be a serious disease, and some view it as an inevitable consequence of ageing.13,14 Individuals with these views may be less likely to accept preventive therapeutic interventions—this was certainly a theme identified by van Boheemen et al.8 Positive views about RA prediction and prevention are often associated with misperceptions around what being at ‘high risk’ means (eg, some interpret this to mean that they will definitely develop RA) and the likely benefit of ‘preventive’ therapy (eg, for some this means the therapy will definitely prevent them from developing RA).15–17 The development of effective communication tools around predictive testing, preventive interventions and RA itself is therefore essential to facilitate informed decision-making. Although predictive algorithms exist, they do not fully address issues around the time course of RA development or the likely severity of RA after it has developed, which are key considerations for decision-making about preventive therapy. Further research to facilitate comprehensive risk assessment for RA is an essential precursor to the development of effective preventive strategies for this condition.
of effective informational resources for individuals for whom preventive treatment may be appropriate.

Non-pharmacological interventions are preferred by some at-risk individuals, especially for those without symptoms (eg, autoantibody-positive individuals and those with genetic risk factors). Initial evidence suggests that personalised risk information about RA has a positive impact on behavioural intentions and risk-reducing behaviour, while providing reassurance to recipients. Although several ongoing studies are investigating pharmacological interventions to prevent arthritis development, no interventional trials of promoting behavioural interventions, particularly smoking cessation, to reduce risk of RA development and progression have been published. Investigation in this area is needed.

Preventive therapies for other conditions are well established in routine clinical practice; statins and anti-hypertensive medications are widely prescribed to reduce the risk of ischaemic heart disease and bisphosphonates to reduce the risk of fracture. Many entirely asymptomatic individuals with conditions such as hypercholesterolaemia, hypertension and osteoporosis accept such pharmacological therapies. Indeed, for these conditions, long-term, often lifelong, preventive treatment is both required and often accepted. As yet, no pharmacological treatments have been shown to reduce the risk of RA development in the medium to long term. However, this remains an active and important area of research. We need to learn from experiences in other chronic diseases and address the barriers identified by van Boheemen et al. that hinder the efficient development of preventive strategies for the management of RA. Endeavouring to overcome such barriers is likely to be worthwhile, given that a ‘preventive’ approach in RA has clear potential to reduce pain and disability as well as societal costs resulting from lost productivity and healthcare usage at huge scale.

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