Increased mortality in patients with RA-associated interstitial lung disease: data from a French administrative healthcare database

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ABSTRACT

Objectives Interstitial lung disease (ILD) is a severe extra-articular manifestation of rheumatoid arthritis (RA). The objectives of this study were to estimate mortality rate in patients with RA-ILD and identify factors affecting mortality.

Methods Data from a French national claims database (Système National des Données de Santé) from 2013 to 2018 were analysed. Adults with an RA diagnosis (International Classification of Diseases (ICD)-10 codes M05, M06.0, M06.8 and M06.9) were included. ILD diagnosis was defined with ICD-10 code J84. Mortality rates were compared between patients with RA with and without ILD, using Cox proportional hazards regression, after matching 1:1 for age, sex, age at RA-ILD onset and RA duration.

Results Among 173 132 patients with RA, 4330 (3%) also had ILD (RA-ILD). After matching, RA-ILD was associated with an increased mortality rate (HR 3.4, 95% CI 3.1 to 3.9). The HR for mortality was greater for: patients aged <75 years (HR 4.8, 95% CI 3.9 to 5.9) versus ≥75 years (HR 3.0, 95% CI 2.6 to 3.5); patients with ILD onset occurring before RA onset (HR 8.4, 95% CI 5.5 to 13.0) versus ILD onset occurring after RA onset (HR 2.9, 95% CI 2.6 to 3.3); and men (HR 5.2, 95% CI 4.4 to 6.2) versus women (HR 3.6, 95% CI 3.0 to 4.2).

Conclusion In this nationwide cohort study, RA-ILD was associated with increased mortality rate (vs in patients with RA without ILD), notably for those aged <75 years, those whose ILD preceded RA onset and men.

INTRODUCTION

Rheumatoid arthritis (RA) is a systemic inflammatory disease with an estimated global prevalence of 0.5% among adults.1 Extra-articular manifestations are observed in about 50% of patients with RA, with interstitial lung disease (ILD) being one of the most frequent.2 3 Frequency estimates of ILD among patients with RA (RA-ILD) vary considerably in the literature, from 2% to 50%.4-9 This variability is due to several factors, such as the lack of consensus regarding the definition of RA-ILD (ie, clinical vs subclinical ILD), heterogeneity of the tools used to assess ILD (eg, chest X-ray, high-resolution CT (HRCT), pulmonary function tests), heterogeneity of the RA population and different methodological approaches (ie, small cohort studies vs national healthcare database).

RA-ILD is a severe condition. ILD has been associated with a 2-fold to 10-fold increase in mortality in patients with RA; the median survival time for patients with RA-ILD ranges from 3 to 10 years.10-14 RA-ILD is a heterogeneous disease with various progression profiles. Progression of RA-ILD is observed in about half of all patients over a 4-year period, meaning that the other half maintains stable lung disease.15 16 Factors associated with mortality in patients with RA-ILD have been poorly investigated. Older age, higher RA...
disease activity, lower baseline diffusing capacity of carbon monoxide and lower forced vital capacity and some chest HRCT scan features (usual interstitial pneumonia pattern, presence of fibrotic features and extension of abnormalities) have been associated with an increased mortality in patients with RA-ILD. However, most of the studies dedicated to the evaluation of mortality in RA-ILD are small, retrospective case-control studies, thereby limiting interpretation of results.

Existing healthcare databases provide accessible, real-world observations that can be used to advance our current knowledge of RA-ILD. The objectives of this study were to estimate the prevalence, incidence and mortality in RA-ILD. The SNDS database includes: a claims database containing data from approximately 97% of the French population. The SNDS database includes: (1) data regarding diseases, discharges, diagnoses and disability status allowing full expenditure reimbursement, coded using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes, (2) mortality date and (3) medical treatment information made available from drug reimbursement. Investigators had access to patient records as defined by the patient population below. Data from 1 January 2013 to 31 December 2018 were included in the current analysis. No data cleaning methods were required.

**METHODS**

**Study design and data source**

This retrospective analysis used the Système National des Données de Santé (SNDS), a French national healthcare claims database containing data from approximately 97% of the French population. The SNDS database includes: (1) data regarding diseases, discharges, diagnoses and disability status allowing full expenditure reimbursement, coded using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes, (2) mortality date and (3) medical treatment information made available from drug reimbursement. Investigators had access to patient records as defined by the patient population below. Data from 1 January 2013 to 31 December 2018 were included in the current analysis. No data cleaning methods were required.

**Patient population**

Validated ICD-10-CM codes were used to identify patients in the SNDS database. Adults with an RA diagnosis (ICD-10-CM codes M05 (RA with rheumatoid factor), M06.0 (RA without rheumatoid factor), M06.8 (other specified RA) and M06.9 (RA unspecified)) and ≥2 distinct delivery dates of disease-modifying antirheumatic drugs (DMARDs) were included. DMARDs included were abatacept, adalimumab, anakinra, azathioprine, baricitinib, certolizumab pegol, cyclophosphamide, ciclosporin, etanercept, golimumab, hydroxychloroquine, infliximab, leflunomide, methotrexate (MTX), rituximab, sulfasalazine, tocilizumab and tofacitinib. Onset of RA was defined as the first date of occurrence between the two populations (RA-ILD and RA-noILD), the observation was deleted.

**Endpoints and assessments**

For the overall study population, demographic characteristics, prevalence of RA-ILD (2013–2018), incidence of RA-ILD (2014–2018) and mortality (2013–2018) were examined. Timing of ILD onset relative to RA diagnosis was assessed for patients with RA-ILD.

**Statistical analysis**

Descriptive statistics (mean (SD)) and proportions were used to describe the cohort. The prevalence and incidence of RA-ILD were estimated per 100 000 inhabitants and 100 000 person-years, respectively. Characteristics of patients with RA-ILD and patients with RA but without ILD (RA-noILD) were compared in a univariate analysis using a χ² test. Cox proportional hazards regression was used to estimate HRs and corresponding 95% CIs for mortality rate in the matched population. Mortality was evaluated according to age, sex and temporality of ILD onset, compared with RA onset. Sensitivity analyses were performed by estimating HRs after matching for diabetes, arterial disease, dyslipidaemia and cardiac disease, with p values determined by log rank test. To control for potential confounding, a subgroup of patients was matched 1:1 for age, sex, year of birth and duration of RA. If no match was possible between the two populations (RA-ILD and RA-noILD), the observation was deleted.

All statistical analyses were conducted using SAS-Guide V.9.4 software (Statistical Analysis System, Cary, North Carolina, USA).

**Patient and public involvement**

Given the retrospective nature of the current study, there was no patient or public involvement.

**RESULTS**

**Prevalence and incidence**

Of the 175 132 patients with RA included in the overall study population, 4330 (3%) met the criteria for RA-ILD. Overall, the prevalence of RA-ILD was 6.5 per 100 000 inhabitants and the incidence of RA-ILD was 1.0 per 100 000 person-years. Both the prevalence and incidence of RA-ILD were higher in women versus men and increased with age (online supplemental table 1).

**Baseline characteristics of patients with RA-ILD and RA-noILD**

Baseline population characteristics are stated in table 1. Compared with those with RA-noILD, the RA-ILD cohort had a higher proportion of men (40% vs 27%, respectively) and were older at RA diagnosis (mean (SD) age: 63.3±14 vs 56.9±13 years, respectively). Mean (SD) RA disease...
The mortality rate in patients with RA-ILD compared to RA-noILD was 7.67 per 100,000 inhabitants for patients aged ≥75 years (HR 3.0, 95% CI 2.6 to 3.5) (all p<0.001; online supplemental figure 1).

When comparing patients with RA-ILD versus patients with RA-noILD, the mortality rate was higher for patients aged <75 years (HR 4.8, 95% CI 3.9 to 5.9) than for patients aged ≥75 years (HR 3.0, 95% CI 2.6 to 3.5) (figure 2). Further, mortality rates were higher when the onset of ILD preceded RA onset (HR 8.4, 95% CI 5.5 to 13.0) compared with RA onset preceding ILD onset (HR 2.9, 95% CI 2.6 to 3.3) (figure 2). Higher rates for mortality were seen in both male and female patients with RA-ILD when compared with RA-noILD (male: HR 5.2, 95% CI 4.4 to 6.2; female: HR 3.6, 95% CI 3.0 to 4.2) (figure 2).

Treatment patterns and hospitalisations for matched patients with RA-ILD and RA-noILD

Annual treatment patterns and hospitalisations in patients with RA-ILD and RA-noILD are given in table 3. Overall, a lower proportion of patients with RA-ILD received MTX (33–35% vs 61–65% for RA-noILD), while a greater proportion received non-tumour necrosis factor

### Table 1: Patient characteristics before matching

<table>
<thead>
<tr>
<th>Comorbidities, n (%)</th>
<th>RA-noILD (n=168 182)</th>
<th>RA-ILD (n=4330)</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac disease</td>
<td>106 165 (63)</td>
<td>3678 (85)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Arterial disease</td>
<td>32 495 (19)</td>
<td>1644 (38)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Diabetes</td>
<td>21 084 (13)</td>
<td>926 (21)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Dyslipidaemia</td>
<td>55 267 (33)</td>
<td>1935 (45)</td>
<td>&lt;0.001†</td>
</tr>
</tbody>
</table>

*Bivariate analysis using χ² test.
†Bivariate analysis using Student’s t-test.
‡For patients with RA-ILD, this is the date when both RA and ILD diagnoses were assigned; for the matched RA cohort, this is the matching date.
ILD, interstitial lung disease; NS, not significant; RA, rheumatoid arthritis; RA-ILD, RA with ILD; RA-noILD, RA without ILD.

### Table 2: Patient characteristics after matching

<table>
<thead>
<tr>
<th>Comorbidities, n (%)</th>
<th>RA-noILD (n=4293)</th>
<th>RA-ILD (n=4293)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac disease</td>
<td>3131 (73)</td>
<td>3643 (85)</td>
</tr>
<tr>
<td>Arterial disease</td>
<td>1116 (26)</td>
<td>1630 (38)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>655 (15)</td>
<td>914 (21)</td>
</tr>
<tr>
<td>Dyslipidaemia</td>
<td>1761 (41)</td>
<td>1912 (45)</td>
</tr>
</tbody>
</table>

*For patients with RA-ILD, this is the date when both RA and ILD diagnoses were assigned; for the matched RA cohort, this is the matching date.
†There was a significantly higher proportion of patients with RA-ILD with cardiac disease, arterial disease, diabetes and dyslipidaemia compared with RA-noILD.
ILD, interstitial lung disease; NS, not significant; RA, rheumatoid arthritis; RA-ILD, RA with ILD; RA-noILD, RA without ILD.

Mortality rate in patients with RA-ILD

The mortality rate in patients with RA-ILD was 1.71 per 100,000 inhabitants. Over the study period, mortality rate increased with each ascending age group: 0.28 per 100,000 inhabitants for patients aged <65 years, 4.60 per 100,000 inhabitants for patients aged 65–74 years and 11.4 per 100,000 inhabitants for patients aged ≥75 years. Before matching, between-group HR risk of mortality was higher in patients with RA-ILD than in those with RA-noILD (HR 3.4, 95% CI 3.2 to 3.6).

Within the matched subset, the adjusted HR for mortality (HR 3.4, 95% CI 3.1 to 3.9) was threefold greater in patients with RA-ILD than in patients with RA-noILD (figure 1). Sensitivity analyses also illustrated a higher risk of mortality for patients with RA-ILD compared with RA-noILD when matching for arterial disease (HR 2.6, 95% CI 2.3 to 3.0), cardiac disease (HR 3.3, 95% CI 2.9 to 3.7), diabetes (HR 3.1, 95% CI 2.5 to 3.9) and dyslipidaemia (HR 3.0, 95% CI 2.6 to 3.5) (all p<0.001; online supplemental figure 1).
inhibitor (TNFi) biological DMARDs (23–28% vs 6–11% for RA-noILD) and corticosteroids (77–82% vs 61–65% for RA-noILD). Lastly, a larger proportion of patients with RA-ILD were hospitalised compared with patients with RA-noILD (79–98% vs 33–43%, respectively).

**DISCUSSION**

In this large French population-based epidemiological study, RA-ILD was diagnosed in 3% of patients with RA, had a prevalence of 6.5 per 100 000 inhabitants and was associated with a threefold greater HR for mortality than patients with RA-noILD. Increased mortality was more pronounced in patients aged <75 years, patients who developed ILD prior to RA onset and in male patients.

Previous estimates for the prevalence of clinical RA-ILD vary considerably.5–9 Such variation is notably due to methodological differences between studies. The estimate of clinical RA-ILD from the present study (3%; n=4330/173 132) was toward the lower end of previous estimates, 100 80 60 40 20 0 0 500 1000 1500 2000 Time (days) Survival probability (%) Figure 1 Survival in patients with RA-ILD versus RA-noILD in the matched population. ILD, interstitial lung disease; RA, rheumatoid arthritis; RA-ILD, RA with ILD; RA-noILD, RA without ILD.

Figure 2 Forest plot showing HR for mortality in patients with RA-ILD compared with patients with RA-noILD. ILD, interstitial lung disease; RA, rheumatoid arthritis; RA-ILD, RA with ILD; RA-noILD, RA without ILD.

Table 3 Comparison of annual treatment patterns and hospitalisations between patients with RA-noILD and patients with RA-ILD in the matched population

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of treatment</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA-NoILD</td>
<td>Non-MTX csDMARD</td>
<td>19</td>
<td>35</td>
<td>19</td>
<td>33</td>
<td>19</td>
<td>34</td>
</tr>
<tr>
<td>RA-ILD</td>
<td>Non-MTX csDMARD</td>
<td>33</td>
<td>65</td>
<td>39</td>
<td>63</td>
<td>34</td>
<td>61</td>
</tr>
<tr>
<td>RA-NoILD</td>
<td>MTX</td>
<td>65</td>
<td>33</td>
<td>65</td>
<td>35</td>
<td>65</td>
<td>34</td>
</tr>
<tr>
<td>RA-ILD</td>
<td>MTX</td>
<td>16</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>RA-NoILD</td>
<td>TNF</td>
<td>16</td>
<td>8</td>
<td>16</td>
<td>9</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>RA-ILD</td>
<td>TNF</td>
<td>24</td>
<td>9</td>
<td>23</td>
<td>9</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>RA-NoILD</td>
<td>Other bDMARD</td>
<td>6</td>
<td>24</td>
<td>8</td>
<td>23</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>RA-ILD</td>
<td>Other bDMARD</td>
<td>6</td>
<td>24</td>
<td>8</td>
<td>23</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>RA-NoILD</td>
<td>tsDMARD*</td>
<td>88</td>
<td>88</td>
<td>88</td>
<td>88</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>RA-ILD</td>
<td>tsDMARD*</td>
<td>88</td>
<td>78</td>
<td>88</td>
<td>78</td>
<td>88</td>
<td>78</td>
</tr>
<tr>
<td>RA-NoILD</td>
<td>All DMARDs</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>RA-ILD</td>
<td>All DMARDs</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
</tr>
</tbody>
</table>

Data are presented as percentages unless noted otherwise. Percentages do not add up to 100 because patients could be in more than one category.
which is similar to what was found in a recent Danish national healthcare database study and other American health insurance registry studies. Variation among previous estimates using administrative claims to identify patients with RA-ILD is by definition limited to the population of patients meeting the criteria for clinically significant ILD, and concomitantly excludes patients with subclinical RA-ILD. Nonetheless, this approach may be relevant to evaluate the disease burden of RA-ILD, as it considers the most significant cases of ILD.

In previous decades, progress in RA treatment led to a decrease in mortality due to comorbidities, such as cardiovascular events, in patients with RA. However, in a recent American epidemiological study, while RA-related overall mortality rates decreased from 2005 to 2018, RA-ILD-related mortality rates remained stable over the same period, suggesting that improvement of overall outcomes in RA had limited effect in patients with RA-ILD. The increased mortality rate observed in our study is supported by other healthcare claims database analyses showing significantly increased mortality rates in these patients. However, we did have some novel findings. In the current study, the difference in mortality rate between patients with RA-ILD and those with RA-noILD was greatest in patients aged <75 years, in patients being more susceptible to RA-ILD. The increased mortality rate observed in our study is supported by other healthcare claims database analyses showing significantly increased mortality rates in these patients. However, we did have some novel findings. In the current study, the difference in mortality rate between patients with RA-ILD and those with RA-noILD was greatest in patients aged <75 years, in patients being more susceptible to RA-ILD. The increased mortality rate observed in our study is supported by other healthcare claims database analyses showing significantly increased mortality rates in these patients.

Second, the absence of information about HRCT pattern data did not allow for detailed analyses identifying potential characteristics specific to a given RA-ILD pattern. Third, the limited period of analysis (January 2013 to December 2018) did not enable comparative analyses over time. Additionally, data not collected by the SNDS database, such as smoking status, limited the ability to examine alternative variables that may impact mortality rates among patients with RA-ILD. Last, the treatment modalities reported herein reflect everyday clinical practice in France and may not be generalisable to other countries. However, the current study contained notable strengths, such as the size of the overall cohort, which comprised nearly all of the French population. Additionally, congruent with previous work, we used validated diagnostic codes for both RA and ILD stratification, reinforcing the reliability of our findings.

In conclusion, this is the largest European epidemiological study of RA-ILD, highlighting the burden of RA-ILD. Patients with RA-ILD had a threefold increase in mortality rate compared with those with RA-noILD. Higher mortality rates were more evident in patients aged <75 years, patients who developed ILD prior to RA diagnosis and in male patients. The presence of ILD influenced the choice of RA treatment, highlighting the need for international guidelines for management of RA in patients with RA-ILD.

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**To date, an important unmet need in RA-ILD management is the lack of international guidelines regarding how patients with RA-ILD should be treated. Our study revealed differences in RA treatments according to ILD status. Indeed, patients with RA-ILD were less likely to be prescribed MTX and more likely to receive non-TNFi biological DMARDs than those with RA-noILD. These findings align with the perception that some DMARDs, notably MTX, may exert a potentially harmful impact on patients with RA-ILD.**

Regarding MTX, this perception contradicts recent evidence demonstrating the lack of contribution of MTX to RA-ILD occurrence and progression. Besides, recent studies have identified an association between high RA disease activity and mortality in patients with RA-ILD, meaning that inappropriate cessation of the recommended first-line DMD could strongly impact prognosis in such patients. Nevertheless, future studies identifying how specific treatments may affect mortality rates among patients with RA-ILD will better inform clinical decision-making for these patients.

This current study has limitations. First, a healthcare claims database is not adequate to assess preclinical RA-ILD, leading to a potential misclassification bias. Second, the absence of information about HRCT pattern data did not allow for detailed analyses identifying potential characteristics specific to a given RA-ILD pattern. Third, the limited period of analysis (January 2013 to December 2018) did not enable comparative analyses over time. Additionally, data not collected by the SNDS database, such as smoking status, limited the ability to examine alternative variables that may impact mortality rates among patients with RA-ILD. Last, the treatment modalities reported herein reflect everyday clinical practice in France and may not be generalisable to other countries. However, the current study contained notable strengths, such as the size of the overall cohort, which comprised nearly all of the French population. Additionally, congruent with previous work, we used validated diagnostic codes for both RA and ILD stratification, reinforcing the reliability of our findings.
**References**


