How can you encourage medicines optimisation for patients with rheumatoid arthritis?

*In this article, **Geraldine Flavell** complements the material in the medicines optimisation briefing on rheumatoid arthritis (RA).*

These briefings have been developed for pharmacists and pharmacy teams working in England and Wales

Medicines optimisation is all about supporting patients so that they get the best possible outcomes from their medicines. It means using effective consultation skills (see: **www.consultationskillsforpharmacy.com**) in talking and engaging with individuals to understand their beliefs and concerns about their medicines and what they would like their medicine to achieve. It also involves ensuring that the medicine chosen for the patient is clinically appropriate, safe, effective and will help them to achieve their goals. It is about supporting the patient to continue to use their medicines in a way that fits with their lifestyle.

The medicines optimisation briefings we have produced are for pharmacy professionals working in all sectors of healthcare. We believe that, as experts in medicines and their use, pharmacy professionals are well placed to support patients to get the best outcomes from their medicines.

Medicines for rheumatoid arthritis

The briefing distributed with this week's issue of *The Pharmaceutical Journal* focuses on medicines that are used for rheumatoid arthritis. This is the first in a series of briefings that complement and build on each other. The content is not intended to be exhaustive; the aim is to improve your approach to and understanding of patients who have rheumatoid arthritis.

Rheumatoid arthritis (RA) is a long-term, auto-immune condition for which there is no cure, but which can be managed by medicines and lifestyle changes. RA is a systemic disease affecting not just joints, but also other body systems including the eyes and lungs. Dry eye is commonly experienced and can be treated symptomatically. Rheumatologists often order chest X-rays at diagnosis of RA for a baseline and before prescribing biological medicines (often referred to as anti-TNF medicines), to rule out tuberculosis.

Patients with RA may have other conditions, such as depression, cardiovascular disease, diabetes or osteoporosis, and be taking other medicines so pharmacy professionals need to watch out for and question the patient about any possible interactions.

Pharmacy professionals should ensure that they and their RA patients keep a complete patient medication record (PMR), that includes all over-the-counter, hospital only and homecare service medicines, to help advise on drug interactions and side effects.

Pharmacy professionals can be involved in helping a young person make the transition from supported child to independent adult with RA, by discussing medication and management of their RA.

Patients should be encouraged to manage their RA by recognising symptoms which may indicate the onset of a flare-up and by optimising their own pain relief. They need to take their medicines even when they are in remission and even on good days they need to pace themselves and not overdo things. They should attend their monitoring appointments, know their disease activity score, or DAS28 (see box) and learn to recognise when they need to seek advice. Disease modifying anti-rheumatic drugs (DMARDs) and biological medicines can make their lives much better, so patients should be reassured so as not to be anxious about taking any of these medicines. They should not seek to diminish the impact of their disease on their lives or underplay their pain or stiffness as this will minimise DAS28 which can affect decisions about therapies, dosage and medicine use.

Patients may be worried about having to take medicines for the rest of their life, but reassure them that with the appropriate RA medicines, they can live a much better life than without and the risk of irreversible joint damage is significantly reduced.

Their annual review is not just to monitor their joints – RA is a systemic disease and the doctor or specialist nurse needs to check that their eyes, lungs and cardiovascular health are not compromised by the disease.

Disease Activity Score in 28 Joints (DAS28)

DAS28 measures:
- pain and swelling in 28 joints
- a 1-10 scale patient assessment of pain and disease activity
- how many minutes of joint stiffness in the morning
- erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) blood test results.

These are all computed to reach a DAS28 score: greater than 5.1 signifies active to severe disease, less than 3.2 indicates moderate to low disease activity, 2.6 or less is considered clinical remission.

Things to think about when talking with patients about their medicines for rheumatoid arthritis

There are many things to think about when talking to patients about medicines for rheumatoid arthritis. Pharmacy professionals should check and add to what the prescriber has said:

- Is a new medicine instead of, or more likely in addition to, their existing medicines? For example, methotrexate enhances the effects of biological medicines and protects against auto-antibodies which render them ineffective. Two or more DMARDs are usually better than one.
- Folic acid should be prescribed with oral methotrexate.
- Are they taking any other medicines from the hospital, prescribed by the GP, borrowed from a relative or friend or bought over-the-counter?
- When should they expect a new drug to start working (by six months for a biological medicine), how will they know it is working and who will they contact if they think it is not working?

- If the patient notices that symptoms are getting worse, they may be having a flare-up of the disease. Sometimes flares resolve themselves within a couple of weeks, during this time they should be advised to rest as much as possible, get enough sleep and manage their pain relief adequately. If the flare does not resolve in two weeks, they should contact the rheumatology team for advice. A systemic steroid depot injection or directly into a specific joint may be appropriate.
- Patients should not stop their medicines just because they feel better. They need to continue taking them and manage their pain relief adequately.
- Help patients access their medicines by using easy-open caps, popping blister packs for them or supplying or signposting them to aids to meet their needs.
- Pharmacy professionals should make sure they have supplies of up-to-date steroid cards and methotrexate dosing booklets. If the patient is on a biological therapy they should always carry a **biological therapy alert card**.
- Make sure the patient knows when their medicines will be reviewed and by whom – add contact details names of specialist nurse, GP or consultant to their PMR.

Tips

Tips for pharmacy professionals to support patients with rheumatoid arthritis include:

Starting medication

- Agree with patients on a shared agenda – if they want to feel better, they have a responsibility to take the medicines that have been prescribed and adhere to the other therapies recommended eg, exercise or dietary management.
- Methotrexate is the gold standard treatment for RA and, if tolerated, they are likely to be taking it for the rest of their life, whatever else the rheumatologist or GP may also prescribe. You should remind them that the dose is weekly and add the day of dosing to the label. A simple reminder might be methotrexate Monday and folic acid Friday. Can they tell the difference between them?
- Patients sometimes worry that DMARDs and biological medicines are toxic. Point out that they are toxic to the RA not to the patient, providing they take sensible precautions; these medicines have the potential to make their lives much better, but they do have to be taken or used as prescribed to have an effect. These medicines are monitored carefully and action taken if blood results show any abnormalities or cause for concern.
- Patients should have been supported to learn how to self-inject their drugs if this is how they are administered (eg, methotrexate and some biological medicines are in syringes or auto-injector pens) – check that they feel confident and encourage them to contact their supplier or rheumatology nurse/ helpline if not. Check that they have a sharps bin and they know how to dispose of it.
- If taking paracetamol (alone or in combination), take 4 g per day, not less.
- Both men and women taking DMARDs need to use effective contraception and to discuss if they wish to start a family with their specialist nurse and/ or consultant as some DMARDs may require a 'wash out' period before a child is conceived/fathered.

- Encourage patients to keep an eye on their own disease between monitoring appointments. Help them to recognise what their body is telling them – is the RA better or worse today? Keeping a pain/fatigue diary can help.
- Do patients need a home visit to check what help they need to open and take their medicines?
- Encourage pneumonia and annual flu vaccinations.
- Signpost to, and learn from, local patient groups such as those organised by NRAS or Arthritis Care.
- If a patient is commencing biological therapy for their RA ensure they have a biological therapy alert card.

Side-effects and talking to people about them

- As usual, carry out private consultations in your consultation area.
- Let patients know what side effects may occur, how long they are expected to last for and what they can do to minimise their effects.
- Ensure that proton pump inhibitors (PPIs) are prescribed for patients taking NSAIDs.
- Warn patients that sulfasalazine turns urine and tears orange.
- If the patient is taking complementary therapies see: **www.arthritisresearchuk.org/arthritis-information/complementary-and-alternative-medicines/complementary-therapies.aspx**
- Patients should STOP methotrexate and biological medicines if they have a sore throat, a cold or any other signs of infection and RESTART when they feel better.
- They should STOP methotrexate, other DMARDs and biological medicines if they get the red flag signs: shortness of breath, unexplained bruising, blurred vision or uncontrolled diarrhoea and vomiting and consult their GP, consultant or specialist nurse immediately.
- Advise patients to let you know if side-effects last longer or are worse than they expected.

Lifestyle

- Talk to patients about whether their medicines fit in with their daily routine. If not, encourage patients to talk to you about this and the possible alternatives rather than stopping their medicines eg, if taking a medicine makes them feel sick or fatigued perhaps taking before retiring to bed may be a better approach.
- Ask patients if they smoke; stopping smoking is the most effective change a patient with rheumatoid arthritis can make to significantly improve their health as well as the effectiveness of their medications. Offer patients smoking cessation advice when they are ready for it and signpost them to support groups. Have 'quit kits' ready for when they are needed.
- Advise patients to drink very little alcohol (less than recommended levels) when taking methotrexate.
- Advise weight control aiming for a BMI of 25 or less.
- Exercise and keeping joints mobile is key. Even gentle exercise makes a difference. Swimming, yoga, pilates and tai chi are all recommended for RA.

- Patients can still enjoy sex see: **www.nras.org.uk/publications/emotions-relationships-and-sexuality**
- If patients plan to travel, give guidance on travel medicine and vaccines and advise on medicines carrying and storage (see separate box) – will they have access to a fridge?
- In their hand luggage they should carry medicines in a cool box with a letter from their rheumatologist explaining why.
- Injections can be delayed by one day per week to allow for situations such as camping trips where there is no fridge, but see below as times left out of the fridge can vary.
- Encourage patients to consult you before buying or trying complementary therapies, as 'natural' or herbal supplements may interact with prescribed medicines as well as have their own side-effects.
- Find out about local initiatives and projects for patients with rheumatoid arthritis, such as swimming or exercise prescriptions. Do you know how patients can access these and who is eligible?

Storage of biological medicines

Five biological (anti-TNF) RA medicines may be self-administered subcutaneously. They should be stored in a refrigerator at 2-8°C.

Etanercept (Enbrel®) may be stored at temperatures up to a maximum of 25°C for a single period of up to four weeks, after which it should not be refrigerated again. Any remainder should be discarded if not used within four weeks of removal from refrigeration.

A single adalimumab (Humira®) pre-filled syringe/pen may be stored at temperatures up to a maximum of 25°C for a period of up to 14 days. The syringe/pen must be protected from light, and discarded if not used within the 14-day period.

In exceptional circumstances, if certolizumab (Cimzia®) injection has been left out of the fridge and been stored at a temperature not exceeding 25°C (+/- 2°C), the injection may only be used for up to 24 hours after leaving the fridge.

Golimumab (Simponi®) may be left out of the fridge (at temperatures of 10-20°C) without detriment for up to one week. This reduces to no more than one day for temperatures of 20-25°C.

Abatacept (Orencia®) is stable for up to eight hours if left out of the fridge provided that it has been kept in normal light and at a temperature not exceeding 25°C.

For further information, refer to the UKMI Fridge Database: **www.ukmi.nhs.uk/applications/fridge/** (password required).

Case studies

Rani
Rani presents for his MUR and tells you that he has been prescribed etanercept 50 mg weekly which has been supplied by a home delivery company. He is also taking methotrexate. Checking the PMR, you notice that he has received several courses of antibiotics over the last few months. Rani complains that he keeps getting urinary tract infections (UTIs). On questioning, Rani tells you that he has continued to take both the methotrexate and the etanercept during these infections. You point out that he should be advised to stop both medicines on any sign of infection (a cold, sore throat, chills, UTI etc). This is to allow the body to deal with the infection without the immunosuppressant effect of the RA medicines. Rani can restart his RA medicines when he is feeling better. Although it may take a couple of weeks to get the RA back under control, the UTI is less likely to recur.

Jana
You are a primary care pharmacist working in a GP practice, conducting an audit of patients on 'high risk medication' (including methotrexate) to see if patients are managed in line with local shared care protocols. You check that all doses are prescribed weekly and that blood tests are done at the right frequency and that results are documented in the patient-held booklet and acted upon if abnormal. Jana is a 53 year old patient with RA taking 15 mg methotrexate weekly (no folic acid). When you check her repeat medications it is apparent that Jana takes cyclical courses of trimethoprim 200 mg twice daily for one week alternating with cefalexin 500 mg twice daily for one week. The patient records indicate that Jana has been initiated on these cyclical antibiotics by a consultant urologist as she has suffered from recurrent UTIs. The urologist does not appear to be aware that Jana is taking weekly methotrexate as there is no acknowledgement of this in any correspondence with the GP. Jana's GP surgery is a dispensing practice and this high risk combination of methotrexate and trimethoprim (increased risk of haematological toxicity) has not been flagged up with the prescribing GP. You alert the GP and the trimethoprim is immediately stopped and removed from Jana's repeat medication list. A record is made on Jana's medication screen that trimethoprim must be avoided in future. The GP contacts the urologist who decides to adopt a 'watch and wait' approach for the treatment of future UTIs.

You can make a difference by supporting your patients – don't assume someone else has already done your job for you.

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